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Prior to adoption and gubernatorial/legislative review of a proposed PERMANENT rulemaking action, an agency must publish a Notice of Rulemaking Intent in the Register. In addition, an agency may publish a Notice of Rulemaking Intent in the Register prior to adoption of a proposed EMERGENCY or PREEMPTIVE rulemaking action.

A Notice of Rulemaking Intent announces a comment period, or a comment period and public hearing, and provides other information about the intended rulemaking action as required by law, including where copies of proposed rules may be obtained. For additional information on Notices of Rulemaking Intent, see 75 O.S., Section 303.

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

[OAR Docket #21-702]

RULEMAKING ACTION:
Notice of proposed PERMANENT rulemaking

PROPOSED RULES:
252:410-1-7. Incorporation of federal regulations by reference [AMENDED]
Subchapter 5. Certification of Industrial Radiographers
252:410-5-5. Out-of-State certification: Reciprocity recognition [AMENDED]
Subchapter 7. Radiation Management Authorizations; Procedures and Requirements
Part 1. General Provisions Common to All Authorizations
252:410-7-1. Radiation management authorizations in general [AMENDED]
252:410-7-5. Authorization transfers [AMENDED]
Part 3. Reciprocity Recognition
252:410-7-31. DEQ reciprocity recognition [AMENDED]
Subchapter 10. Radioactive Materials Program
Part 37. Physical Protection of Category 1 and Category 2 Quantities of Radioactive Material
252:410-10-37. 10 CFR 37 Incorporations by reference [AMENDED]
Part 71. Packaging and Transporting Radioactive Material
252:410-10-71. 10 CFR 71 Incorporations by reference [AMENDED]

SUMMARY:
The proposed rulemaking consists of four main elements:
(1) The first element is to amend Chapter 410, Subchapter 1 (General Provisions) [See OAC 252:410-1-7(a) and (b)] to change the date for incorporation of federal regulations by reference to January 1, 2021 for 10 CFR and July 1, 2020 for 40 CFR. (2) The second element of this rulemaking is to amend the regulations related to the industrial radiography certification. All industrial radiography certification requests for active-duty military personnel and their spouse will be processed pursuant to 59 O.S. § 4100.8. (3) The third element is to remove references to revoked Subchapter 19. (4) The fourth element is to clarify communication requirements in 252:410-10-37 and 252:410-10-71.

The gist of this rulemaking is to maintain compatibility with federal regulations and meet the requirements of 59 O.S. § 4100.8. This rulemaking also completes the rule review directed by the Governor.

AUTHORITY:
Environmental Quality Board; 27A O.S. §§ 2-2-101, and 2-2-104.
Radiation Management Advisory Council; 27A O.S. § 2-2-201.
Radiation Management Act; 27A O.S. §§ 2-9-104, and 2-9-105.

COMMENT PERIOD:
Written comments on the proposed rules may be submitted to the contact person from August 16, 2021 through September 29, 2021. Oral comments may be made at the Radiation Management Advisory Council meeting at 10:00 a.m. on September 30, 2021 and at the Environmental Quality Board meeting at 9:30 a.m. on November 9, 2021.

PUBLIC HEARINGS:
Before the Radiation Management Advisory Council at 9:00 a.m. on September 30, 2021, at the DEQ Headquarters, located at 707 North Robinson, Oklahoma City, OK 73102.

If the Council recommends adoption, the proposed rules will be considered by the Environmental Quality Board at 9:30 a.m. on Tuesday, November 9, 2021, at Tri-County Tech, 6101 SE Nowata Road, Bartlesville, OK, 74006.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:
The Department requests that business entities affected by these proposed rules provide the Department, within the comment period and in dollar amounts if possible, the increase or decrease in the level of direct costs such as fees, and the indirect costs such as reporting, record keeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rules.

COPIES OF PROPOSED RULES:
Copies of the proposed rules may be obtained from the contact person, may be viewed on the DEQ website at www.deq.ok.gov/land-protection-division/land-protection-division-proposed-rules/, or may be reviewed at the Department of Environmental Quality, 707 N. Robinson, Oklahoma City, Oklahoma 73102.

RULE IMPACT STATEMENT:
The Rule Impact Statement for the proposed rules will be on file at the Department of Environmental Quality and may be requested from the contact person, or viewed on the DEQ website at www.deq.ok.gov/land-protection-division/land-protection-division-proposed-rules/.
NOTICES OF RULEMAKING INTENT

CONTACT PERSON:

Mike Broderick, Environmental Programs Manager, Land Protection Division, Radiation Management Section, may be reached by phone at (405) 702-5100 or fax at (405) 702-5101. Please email written comments to mike.broderick@deq.ok.gov. Mail should be addressed to Department of Environmental Quality, Radiation Management Section, P.O. Box 1677, Oklahoma City, OK 73101-1677.

ADDITIONAL INFORMATION:

Persons with disabilities who desire to attend the public hearing and need assistance should notify the contact person three days in advance of the meeting during business hours at 405-702-5100 or by using TDD relay number 1-800-522-8506.

OAR Docket #21-702; filed 7-21-21
Upon disapproval by the Legislature of an agency’s rules, the agency must publish a notice of such legislative disapproval in the
Register.
For additional information on legislative disapprovals, see 75 O.S., Sections 308 and 308.3.

TITLE 725. OKLAHOMA TOURISM AND
RECREATION DEPARTMENT
CHAPTER 30. DIVISION OF STATE PARKS

[OAR Docket #21-683]

RULEMAKING ACTION:
Legislative disapproval of Permanent rules

RULES:
Subchapter 4. Public Use and Recreation

725:30-4-4 [AMENDED]

LEGISLATIVE DISAPPROVAL:
This rule was disapproved by the Legislature on June 11, 2021 by HJR 1046.

[OAR Docket #21-683; filed 7-9-21]
"If an agency finds that a rule is necessary as an emergency measure, the rule may be promulgated" if the Governor approves the rules after determining "that the rule is necessary as an emergency measure to do any of the following:

- protect the public health, safety or welfare,
- comply with deadlines in amendments to an agency’s governing law or federal programs,
- avoid violation of federal law or regulation or other state law,
- avoid imminent reduction to the agency’s budget, or
- avoid serious prejudice to the public interest." [75 O.S., Section 253(A)]

An emergency rule is considered promulgated immediately upon approval by the Governor, and effective immediately upon the Governor’s approval or a later date specified by the agency in the emergency rule document. An emergency rule expires on September 15 following the next regular legislative session after its 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 cites to 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.

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**TITLE 150. OKLAHOMA DEPARTMENT OF COMMERCE**

**CHAPTER 65. OKLAHOMA QUALITY JOBS PROGRAM**

[OAR Docket #21-700]

**RULEMAKING ACTION:**
EMERGENCY adoption

**RULES:**
Subchapter 13. Oklahoma Remote Quality Jobs Incentive Act [NEW]
150:65-13-1. Purpose [NEW]
150:65-13-2. Definitions [NEW]
150:65-13-3. Eligible entities [NEW]
150:65-13-5. Cost/benefit analysis; limitation of benefit [NEW]
150:65-13-6. Incentive contract [NEW]

**AUTHORITY:**
Oklahoma Department of Commerce; 68 O.S. §4508

**ADOPTION:**
July 1, 2021

**EFFECTIVE:**
Immediately upon Governor's approval

**APPROVED BY GOVERNOR:**
July 19, 2021

**EXPIRATION:**
Effective through September 14, 2022, unless superseded by another rule or disapproved by the Legislature

**SUPERSEDED EMERGENCY ACTIONS:**
n/a

**INCORPORATIONS BY REFERENCE:**
n/a

**FINDING OF EMERGENCY:**
This rule is necessary because a compelling public interest requires an emergency rule and imminent peril exists to the preservation of public welfare. Adoption of these rules is necessary to provide an application process and provide guidelines for establishments that recruit highly skilled workers working in quality jobs to the State. Failure to approve the emergency rules would leave the program inactive until permanent rules could be approved next legislative session. This would cause these jobs not to relocate to the state, which would damage efforts to improve the Oklahoma workforce and reduce state revenues in the form of income tax.

**GIST/ANALYSIS:**
This action establishes the application process for the Oklahoma Remote Quality Jobs Incentive Act. It also provides criteria for receipt of the incentive and provides clarity and transparency as to how a proxy establishment who recruits highly skilled workers performing highly paid quality jobs to the state.

**CONTACT PERSON:**
B. Joshua McGoldrick, General Counsel and Chief of Staff, Oklahoma Department of Commerce, 900 N. Stiles Avenue, Oklahoma City, OK, 73104, 405-815-5153, josh.mcgoldrick@okcommerce.gov

**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(F):**

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**SUBCHAPTER 13. OKLAHOMA REMOTE QUALITY JOBS INCENTIVE ACT**

**150:65-13-1. Purpose**
The purpose of these rules is to implement the Oklahoma Remote Quality Jobs Incentive Act established in 68 O.S. §4501 et. seq.

**150:65-13-2. Definitions**
For purposes of this subchapter, the following words and terms have the following meaning unless the context clearly indicates otherwise:

"Application date" means the date on which the proxy establishment's application is first received and stamped by a Remote Quality Jobs representative at the Oklahoma Department of Commerce.

"Approval date" means the date on which the Executive Director of the Department of Commerce issues the offer to a proxy establishment to receive benefits pursuant to the Oklahoma Remote Quality Jobs program. If the Director issues an offer to a proxy establishment, the Application Date as defined in these rules will be considered the Approval Date for purposes of the act.

"Commission" means the Oklahoma Tax Commission and any successor agencies thereto.

"Department" means the Oklahoma Department of Commerce and any successor agencies thereto.

"Director" means the Executive Director of the Oklahoma Department of Commerce.

"Effective date" means the date that the signed and accepted incentive contract is received by the Department. An approved project may have an Effective Date which is different than the Start Date.
"Qualifying basic health benefits plan" means a health benefits plan providing coverage for basic hospital care, physician care, mental health care, substance abuse treatment, prescription drugs and prenatal care where not more than fifty percent (50%) of the cost of the premium is paid by the remote worker. Services provided by an Employee Assistance Plan (EAP) are not sufficient to meet this definition. "Remote Quality Jobs Program" or "Act", means the Oklahoma Remote Quality Jobs Incentive Act. "Remote quality jobs representative" means the Department professional, trained in the Remote Quality Jobs Program, who is so designated by the Executive Director, and whose responsibilities include direct contact with applicants and clients, analysis of data, initiation of project proposals, preparation of project profiles and preparation of incentive offers. "Remote worker" means as defined in 68 O.S. §4503. The twelve (12) month period referred to in the statutory definition refers to the twelve (12) month period immediately preceding the approval date of the incentive agreement. "Start date" means the date on which a proxy establishment may begin accruing benefits for the creation of new direct jobs. This date is set by agreement and is not more than twenty-four (24) months from the Application Date.

150:65-13-3. Eligible entities
(a) A proxy establishment may receive quarterly payments for a ten-quarter period if they facilitate the attraction of remote workers to the State of Oklahoma.
(b) A proxy establishment may be deemed to "facilitate the attraction of remote workers to the State of Oklahoma" if they participate in all of the following activities:
   (1) Engage in marketing designed to attract qualifying remote workers to relocate to a location within the State of Oklahoma;
   (2) Facilitate visits and tours, either virtually or in person, for prospective qualifying remote workers to become familiar with the benefits of relocating to the State of Oklahoma; and
   (3) Provide a monetary incentive to a qualifying remote worker or his/her assignee to relocate to a location within the State of Oklahoma payable in full or in part upon and/or within a year of their relocation to Oklahoma.

150:65-13-4. Application
(a) An eligible proxy establishment may obtain an application for acceptance into the Remote Quality Jobs program from the Department. Upon completion of all information submitted as part of the application, the Director will determine whether an applicant is qualified to receive incentive payments under the Program.
(b) To apply, a qualified proxy establishment may submit an application for participation in the Remote Quality Jobs program to the Department.
(c) As part of the Application, the proxy establishment is responsible for supplying all of the following information:
   (1) The proposed Start Date of the contract.
   (2) The number of new direct jobs to be included as part of the contract.
   (3) The yearly average salary of the Remote Workers hired in the new direct jobs.
   (4) Proof of a Qualifying Basic Health Benefits Plan for each Remote Worker to be covered by the contract.
   (5) The name of each Remote Worker to be included in the contract.
   (6) The name of the current employer of each Remote Worker to be covered by the contract.
   (7) The amount of the direct monetary incentive to be paid out by the proxy establishment to each Remote Worker the proxy establishment intends to claim under the contract.
   (8) Any other information or documentation deemed relevant by the Department to ensure the project meets statutory criteria.
(d) A proxy establishment may submit the information set forth above at any time between the Application Date until sixty (60) days prior to the Start Date of the contract.
(e) A proxy establishment that is receiving incentive payments pursuant to the Remote Quality Jobs Program cannot apply for additional incentive payments for any new projects unless and until either:
   (1) the establishment's actual verified annual gross payroll for new direct jobs under the establishments existing contracts has met the statutory criteria as set out in Section 4504 of Title 68 of the Oklahoma Statutes for one (1) calendar quarter or
   (2) the annual projected payroll for each of the proxy establishment's existing contracts under the act exceeds the mandatory annual gross payroll set forth in 68 O.S. §4504(B) and no less than nine (9) months have passed since the Application Date for the proxy establishment's most recent existing contract.

150:65-13-5. Cost/benefit analysis; limitation of benefit
In conducting the cost/benefit analysis to determine the net benefit rate, the Department will consider the following factors:
(1) The estimated direct state benefits including, but not limited to, the anticipated level of new tax revenues to the state.
(2) The estimated direct state costs including, but not limited to, the added cost to the state of providing services.
(3) The payments to be made by the proxy establishment to Remote Workers covered by the contract within a year of relocation to Oklahoma.
(4) Any other factor deemed relevant by the Department.

150:65-13-6. Incentive contract
(a) After an incentive contract is recommended by the Department, the contract will be prepared for the Director's review and signature. The signed document will then be forwarded
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to the proxy establishment. The tendered contract may be accepted by the proxy establishment within sixty (60) days of the date of signing by the Director, unless the Director extends this period at the establishment’s request.

(b) The incentive contract will be on a form prescribed by the Department which includes all of the following information:

(1) The net benefit rate which will be multiplied by verified gross quarterly payroll of the Remote Workers to determine the amount of quarterly payments;

(2) The maximum amount of benefit payments available, which is the lesser amount of the cumulative payments to be made by the proxy establishment to Remote Workers or the estimated net direct state benefits under the contract;

(3) The project’s Approval Date;

(4) The project’s Start Date;

(5) The projected number of new direct jobs;

(6) The average annual wage of new direct jobs;

(7) Any other information the Department deems necessary to carry out the provisions of the statute.

c) The original incentive contract, signed by the chief executive officer or authorized representative, may be returned to the Department by any means acceptable to the Department.

150:65-13-7. Transmittal of information

(a) The Department will notify the Commission of each approved incentive offer.

(b) The Department will provide the Commission with all of the following documentation for each approved incentive offer:

(1) A copy of the executed incentive contract;

(2) The results of the cost-benefit analysis;

(3) Any other information deemed by both the Department and the Commission to be reasonably necessary for administration of the program.

[EFFECTIVE:
Immediately upon Governor’s approval
APPROVED BY GOVERNOR:
July 19, 2021
EXPIRATION:
Effective through September 14, 2022, unless superseded by another rule or disapproved by the Legislature
SUPERSEDED EMERGENCY ACTIONS:

INCORPORATIONS BY REFERENCE:
n/a
FINDING OF EMERGENCY:
This rule is necessary because a compelling public interest requires an emergency rule and imminent peril exists to the preservation of public welfare. Adoption of these rules provides the mechanism to incentivize production companies to produce films in the State. Production of these films creates jobs, promotes economic development and increases Oklahoma’s tax base. Failure to adopt these emergency rules will cause the incentive to be unusable until they can be adopted on a permanent basis, cause uncertainty for production companies and will ultimately cause a loss of jobs, tax revenues and negative economic impact on the State as these projects would likely choose other states instead of Oklahoma. These negative impacts will be felt even more strongly in rural Oklahoma as many of these incentives are based on filming in these rural areas.

GIST/ANALYSIS:
This action establishes the application process for the Filmed in Oklahoma Act located at 68 O.S. §631 et. seq. It also provides criteria for receipt of the incentive and provides clarity and transparency as to how a production company who seeks to produce film projects in Oklahoma can qualify for these incentives.

CONTACT PERSON:
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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(F):

SUBCHAPTER 1. FILMED IN OKLAHOMA ACT

150:150-1-1. Purpose
These rules implement the Filmed In Oklahoma Act at the Oklahoma Film and Music Office (OFMO) within the Oklahoma Department of Commerce.

150:150-1-2. Definitions
In addition to the definitions in the Filmed in Oklahoma Act, the following terms used in this Subchapter have the following meanings, unless the context clearly indicates otherwise:

"Above-the-Line personnel" or "ATL" means as defined in 68 O.S. §3632. It includes individuals hired or credited on screen for the production as producers (all levels), principal cast (SAG Schedule F/Run of Show or equivalent), screenwriters and the Film director.

"Act" means the Filmed in Oklahoma Act.

"Application estimate" means the estimated QPEs submitted to OFMO prior to the start of principal photography.

"Commission" means the Oklahoma Tax Commission or its successor entity.
"Conditional Pre-Qualification" or "Conditionally Pre-Qualified" means the status or act of approval being granted to a Production's Eligibility Application by OFMO.

"Department" means the Oklahoma Department of Commerce.

"Eligibility application" means the application of eligibility for the program. If the application is approved by OFMO, the film is "Conditionally Pre-Qualified".

"Episodic pilot" means a standalone episode of a television series used to sell the show to a television station, television network, cable television station or streaming service.

"Final application" means the package submitted to OFMO documenting all criteria for a rebate has been met and the Production Company is requesting payment of a Rebate Claim. This package includes all documentation reasonably necessary to prove eligibility that has not previously been provided to OFMO.

"Hub Location" means the Municipality where most of the principal photography conducted in Oklahoma on the film has occurred.

"Loan-out corporation" or "Loan-out company" means a corporation or limited liability company actively registered with the Oklahoma Secretary of State to do business in this state as a foreign or domestic entity used by Above-the-line personnel and Crew to report payments received from the Production as Oklahoma earnings for the personnel or Crew member.

"Master tradesperson" means a skilled and experienced tradesperson who instructs an Apprentice through use of practical experience so the Apprentice may learn a trade, craft or profession.

"Municipality" means an incorporated city or town. If a location is not in an incorporated city or town, it is considered part of the nearest incorporated city, or town.

"Office" or "OFMO" means the Oklahoma Film and Music Office or its successor entity.

"Oklahoma based" means as defined in 68 O.S. §3632. This term includes a business entity registered and in good standing as a Domestic entity with the Oklahoma Secretary of State and that files an Oklahoma income tax return.

"Oklahoma expatriate" means a person who has previously resided for at least one year, but does not currently reside, in Oklahoma.

"Oklahoma resident" means a person who is a resident under the Oklahoma Tax Code at the time of hire.

"Oklahoma vendor" means a seller, renter or lessor of goods or services who charges Oklahoma sales tax under an Oklahoma Sales Tax Permit on taxable transactions and is either (1) Oklahoma-Based or (2) a foreign business entity with an active registration to do business in Oklahoma and an Oklahoma physical location for transacting business.

"Payroll burden" means employer-paid taxes (e.g. FICA, Medicare and Unemployment Insurance) and payroll-associated payments made on a specific employee's behalf by law or collective labor bargaining agreement (e.g. union dues and union fringes). Payroll Burden includes the employer-paid portion of health insurance for an employee, if such insurance was paid to an Oklahoma-Based insurance company or obtained through a licensed Oklahoma insurance broker.

"Per Diem" means fixed payments made to Crew and Above-the-line personnel regardless of residency in lieu of reimbursement for lodging/housing, meals and incidentals, up to a maximum of the Per Diem Rate allowed for the applicable location and date in the U.S. General Services Administration Per Diem Rates. This does not include car and travel stipends, as these expenses are ineligible for rebate.

"Principal photography" means the filming of significant components of a Film which involve principal cast or, in the case of Films that do not involve live actors, the beginning of substantive work on the animation or graphics that form the Film's primary visual story.

"Production" means a project to make a Film.

"Production budget" means the total budgeted cost of the Production.

"Production company" means as defined in 68 O.S. §3632. Eligibility and Final Applications are filed by the Production Company and, unless previously agreed to in writing by the OFMO, payment of approved Rebate Claims is made to the Production Company.

"Project filmed in this state" means that at least one of the film's principal photography production days have occurred in Oklahoma. A project that does not meet this threshold is a "project filmed outside this state".

"Proof of funding" means demonstration in a form acceptable to the OFMO that a Production has or will have funding in place to cover the Production Budget. Acceptable forms approved by the OFMO may include a letter of intent from a recognized industry financier, written verification of dedicated deposits in a recognized financial institution or a letter of credit from an acceptable guarantor.

"Qualified production expenditure amount" or "QPE" means a qualified production expenditure.

"Rebate claim" means the formal request for OFMO to issue a Rebate under the Program.

"Rebate enhancement" means the additional incentive amounts a project may be eligible for which may be offered in addition to the base incentive amount. These Rebate Enhancements are specifically listed in 68 O.S. §§3635(B) and 3636(B).

"Rebate schedule" means a schedule of dates, deadlines, and submittals the Production is to achieve to submit the Final Application and have its Rebate Claim approved.

"Salaries" or "Wages" means those salaries and wages designated as Oklahoma earnings on payroll records along with the associated Payroll Burden, Per Diem and Housing Allowance.

"Scouting expenses" means costs incurred to identify locations, crew, facilities, services and equipment to be used in the production.

"Series season" means a group of episodes of the same Eligible Television Series which are either released simultaneously or at regular intervals to be aired within a certain time frame through traditional television content providers or through a streaming service.
"Start of pre-production" means the opening of an Oklahoma office for the production, or incurring QPE other than Scouting Expenses, or otherwise commencing business on the Production in Oklahoma other than scouting.

"Television series" means a group of two or more episodes of a production with a common series title and general theme intended to be released for viewing through a traditional television content provider or through a streaming service.

150:150-1.3. Program criteria and qualification

(a) Applying for rebate eligibility:

(1) Applications and all necessary forms may be submitted to OFMO through the OFMO website or as otherwise specified by OFMO.

(2) Unless otherwise authorized by OFMO, Eligibility Applications submitted for projects filmed inside the State pursuant to 68 O.S. §3635 may be submitted no earlier than one (1) year prior to the start of Principal Photography but no later than forty-five (45) days prior to the start of Principal Photography. The exact specifications of the Eligibility Application are shown on the OFMO website, and include but are not limited to:

(A) General information about the Production;
(B) Contact information;
(C) Preliminary production milestone dates;
(D) A copy of the screenplay (or treatment if appropriate);
(E) The Production Budget top sheet and estimated headcount;
(F) Various acknowledgements of program and OFMO criteria and agreements to abide by.

Eligibility Applications may be submitted to OFMO after the start of Principal Photography if OFMO deems that conditions exist which make submission prior to the start of principal photography not feasible.

(3) Unless otherwise authorized by OFMO, Eligibility Applications for post-production activity on a Project filmed outside of this State pursuant to 68 O.S. §3636 may be submitted no earlier than one (1) year prior to the occurrence of the post-production activity occurring in Oklahoma but no later than fourteen (14) days prior to the occurrence of the post-production activity occurring in Oklahoma. The exact specifications of this Eligibility Application are shown on the OFMO website, and include but are not limited to:

(A) The post-production budget or budget top sheet including post-production services and
(B) Proof of funding for the post-production services.

(4) Applicants may track the status of their Eligibility Application on the OFMO website.

(5) Application does not guarantee acceptance. OFMO considers each Eligibility Application individually based upon many factors, including compliance with these Rules, the Act, the benefits of the project to Oklahoma (such as economic impact, jobs, tourism, branding, image and follow-on work), funds available, anticipated future Program needs, and other projects applying for a rebate.

(b) Application Estimate. If the Eligibility Application is approved, the Application Estimate will be multiplied by the rebate percentage deemed appropriate by the Department. The resultant amount is the amount that may later be paid as the Rebate Claim (the "Potential Rebate Claim").

(c) If the Final Application and Rebate Claim are later approved:

(1) If the QPE are less than or equal to the application Estimate, the Rebate claim may be paid in full up to the Potential Rebate Claim amount. Any amount of the Potential Rebate Claim that has been Pre-Qualified but is less than the actual Rebate Claim may be deemed not Pre-Qualified and will not count toward the limitations set forth in 68 O.S. §3634.

(2) If the actual QPE are more than the Application Estimate, the amount that may be paid on the Rebate Claim is limited to the Potential Rebate Claim Amount. QPE that exceed the Potential Rebate Claim Amount are considered an additional claim and may, at OFMO's discretion, be approved for payment. If the additional claim is approved, the additional amount agreed to be paid counts toward the Conditional Pre-Qualification limits set forth in 68 O.S. §3634 of the then current fiscal year.

(d) Rebate Schedule. For Projects filmed in this State pursuant to 68 O.S. §3635, unless otherwise agreed by OFMO in writing, after Conditional Pre-Qualification, OFMO and the Production Company will establish a schedule of dates based upon the following benchmarks:

(1) 45 calendar days prior to Principal Photography - submit Application Estimate and Proof of Funding for at least fifty percent (50%) of the Production budget unless otherwise agreed upon beforehand by OFMO.

(2) Prior to paying salaries or wages to a Production Company's employee in Oklahoma - submit a certificate of workers' compensation insurance with limits pursuant to Oklahoma Law.

(3) 30 calendar days prior to Principal Photography - submit the following:

(A) Proof of funding for the Production Budget;
(B) Updated filming schedule.

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(C) Updated screenplay (or treatment if appropriate);
(D) Copy of the completion bond as described in "(e)" below, if applicable;
(E) Additional documents as reasonably requested by OFMO.

(4) 10 calendar days prior to Principal Photography:
(A) Submit a certificate of general liability insurance with a minimum limit of $1,000,000 in coverage (or a binder for such with a state date no later than the estimated Start of Pre-Production);
(B) Submit a certificate of automobile liability insurance with minimums of $250,000/500,000/250,000 coverage (or a binder for such with a state date no later than the estimated Start of Pre-Production) or certification that no employee of the Production will drive an automobile as part of the Production.

(5) During Principal Photography - submit the following (preferably in advance, if practical):
(A) Updates to the filming schedule;
(B) Updates to the screenplay (or treatment if appropriate);
(C) Call Sheets.

(6) Within 90 calendar days of completion of the Production (or payment date of last QPE, if later):
(A) Upload through the OFMO website the list of Oklahoma Crew, Oklahoma Expatriates and Oklahoma Vendors used on the Production;
(B) Submit the Final Application.

(e) Completion Bond. Unless a Production is backed by a major studio or other financing source acceptable to OFMO, the Production will post a Completion Bond from a guarantor acceptable to OFMO guaranteeing completion of the Production and payment of all Oklahoma liabilities. In lieu of a Completion Bond, a Production may produce evidence acceptable to OFMO that all Crew, vendors and taxes have been paid and there are no outstanding or potential liens in Oklahoma against the Production Company.

(f) End of Production credits:
(1) The end credit crawl of all release prints of a Film will include "filmed in Oklahoma using the Filmed in Oklahoma Act" and a logo provided by OFMO.

(2) If the production does not contain end credits, the production company will provide equivalent value as determined by OFMO prior to payment of the Rebate Claim.
If the production does not intend to use end credits, this should be disclosed to OFMO prior to Conditional Pre-Qualification of the project.

(g) Certified Public Accountant's Report: Final Applications will be accompanied by a CPA's Report, prepared at the expense of the Applicant, attesting that the amounts in the Final Application are QPE that comply with these rules.

(1) Reports will be prepared by a CPA currently licensed by the State of Oklahoma and who is independent under the American Institute of certified Public Accountants' (AICPA) Independence Rule.

(2) CPAs will carry professional liability insurance, in a form and from a carrier acceptable to OFMO, for at least $500,000.

(3) The CPA's examination will be conducted according to the AICPA's Attestation Standards.

(4) Reports will use a materiality threshold set by OFMO and published on its website.

(5) CPAs will work with the Production Company to resolve exceptions or discrepancies prior to submitting the Final Application, such that the CPA's Report attests to the validity and accuracy of the amounts on the Application without exception.

(6) The CPA's Report will attest:
(A) Actual Production expenditures were at least $50,000 and QPE at least $25,000;
(B) All amounts on the Application are properly calculated and materially accurate;
(C) All Oklahoma payroll tax returns due from the Production Company (or its payroll processor) have been filed;
(D) All Oklahoma income tax returns for the Production Company due as of the review date have been filed.

(7) The CPA will retain all workpapers for the CPA's Report for seven years, during which they may be subject to audit by OFMO or its agents, upon a request by OFMO.

Final Application:

(1) Upon completion of the Production and mandates herein, the Production Company may submit a Final Application.

(2) Submitting a Final Application does not guarantee approval. OFMO may approve or disapprove of all claims within 60 calendar days of receipt of a properly completed Final Application.

(3) If a Final Application or Rebate Claim is denied, the Production Company may attempt to correct any discrepancies or problems and resubmit within thirty (30) days of denial.

(4) Once a Final Application is approved by OFMO, Amendments are not allowed:

(5) The Oklahoma Tax Commission will, upon notification of approval from the OFMO, issue payment for all approved Rebate Claims, subject to any statutory limitations and any other written agreements between the Production Company and the Department.

Delays, Transferability and Expiration:

(1) A Conditionally Pre-Qualified Production may delay the start of Principal Photography two times for a total delay of up to one hundred eighty (180) days from the date when principal photography was originally scheduled to begin. If the start is delayed a third time, or a Production does not start by the date specified in their latest update to the Production Schedule submitted to OFMO, Pre-Qualification is revoked, the Eligibility Application is denied and the Production cannot apply again until the following fiscal year.
(2) Conditional Pre-Qualification is specific to the Production and Production Company and is non-transferable. Productions, screenplays and budgets may evolve as long as they are substantially similar to those submitted in the Eligibility Application.

(3) Unless otherwise approved by OFMO, Conditional Pre-Qualification expires two (2) years from the start of Principal Photography.

(4) If Conditional Pre-Qualification expires or is revoked, the Potential Rebate Claim amount from the revoked or expired Conditional Pre-Qualification does not count toward the Conditional Pre-Qualification cap set forth in 68 O.S. §3634.

150:150-1-4. Multi-film deals

(a) As part of the Eligibility Application, an applicant will provide information as requested by OFMO indicating whether the film being produced is intended to be part of a "Multi-Film" Deal.

(b) If an applicant indicates that a film is part of a Multi-Film Deal, and provides the requested documentation, the Department may Conditionally Pre-Qualify the Multi-Film Deal Rebate Enhancement amount in a manner consistent with these rules. The Multi-Film Deal Rebate Enhancement amount Conditionally Pre-Approved for each Film in a Multi-Film Deal may only be approved for payment after approval of the Final Application of the third film in the Multi-Film Deal.

(c) After approval of the Final Application of the third film in a Multi-Film deal, and for each subsequent film that is part of the Multi-Film deal, the Department may formally approve the Rebate Enhancement applicable for the Multi-Film Deal and notify the Commission so the Conditionally Pre-qualified Rebate Enhancement for the Multi-Film deal may be paid.

(d) Episodic filmed as part of a single Series Season do not qualify for the Multi-Film Deal incentive enhancement.

(e) A television Episodic Pilot which is part of a Multi-Film Deal for purposes of the incentive enhancement cannot receive an Incentive Enhancement for a television Episodic Pilot as otherwise provided in the act.

150:150-1-5. Apprentices

(a) OFMO may maintain a list of trades or departments deemed necessary for a film production where an Apprentice may be utilized to qualify for the rebate pursuant to the Act and list these trades on the OFMO website.

(b) A person is considered an Apprentice as defined by the act, if he or she meets all of the following criteria:

(1) The Apprentice is an Oklahoma resident;

(2) The Apprentice is supervised by an experienced Master Tradesperson in the trade, craft or profession being practiced by the Apprentice in the production;

(3) The Apprentice works in a trade recognized by OFMO as necessary for a film production;

(4) The Apprentice works under the supervision of the Master Tradesperson at least one-half (1/2) of the days the Master Tradesperson under which the Apprentice is learning is actively engaged in the film;

(5) The Apprentice completes a questionnaire or survey provided by OFMO to be returned to OFMO with the Final Application.

150:150-1-6. Soundstage certification

(a) A facility may be considered a State Certified Industry Standard Soundstage Facility (State Certified Soundstage Facility), if a building, or complex of buildings, building improvements and associated back-lot facilities on a property meets all of the following criteria:

(1) Multiple Productions are, or are intended to be, regularly produced at the facility throughout the year;

(2) The primary revenue source for such a facility is from industry Productions and ancillary services to such Productions;

(3) The facility is marketed and made available to third party productions planning to rent such facility and the facility is able to be listed on the OFMO website for such rental;

(4) The facility provides additional industry specific on-site services and amenities for third party Productions;

(5) The facility contains at least 7,500 sq feet of combined and dedicated studio space which:

(A) Features acoustically treated walls;

(B) Achieves a noise criterion rating of 30 or better

(C) Has a height of at least 15 feet and;

(D) Is equipped with sufficient heating and air conditioning for filming without the need for supplemental units (but supplemental units may be used)

(E) Otherwise meets the criteria for a qualified soundstage facility as defined in the Act.

(b) OFMO may compile and maintain a list of State Certified Soundstage Facilities located within the State of Oklahoma and may make this list available either through request or by publishing a regularly updated list on the OFMO website.

(c) A soundstage facility may apply to OFMO and request to be listed as a State Certified Soundstage Facility by contacting OFMO and making application to the Department in a manner and on an application provided by OFMO.

150:150-1-7. Incentive amounts

(a) The base incentive amount and all Rebate Enhancement percentages set forth in 68 O.S. §3635 and §3636 are the maximum possible incentive percentage amounts payable under each specific circumstance. The decision as to whether to offer an incentive, and how much of an incentive may be offered is made at the discretion of OFMO.

(b) The actual rebate percentage approved for a project, if any, is determined by the Department in a way that achieves the maximum possible impact for the Oklahoma economy.

(c) In determining the rebate percentage amount to be approved, if any, pursuant to either 68 O.S. §3635 or §3636, the Department may consider the following:

(1) Benefits of the project to the State (including economic impact, industry infrastructure impact, jobs, tourism, branding, image and follow-on work);
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(2) The amount of rebate payments conditionally pre-qualified by the Department for the current fiscal year;
(3) Impact on the ability of the Department to commit funds to additional projects for the current fiscal year;
(4) The amount of incentive believed to be necessary to win the project.
(d) The incentive percentage to be approved for a project may be determined at the time of Conditional Pre-Qualification of the application with the following limitations:
(1) If a project fails to meet the criteria for a particular Rebate Enhancement for which the project was initially pre-qualified to receive, the percentage of that specific incentive enhancement is removed from the total percentage of the incentive offer.
(2) If a project underperforms with regards to any of the Rebate Enhancement categories from what they projected in the initial application, the additional incentive amount offered for that category may be reduced.
(3) If a project uses fewer apprentices than the amount claimed at the time of Conditional Pre-Qualification, the base incentive amount may be reduced.
(4) If the Rebate Claim amount is fifteen or more percent (15%+) lower than the amount for which the Film was pre-qualified, one percent (1%) of the Rebate amount for which the Film would otherwise be paid may be reduced due to the reduced economic benefit to the State.
(e) OFMO may utilize a scoring system to provide guidelines as to the amount of incentive offered for a project, if any. OFMO may also rank projects to determine which projects should receive priority in receiving an incentive offer. Any list created by OFMO ranking projects is not subject to the Open Records Act.
(f) OFMO may prioritize projects on a project ranking list which meet the following criteria:
(1) Projects which are the second or subsequent film in a Multi-Film Deal;
(2) Projects which are part of a television series filmed in Oklahoma where either the series Television Pilot or a previous Series Season was filmed in Oklahoma;
(3) Post-production activity occurring in Oklahoma on a television series filmed outside of Oklahoma where post-production activity on either the series Television Pilot or a previous Series Season had occurred in Oklahoma.

150:150-1-8. Qualified production expenditures
(a) A Qualified Production Expenditure, or production cost, includes Oklahoma expenditures or production costs as defined in 68 O.S. §3632 including the following expenditures, whether paid directly or through an Oklahoma based entity, subject to statutory limitations:
(1) Salary Costs for Oklahoma Resident Crew;
(2) Salary Costs for Oklahoma Expatriate Crew;
(3) Payments to the owner(s) of an Oklahoma Loan-Out Company for Oklahoma Resident Crew;
(4) Payments to the owner(s) of an Oklahoma Loan-Out Company or salary payments for Crew that is not Oklahoma-Based or who are non-residents, other than above-the-line personnel, subject to the sunset limitations in 68 O.S. §3635(A);
(5) Subject to the twenty-five percent limitation, the sum of:
(A) payments to Oklahoma-Based above the line personnel;
(B) payments to Oklahoma Loan-Out Companies for Above-the-line personnel; and
(C) payments to an Oklahoma-Based entity for using the Film's underlying creative work (e.g., screenplay, treatment, or novel).
(6) Permits and fees paid to an Oklahoma state, county, or municipal governmental or quasi-governmental entity;
(7) Payments to an Oklahoma Vendor for the following:
(A) Studio, stage or set construction and dismantling;
(B) Production scheduling, management, administration and operations;
(C) Casting and security services;
(D) Wardrobe and make-up materials, consumables and services;
(E) Set props and accessories (individual props costing in excess of fifty thousand dollars ($50,000) may only be included as a QPE if prior approval is granted by the OFMO);
(F) Cameras, film, microphones, tape, digital storage media and other materials and equipment used to record sound and images;
(G) Photography, visual image editing, animation, computer graphics and effects, and related visual services;
(H) Sound (other than music) recording, editing, synchronization and related services;
(I) Licensing or use rights for music, or recording of songs or musical score, used in the Film;
(J) Lighting and electrical materials, equipment and services;
(K) Location, building, facility, equipment, prop and wardrobe rental;
(L) Stunts, special effects, pyrotechnics, firefighting, safety, handling/wrangling, security and other specialty services;
(M) Lodging and accommodations (whether paid for directly by the Production Company, paid through a third party who is paid by the production company, or provided as an allowance in the amount of actual costs of housing) for ATL and Crew;
(N) Food, restaurants and catering (whether paid for directly by the Production company or paid through a third party who is paid by the Production Company);
(O) Transportation of ATL, Crew, equipment and supplies (whether paid for directly by the Production company or paid through a third party who is paid by the Production Company);
(P) Travel costs to and from Oklahoma paid to or through an Oklahoma travel agent;
(Q) Completion bonds and insurance where either the guarantor or the is an Oklahoma Vendor;
(R) Shipping and postage for packages originating or terminating within Oklahoma;
(S) Fees, interest and financing charges paid to Oklahoma-Based Vendors and Oklahoma Based financial institutions and companies;
(T) Other materials, supplies and contracted services approved in advance by OFMO;
(U) CPA Report.
(8) Payments to an Oklahoma Vendor for the following valid Scouting Expenses of the Production:
   (A) Location scouting, planning and packaging services;
   (B) Travel costs to and from Oklahoma paid to a travel agent;
   (C) Lodging and accommodations within Oklahoma;
   (D) Transportation within Oklahoma;
   (E) Meals purchased within Oklahoma.
(9) Reimbursements made to individuals for goods and services provided by an Oklahoma Vendor that would have been OPE if paid directly by the Production, provided the individual provides a receipt for such goods and services;
(10) Reimbursements made for automobile mileage and toll fees paid to crew for travel beginning from a location in Oklahoma and ending at another location in Oklahoma as long as:
   (A) mileage payments are limited to the current Internal Revenue Service (IRS) standard mileage rates and
   (B) payment of mileage is compliant with IRS rules for claiming mileage.
(11) Box rental fees paid to an Oklahoma resident crew member or an Oklahoma Expatriate crew member for the crew member using his or her own equipment or resources on a Film;

150:150-1-9. Oklahoma expatriate crew program
(a) OFMO may maintain a roster of Oklahoma Expatriate Crew and make such roster available to a Production Company upon request.
(b) The Expatriate roster may consist of Oklahoma Expatriates who are:
   (1) Registered as an Oklahoma Expatriate with OFMO and;
   (2) Have completed a Declaration of Expatriate Status satisfactory to OFMO.

[TITLE 175. STATE BOARD OF
COSMETOLOGY AND BARBERING
CHAPTER 20. MASSAGE THERAPY

[OAR Docket #21-696]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
Subchapter 5. Licensure of Massage Therapists
175:20-5-3.1 [NEW]

AUTHORITY:
59 O.S. § 4200.9(B)(1); Massage Therapy Practice Act; State Board of Cosmetology and Barbering

ADOPTION:
June 21, 2021

EFFECTIVE:
Immediately upon Governor's approval

APPROVED BY GOVERNOR:
June 29, 2021

EXPIRATION:
Effective through September 14, 2022, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:
 n/a

INCORPORATIONS BY REERENCE:
 n/a

FINDING OF EMERGENCY:
The rule is necessary as an emergency measure pursuant to 75 O.S. § 253(A)(1)(a) and (e) to protect the public health, safety and welfare and avoid serious prejudice to the public interest by ensuring that certain massage therapists, whose licenses are invalid based on lack of renewal due to the COVID-19 Pandemic, have an opportunity to come into compliance with the rules established by the Oklahoma Board of Cosmetology

GIST/ANALYSIS:
Establish a tolling period in calculating the timeframe for grace periods and inactive status related to the renewal of massage therapy licenses. The tolling period is from March 17, 2020 through January 31, 2021, during which period the Governor of the State of Oklahoma declared a State of Emergency and extended all expiring occupational licenses.

CONTACT PERSON:
John Funderburk, Oklahoma, State Board of Cosmetology and Barbering.
Tel. 405-522-7616, John.Funderburk@cosmo.ok.gov.

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(F):

SUBCHAPTER 5. LICENSURE OF MASSAGE THERAPISTS

175:20-5-3.1. Clarification of license renewal procedures following COVID-19 pandemic
(a) Pursuant to its authority under 59 O.S. § 4200.9(B)(1) to establish expiration dates for massage therapy licenses, the State Board of Cosmetology and Barbering shall not include, in calculating the timeframe for grace periods and inactive status related to the renewal of massage therapy licenses, the period from and including March 17, 2020 through January 31, 2021, during which period the Governor of the State of Oklahoma

[OAR Docket #21-701; filed 7-21-21]
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had declared a State of Emergency and extended all expiring occupational licenses.
(b) All persons who were licensed as massage therapists in accordance with 59 O.S. § 4200.5(A), and who maintained their licenses in good standing consistent with Oklahoma law and section (a) of this rule, above, as determined by the Board within its exclusive discretion, shall retain their grandfathered status.
(c) All other requirements set forth in 59 O.S. § 4200.9 must be met in order to obtain renewal of a massage therapy license, including, but not limited to, providing adequate proof of completion of all continuing education requirements and payment of all renewal fees and late fees, as prescribed by the Board.

[OAR Docket #21-696; filed 7-15-21]

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 681. MEDICAL MARIJUANA REGULATIONS

[OAR Docket #21-697]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
310:681-1-4 [AMENDED]
Subchapter 2. Medical Marijuana Licenses
310:681-2-3 [AMENDED]
Subchapter 3. Transporter License
310:681-3-1 [AMENDED]
310:681-3-6 [AMENDED]
Subchapter 4. Research Facilities and Education Facilities
310:681-4-2 [AMENDED]
310:681-4-5 [AMENDED]
Subchapter 5. Medical Marijuana Businesses
310:681-5-1.1 [AMENDED]
310:681-5-2 [AMENDED]
310:681-5-2.1 [NEW]
310:681-5-3 [AMENDED]
310:681-5-4 [AMENDED]
310:681-5-4.1 [NEW]
310:681-5-5 [AMENDED]
310:681-5-6 [AMENDED]
310:681-5-6.2 [NEW]
310:681-5-6.3 [NEW]
310:681-5-6.4 [NEW]
310:681-5-18 [AMENDED]
Subchapter 7. Packaging, Labeling, and Advertising
310:681-7-1 [AMENDED]
Subchapter 8. Laboratory Testing
310:681-8-3 [AMENDED]
Subchapter 9. Waste Disposal Facilities
310:681-9-1 [AMENDED]
310:681-9-1.1 [AMENDED]
310:681-9-2 [AMENDED]
310:681-9-3 [AMENDED]
310:681-9-4 [AMENDED]
310:681-9-7 [AMENDED]

AUTHORITY:
Commissioner of the Oklahoma State Department of Health; 63 O.S. § 1-104

ADOPTION:
June 21, 2021

EFFECTIVE:
Immediately upon Governor's approval

APPROVED BY GOVERNOR:
June 28, 2021

EXPIRATION:
Effective through September 14, 2022, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

FINDING OF EMERGENCY:
Chapter 681 is being amended to conform the regulations to statutory changes that go into effect on July 1, 2021.

GIST/ANALYSIS:
The rules amend the Definitions section to add new terms used in the new and amended sections of Chapter 681. The amendments conform to the statutory requirements for the distance between a school and a medical marijuana business that go into effect on July 1, 2021. The rules also provide regulatory requirements for the seed-to-sale tracking system. The rules require that commercial licensees track inventory, cultivation, manufacturing and transactions for the purpose of reporting the information to the Department.

CONTACT PERSON:
Audrey C. Talley, Agency Rule Liaison, Oklahoma State Department of Health, 123 Robert S. Kerr Avenue, Oklahoma City, OK 73102, 405-426-8563. AudreyT@health.ok.gov

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(F):

SUBCHAPTER 1. GENERAL PROVISIONS

310:681-1-4. Definitions
The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:
"Actively operating" or "Actively conducting business operations" means a commercial licensee that possesses, sells, purchases or transfers medical marijuana and/or medical marijuana products to or from its licensed premises in a regular or seasonal capacity.
"Advertising" means the act of providing consideration for the publication, dissemination, solicitation, or circulation of visual, oral, or written communication to induce directly or indirectly any person to patronize a particular medical marijuana business or to purchase any particular medical marijuana or medical marijuana products. "Advertising" includes marketing but does not include packaging and labeling.
"Applicant" means the natural person or entity in whose name a license would be issued.
"Application status" means the status of a submitted application and includes the following:
(A) "Submitted" means the application has been submitted but a review is not yet complete;
(B) "Rejected" means the application has been reviewed but contains one or more errors requiring correction by the applicant at no additional fee before a final determination on the application can be made. "Rejected" does not mean the application is denied;
(C) "Approved" means the application has been approved and that a license will be issued and mailed to the applicant; and
(D) "Denied" means the applicant does not meet the qualifications under Oklahoma law and this Chapter for a license.

"Authority" or "OMMA" means the Oklahoma Medical Marijuana Authority, a division of the Oklahoma State Department of Health.

"Batch number" means a unique numeric or alphanumeric identifier assigned prior to any testing to allow for inventory tracking and traceability.

"Business license" means a license issued by the Department to a medical marijuana dispensary, grower, processor, testing laboratory, or transporter.

"Cannabinoid" means any of the chemical compounds that are active principles of marijuana.

"Caregiver" means a family member or assistant who regularly looks after a licensed patient whom a physician certifies is homebound or needs assistance.

"CFR" means the Code of Federal Regulations, the compilation of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government which is published by the U.S. Government Printing Office. Citations in this Chapter to the CFR refer sequentially to the Title, Part and Section numbers.

"Child-resistant" means packaging that is:

(A) Designed or constructed to be significantly difficult for children under five (5) years of age to open and not difficult for normal adults to use properly as defined by 16 CFR § 1700.15 (1995) and 16 CFR § 1700.20 (1995);

(B) Opaque so that the outermost packaging does not allow the product to be seen without opening the packaging material; and

(C) Resealable to maintain its child-resistant effectiveness for multiple openings for any product intended for more than a single use or containing multiple servings.

"Clone" means a non-flowering plant cut from a mother plant that is capable of developing into a new plant and has shown no signs of flowering.

"Commercial license" means any license issued to an individual or entity that is not a patient, caregiver, or transporter agent.

"Commercial licensee" means an individual or entity issued a commercial license and does not mean a patient, caregiver, or transporter agent.

"Commissioner" means the State Commissioner of Health of the Oklahoma State Department of Health.

"Complete(d) application" means a document prepared in accordance with Oklahoma law, these Rules, and the forms and instructions provided by the Department, including any supporting documentation required by the Department and the license fee.

"Decontamination" means a process that attempts to remove or reduce to an acceptable level a contaminant exceeding an allowable threshold set forth in these Rules in a harvest batch or production batch.

"Department" means the Oklahoma State Department of Health or its agent or designee.

"Dispense" means the retail selling of medical marijuana or medical marijuana products that are packaged and labeled in accordance with the law to a licensed patient, the licensed patient's parent(s) or legal guardian(s) if licensed patient is a minor, or a licensed caregiver.

"Dispensary" or "Commercial Dispensary" means an individual or entity that has been issued a medical marijuana business license by the Department, which allows the dispensary to purchase medical marijuana or medical marijuana products from a licensed processor, grower, or dispensary; to sell medical marijuana and medical marijuana products to a licensed patient, to the licensed patient's parent(s) or legal guardian(s) if licensed patient is a minor, and a licensed caregiver; and to sell, transfer, and transport or contract with a commercial transporter to transport medical marijuana or medical marijuana products to another licensed dispensary, a research facility, and an educational facility; and to transfer to testing laboratories.

"Dispose" or "Disposal" means the final disposition of medical marijuana waste by either a process which renders the waste unusable through physical destruction or a recycling process.

"Disqualifying criminal conviction" means:

(A) Any non-violent felony conviction within last two (2) years of submitting an application to the Department; and

(B) Any violent felony conviction for an offense listed in 57 O.S. § 571(2) within last five (5) years of submitting an application to the Department; or

(C) Incarceration for any reason during submission of application to the Department.

"Education facility" means an individual or entity that has been issued a license by the Department to operate a facility providing training and education to individuals involving the cultivation, growing, harvesting, curing, preparing, packaging, or testing of medical marijuana, or the production, manufacture, extraction, processing, packaging, or creation of medical-marijuana-infused products or medical marijuana products for the limited education and research purposes permitted under state and federal law and these Rules; to transfer, by sale or donation, medical marijuana grown within its operation to licensed research licensees; and to transfer to licensed testing laboratories.

"Entity" means an individual, sole proprietorship, a general partnership, a limited partnership, a limited liability company, a trust, an estate, an association, a corporation, or any other legal or commercial entity.

"Entrance to a private or public school" means an opening, such as a door, passage, or gate, that allows access to any public or private schools, including school buildings, facilities, or other indoor and outdoor properties utilized for classes or school activities.

"Error in measurement" means a mistake made by the Department or a municipality in the setback measurement process where either the distance between a medical marijuana dispensary and a school is miscalculated due to mathematical
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error or the method used to measure the setback distance is inconsistent with 63 O.S. § 425(G).

"Error in measurement allowance" means an allowance of an error in measurement of the distance between a medical marijuana dispensary and a school up to and including five hundred (500) feet when remeasured after an original license has been issued.

"Flower" means the reproductive organs of the marijuana or cannabis plant referred to as the bud or parts of the plant that are harvested and used to consume in a variety of medical marijuana products.

"Flowering" means the reproductive state of the marijuana or cannabis plant in which there are physical signs of flower or budding out of the nodes of the stem.

"Food" has the same meaning as set forth in 63 O.S. § 1-1101 ("food" means (1) articles used for food or drink for man, (2) chewing gum, and (3) articles used for components of any such article) and set forth in the Oklahoma Administrative Code ("OAC") OAC 310:257-1-2 and OAC 310:260-1-6 ("food" means any raw, cooked, or processed edible substance, ice, beverage or ingredient used or intended for use or for sale in whole or in part for human consumption).

"Grower" or "Commercial grower" means an individual or entity that has been issued a medical marijuana business license by the Department, which allows the grower to grow, harvest, dry, cure, package, sell, transfer, and transport or contract with a commercial transporter for the transport of medical marijuana in accordance with Oklahoma law and this Chapter to a dispensary, processor, grower, research facility, education facility, or testing laboratory.

"Harvest Batch" means a specifically identified quantity of usable medical marijuana, no greater than ten (10) pounds, that is uniform in strain, cultivated utilizing the same cultivation practices, harvested at the same time from the same location, and dried or cured under uniform conditions.

"Immature plant" means a nonflowering marijuana plant that has demonstrated signs of flowering.

"Indirect beneficial owner" means an individual or entity who indirectly, through any contract, arrangement, understanding, relationship or otherwise, owns ten percent (10%) or more of the equity interests of a grower, processor, or dispensary.

"Information panel" has the same definition as set forth in 21 CFR § 101.2 and means "that part of the label immediately contiguous and to the right of the principal display panel as observed by an individual facing the principal display panel."

"Integration" or "Integrated" means a third-party vendor's software application or software service that has been fully validated to share inventory tracking or other data directly with the State inventory tracking system via a secure Application Programming Interface ("API").

"Inventory tracking system" or "State inventory tracking system" means the required tracking system established by the Department that accounts for medical marijuana from either the seed or immature plant stage until the medical marijuana or medical marijuana product is sold to a patient at a medical marijuana dispensary, transferred to a medical marijuana research facility, disposed of in accordance with these rules or used in a research project by a medical marijuana research facility, that accounts for the entire life span of medical marijuana, from either the seed or immature plant stage until the medical marijuana or medical marijuana product is consumed, used, disposed of or otherwise destroyed.

"Label" carries the same definition as set forth in 63 O.S. § 1-1101 and means a display of written, printed, or graphic matter upon the immediate container of any article; and a requirement made by or under authority of this article that any word, statement, or other information appearing on the label shall not be considered to be complied with unless such word, statement, or other information also appears on the outside container or wrapper, if there be any, of the retail package of such article, or is easily legible through the outside container or wrapper.

"License" means a state issued license or other state issued documentation proving the holder of such license is a member of a state-regulated medical marijuana program.

"License number" means the unique multi-character identifier issued and printed upon each license.

"Licensee" means any natural born person or entity that holds a medical marijuana license provided for in this Chapter, excluding inmates of any local, county, state, or federal correctional facility or jail.

"Licensed Packager" means as used in 63 O.S. § 422(C) a processor.

"Licensed premises" means the premises specified in an application for a medical marijuana business, research facility, education facility, or waste disposal facility that is owned or in lawful possession of the licensee and within which the licensee is authorized to operate.

"Lot" means the food produced during a period of time indicated by a specific code.

"Marijuana" means the same as the term that is defined in 63 O.S. § 2-101 and shall not include any plant or material containing delta-8 or delta-10 tetrahydrocannabinol which is grown, processed or sold pursuant to the provisions of the Oklahoma Industrial Hemp Program.

"Mature plant" means harvestable female marijuana plant that is flowering.

"Medicaid" means the program that is also commonly known in Oklahoma as "SoonerCare."

"Medical marijuana" means marijuana that is grown, processed, dispensed, tested, possessed, or used for a medical purpose.

"Medical marijuana business" means an individual or entity licensed by the Department as a medical marijuana dispensary, grower, processor, testing laboratory, or transporter.

"Medical marijuana concentrate" ("Concentrate") means a substance obtained by separating cannabinoids from any part of the marijuana plant by physical or chemical means, so as to deliver a product with a cannabinoid concentration greater than the raw plant material from which it is derived. Categories of concentrate include water-based medical marijuana concentrate, food-based medical marijuana concentrate,
solvent-based concentrate, and heat- or pressure-based medical marijuana concentrate as those terms are defined in the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq.

"Medical marijuana product" means a product that contains cannabinoids that have been extracted from plant material or the resin therefrom by physical or chemical means and is intended for administration to a licensed patient, including but not limited to concentrates, oils, tinctures, edibles, pills, topical forms, gels, creams, and other derivative forms, except that this term does not include live plant forms.

"Medical marijuana research" means research on medical marijuana and medical marijuana products for public purposes, including the advancement of (A) Public health policy and public safety policy, (B) Agronomic and horticultural best practices, and (C) Medical and pharmacopoeia best practices. For purposes of this Chapter, this term does not include biomedical and clinical research that is subject to federal regulations and institutional oversight and shall not be subject to Department oversight.

"Medical marijuana waste" means

(A) unused, surplus, returned or out-of-date marijuana; recalled marijuana; unused marijuana; plant debris of the plant of the genus cannabis, including dead plants and all unused plant parts, except the term shall not include seeds, roots, stems, stalks and fan leaves;

(B) all product which is deemed to fail laboratory testing and cannot be remediated or decontaminated, or

(C) all product and inventory from commercial licensees that:

(i) have gone out of business,

(ii) are not subject to the provisions of Section 1560 of Title 12 of the Oklahoma Statutes, and

(iii) are unable to lawfully transfer or sell the product and inventory to another commercial licensee.

"Minor" means any natural person younger than eighteen (18) years of age.

"Mother plant" means a marijuana plant that is grown or maintained for the purpose of generating clones, and that will not be used to produce plant material for sale to a processor or dispensary.

"Municipality" means the same definition as set forth in the Oklahoma Municipal Code, 11 O.S. § 1-102, and "means any incorporated city or town."

"Nonoperational" means a commercial licensee that cannot provide proof that it is actively operating or working towards operational status.

"Officer of a corporate entity" or "Principal officer" means an officer identified in the corporate bylaws, articles of organization or other organizational documents, or in a resolution of the governing body.

"Officer of a municipality" means the same definition as set forth in the Oklahoma Municipal Code, 11 O.S. § 1-102, and means any person who is elected to an office in municipal government or is appointed to fill an unexpired term of an elected office, and the clerk and the treasurer whether elected or appointed.

"Oklahoma resident" or "Resident" means an individual who can provide proof of residency as required by OAC 310:681-1-6 (relating to proof of residency) or OAC 310:681-5-3.1 (relating to proof of residency for commercial business licensees).

"Oklahoma uniform symbol" or "Universal symbol" means the image, established by the Department and made available to commercial licensees through the OMMA website, which indicates the package contains medical marijuana or medical marijuana products with THC and must be printed at least one-half inch in size by one-half inch in size in the color designated by the Department.

"Openly in existence" means any building, location, or structure on a school site that has visible outward markings indicating the building, location or structure was operating as a school which would serve as sufficient notice of the existence of the school or a reason for further inquiry on the part of the medical marijuana dispensary license applicant. "Openly in existence" shall not mean any school that operated secretly or discreetly without any signs or other markings on any building, location, or structure on the school site, undeveloped land or a structure owned by a school that was not openly used and marked as a school site, or any school site that was established after the medical marijuana dispensary had been established and licensed by the Department.

"Out-of-state medical marijuana patient license" means an unexpired medical marijuana patient license issued by another U.S. state, which is the substantial equivalent of the Oklahoma medical marijuana patient license issued pursuant to OAC 310:681-2-1 and OAC 310:681-2-2.

"Owner" means, except where the context otherwise requires, a direct beneficial owner, including, but not limited to, all persons or entities as follows:

(A) All shareholders owning an interest of a corporate entity and all officers of a corporate entity;

(B) All partners of a general partnership;

(C) All general partners and all limited partners that own an interest in a limited partnership;

(D) All members that own an interest in a limited liability company;

(E) All beneficiaries that hold a beneficial interest in a trust and all trustees of a trust; All persons or entities that own interest in a joint venture;

(F) All persons or entities that own an interest in an association;

(G) The owners of any other type of legal entity; and

(H) Any other person holding an interest or convertible note in any entity which owns, operates, or manages a licensed medical marijuana facility.

"Package" or "Packaging" means any container or wrapper that a medical marijuana business may use for enclosing or containing medical marijuana or medical marijuana products, except that "package" or "packaging" shall not include any carry-out bag or other similar container.
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"Patient" or "Licensed patient" means a person that has been properly issued a medical marijuana license pursuant to Oklahoma law and these Rules.

"Pesticide" means
(A) any substance or mixture of substances intended for preventing, destroying, repelling, or mitigating any pest, or
(B) any substance or mixture of substances intended for use as a plant regulator, defoliant or desiccant. "Pesticide" shall not include any article that is a "new animal drug" as designated by the United States Food and Drug Administration.

"Physician" or "Oklahoma Physician" means a doctor of medicine, a doctor of osteopathic medicine, or a doctor of podiatric medicine who holds a valid, unrestricted and existing license to practice in the State of Oklahoma.

"Plant material" means the leaves, stems, buds, and flowers of the marijuana plant, and does not include seedlings, seeds, clones, stalks, or roots of the plant or the weight of any non-marijuana ingredients combined with marijuana.

"Political subdivision" means any county or municipal governments.

"Preschool" or "public early childhood education program" offered under 70 O.S. §§ 11-103.7 and 1-114 (B) or similar program offered by a private school whose primary purpose is to offer educational (or academic) instruction. Preschool does not include a homeschool, daycare, or child care facility licensed under the Oklahoma Child Care Facilities Licensing Act, 10 O.S. § 401 et seq.

"Principal display panel" has the same definition as set forth in 21 CFR § 101.1 and "means the part of a label that is most likely to be displayed, presented, shown, or examined under customary conditions of display for retail sale."

"Private school" means a preschool, elementary, middle, or high school maintained by private individuals, religious organizations, or corporations, funded, at least in part, by fees or tuition, and open only to pupils selected and admitted based on religious affiliations or other particular qualifications. "Private school" shall not include a homeschool, daycare, or child care facility licensed under the Oklahoma Child Care Facilities Licensing Act, 10 O.S. § 401 et seq.

"Process" means to distill, extract, manufacture, prepare, or otherwise produce a medical marijuana product.

"Processor" or "Commercial Processor" means an individual or entity that has been issued a medical marijuana business license by the Department, which allows the processor to: purchase medical marijuana or medical marijuana products from a grower or processor; process, package, sell, transfer, and transport or contract with a commercial transporter to transport medical marijuana and medical marijuana products that they processed to a licensed dispensary, processor, or testing laboratory in accordance with Oklahoma law and this Chapter; and process medical marijuana received from a licensed patient into a medical marijuana concentrate, for a fee.

"Production batch" means
(A) Any amount of medical marijuana concentrate, not to exceed ten (10) pounds, of the same category and produced using the same extraction methods, standard operating procedures, and an identical group of harvest batch of medical marijuana; and
(B) Any amount of finished medical marijuana product, not to exceed ten (10) pounds, of the same exact type, produced using the same ingredients, standard operating procedures, and same production batch of medical marijuana concentrate or same harvest batch of medical marijuana.

"Public institution" means any entity established or controlled by the federal government, state government, or a local government or municipality, including, but not limited, institutions of higher education and related research institutions.

"Public money" means any funds or money obtained from any governmental entity, including, but not limited, research grants.

"Public school" means a preschool, elementary, middle, or high school established under state law, regulated by the local state authorities in the various political subdivisions, funded and maintained by public taxation, and open and free to all children of the particular district where the school is located.

"Publicly traded company" means a business entity organized under the laws of the United States or Canada where the domicile for the business entity permits the sale of marijuana, or such business entity has a class of securities that are registered and traded for investment pursuant to the Securities Exchange Act of 1934 or listed and traded for investment on a reputable recognized foreign stock exchange or foreign market.

"Quality assurance laboratory" means a laboratory designated by the Department to conduct surveillance of testing laboratories for compliance purposes.

"Registered to conduct business" means any individual or entity that is required under Oklahoma law to register with the Oklahoma Secretary of State and/or the Oklahoma Tax Commission and has provided sufficient proof to the Department of its good standing with such.

"Remediation" means the process by which the medical marijuana flower or trim, which has failed microbial testing, is processed into solvent-based medical marijuana concentrate and tested in accordance with these Rules.

"Research project" means a discrete scientific endeavor to answer a research question or a set of research questions related to medical marijuana and is required for a medical marijuana research license.

"Research facility" means an individual or entity that has been issued a license by the Department to grow, cultivate, possess, and transfer to testing laboratories, and to transfer by sale or donation to other licensed research facilities, medical marijuana for the limited research purposes permitted under state and federal law and these Rules.

"Retailer" or "Retail marijuana establishment" as used in 63 O.S. § 420 et seq. means an entity licensed by the State Department of Health as a medical marijuana dispensary.

"Revocation" means the Department’s final decision in accordance with the Oklahoma Administrative Procedures Act, 75 O.S. § 250 et seq., that any license issued by the Department pursuant to Oklahoma law and this Chapter is rescinded.

"RFID" means Radio Frequency Identification.
"Rules" means, unless otherwise indicated, the rules as adopted and set forth in OAC 310:681.

"Sampler" means a person who is employed by or is an owner of a licensed laboratory, grower, or processor and is authorized by that employer to collect samples in accordance with the testing laboratory's standard operating procedures and these Rules.

"Seedling" means a marijuana plant that has no flowers.

"Seed-to-sale tracking system" means an electronic inventory tracking system utilized by a commercial licensee to track inventory, any steps through the process of cultivating or manufacturing medical marijuana and/or medical marijuana products, transactions with other licensees, testing, and other required information for the purpose of reporting that information to the Department in accordance with Oklahoma law, rules, and regulations.

"Shipping container" means a hard-sided container with a lid or other enclosure that can be secured into place. A shipping container is used solely for the transport of medical marijuana, medical marijuana concentrate, or medical marijuana products between medical marijuana businesses, a medical marijuana research facility, or a medical marijuana education facility.

"State question" means Oklahoma State Question No. 788 and Initiative Petition Number 412.

"Strain" means the classification of marijuana or cannabis plants in either pure sativa, indica, afghanica, ruderalis, or hybrid varieties.

"Terpenoids" means isoprenes that are the aromatic compounds found in cannabis, including, but not limited to: limonene, myrcene, pinene, linalool, eucalyptol, α-terpinene, β-caryophyllene, caryophyllene oxide, nerolidol and phytol.

"Testing laboratory" or "Laboratory" means a public or private laboratory licensed pursuant to state law and these Rules to conduct testing and research on medical marijuana and medical marijuana products.

"THC" means tetrahydrocannabinol, which is the primary psychotropic cannabinoid formed by decarboxylation of naturally tetrathydrocannabinolic acid, which generally occurs by exposure to heat.

"Transporter" or "Commercial Transporter" means an individual or entity issued a medical marijuana commercial license by the Department, which allows the transporter to transport, store, and distribute medical marijuana and medical marijuana products to and from the licensed premises of commercial licensee. As used in this Chapter, "Transporter" or "Commercial Transporter" does not mean licensed commercial growers, processors, and dispensaries who are automatic holders of transporter licenses.

"Transporter Agent" means an agent, employee, officer, or owner of commercial transporter, grower, processor, or dispensary who has been issued a transporter agent license by the Department to transport medical marijuana and medical marijuana products on behalf of the said commercial transporter, grower, processor, or dispensary.

"Transporter license" means a medical marijuana business license issued by the Department either (A) automatically to commercial growers, processors, and dispensaries upon approval of a business license, or (B) to commercial transporters solely for the transportation, storage, and distribution of medical marijuana and medical marijuana products.

"Usable medical marijuana" means the dried leaves, flowers, oils, vapors, waxes, and other portions of the marijuana plant and any mixture or preparation thereof, excluding seed, roots, stems, stalks, and fan leaves.

"Waste disposal facility" means an individual or entity that has been issued a medical marijuana waste disposal facility license by the Department to dispose of medical marijuana waste as authorized in Oklahoma law and these Rules.

"Waste disposal facility license" means a license issued by the Department to possess, transport, and dispose of medical marijuana waste. The waste disposal facility license shall be issued to the location submitted by the applicant that is first approved by the Department.

"Waste disposal facility permit" means a permit issued by the Department to a waste disposal licensee to possess, transport, and dispose of medical marijuana waste at the location submitted on the permit application. Waste disposal facility permits shall be required for each approved facility operated by a waste disposal facility licensee.

"Wholesale package" means medical marijuana from the same harvest batch or multiple units of medical marijuana product from the same production batch that are combined together as a single unit for the purpose of RFID tagging and are transported to a single commercial licensee.

"Working towards operational status" means a commercial licensee that:

(A) Has applied for any additional permits, registrations, or licenses required by the Department or another Oklahoma agency, organization, or political subdivision to lawfully conduct operations at the licensed premises and is awaiting issuance of such permit(s), registration(s), or other license(s);

(B) Is performing construction or other material changes to the licensed premises in preparation of operations at the licensed premises;

(C) Is onboarding or training initial staff in preparation of operations at the licensed premises;

(D) Is in the process of purchasing or is awaiting receipt or delivery of physical materials essential to operations at the licensed premises, such as furniture or equipment; or

(E) Any additional actions determined to be sufficient by the Department.

SUBCHAPTER 2. MEDICAL MARIJUANA LICENSES

310:681-2-3. Application for caregiver's license

(a) Applications for a caregiver's license for caregivers of a licensed patient may be made at any time during the term of the patient license.

(b) Only one caregiver's license shall be issued for each patient license, except in the case of a licensed patient under the age of eighteen (18) whereby two (2) parents and/or legal
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guardians may be recognized as the minor's caregivers, if such minor is homebound.
(c) A caregiver's application will be accepted for a patient who has a physician's attestation that the patient is homebound or does not have the capability to self-administer or purchase medical marijuana due to developmental disability or physical or cognitive impairment and would benefit by having a designated caregiver to manage medical marijuana on the behalf of the patient as provided in OAC 310:681-2-1(c)(4)(E)(iv).
(d) The caregiver's application shall be made on a form provided by the Department and shall include the following:
   (1) All information and documentation for the caregiver provided for in OAC 310:681-2-1(a) and (c) except there shall be no medical certification from an Oklahoma Physician nor fee assessed for a caregiver's license;
   (2) A signed and dated attestation from the patient license holder or patient applicant, or the patient's parent(s) or legal guardian(s) if patient is under eighteen (18) years of age, appointing the caregiver as their designee under this provision. If the patient license holder is incapacitated or subject to legal guardianship, a durable medical power of attorney or a court order for guardianship may be submitted and the person appointed to act under that document may execute the notarized statement; and
   (3) The patient license number shall be included in the application.
(e) A caregiver issued and in possession of a valid, unexpired OMMA caregiver license may exercise the same rights as the medical marijuana patient license holder for whom he or she is designated caregiver, except that:
   (1) A caregiver may not use the medical marijuana or medical marijuana products obtained on behalf of the medical marijuana patient license holder; and
   (2) A caregiver may only exercise cultivation rights on behalf of up to five (5) medical marijuana patient license holders and shall not charge a medical marijuana patient licensee for cultivating medical marijuana in excess of actual costs incurred in cultivating the medical marijuana.
(f) A caregiver shall immediately notify the Department in a manner prescribed by the Department if the medical marijuana patient license holder for whom he or she is designated caregiver is deceased.

SUBCHAPTER 3. TRANSPORTER LICENSE

310:681-3-1. License for transportation of medical marijuana
(a) A medical marijuana transporter license shall be issued to qualifying applicants for grower, processor, or dispensary licenses at the time of approval. This license shall enable licensed growers, processors, and dispensaries through their licensed transporter agents to transport medical marijuana or medical marijuana products to other commercial licensees. This license shall not authorize licensed growers, processors, or dispensaries to transport, store, or distribute medical marijuana or medical marijuana products on behalf of other medical marijuana licensees.
(b) A medical marijuana commercial transporter license shall be issued as an independent business license to applicants meeting the requirements set forth in OAC 310:681-5-3, OAC 310:681-5-3.1, and OAC 310:681-5-3.2. This license shall be subject to the same restrictions and obligations as any commercial licensee and shall enable the commercial transporter to:
   (1) transport, store, and distribute medical marijuana and medical marijuana products on behalf of other commercial licensees;
   (2) contract with multiple commercial licensees; and
   (3) maintain multiple warehouses at licensed premises that are approved by the Department for the purpose of temporarily storing and distributing medical marijuana and medical marijuana products.
(c) A commercial transporter applicant or licensee must obtain and submit to the Department for each warehouse location a certificate of compliance issued by the political subdivision where the licensed premises is to be located certifying compliance with the categories listed in 63 O.S. § 426.1(E), and the licensed premises shall meet security requirements applicable to a medical marijuana business.
(d) A commercial transporter shall be responsible for any and all medical marijuana and medical marijuana products within its custody, control, or possession. A commercial transporter applicant or licensee must have each warehouse location inspected and approved by the Department prior to its use.
(e) No person or entity shall transport or otherwise transfer any medical marijuana or medical marijuana products without both a valid transporter license and a valid transporter agent license. A commercial transporter shall be responsible for any and all medical marijuana and medical marijuana products within its custody, control, or possession.
(f) No person or entity shall transport or otherwise transfer any medical marijuana or medical marijuana products without both a valid transporter license and a valid transporter agent license.

310:681-3-6. Inventory manifests
(a) Commercial transporters, growers, processors, and dispensaries shall utilize an electronic inventory management system the State inventory tracking system in accordance with OAC 310:681-5-6(d) to create and maintain shipping manifests documenting all transport of medical marijuana and medical marijuana products throughout the State of Oklahoma. (b) When transporting medical marijuana or medical marijuana products, commercial transporters, growers, processors, and dispensaries shall provide copies of the inventory manifests to each originating and receiving licensee at the time the product changes hands.
   (1) The copy of the inventory manifest to be left with the originating licensee shall include, at a minimum:
      (A) The license number, business name, address, and contact information of the originating licensee;
      (B) The license number, business name, address, and contact information of the commercial transporter, grower, processor, or dispensary transporting
the medical marijuana if such licensee is not the originating licensee;
(C) A complete inventory of the medical marijuana and medical marijuana products to be transported, including the quantities by weight or unit of each type of medical marijuana and medical marijuana products and the batch number(s);
(D) The date of transportation and the approximate time of departure;
(E) Printed names, signatures, and transporter agent license numbers of personnel accompanying the transport;
(F) Notation of the commercial transporter, grower, processor, or dispensary authorizing the transport; and
(G) The license number(s), business name(s), address(es), and contact information for all end point recipients.

(2) The copy of the inventory manifest to be left with the receiving licensee shall include, at a minimum:
(A) The license number, business name, address, and contact information for the receiving licensee;
(B) The license number, business name, address, and contact information of the originating licensee;
(C) The license number, business name, address, and contact information of the commercial transporter, grower, processor, or dispensary transporting the medical marijuana if such licensee is not the originating licensee;
(D) A complete inventory of the medical marijuana and medical marijuana products delivered to the receiving licensee, including the quantities by weight or unit of each type of medical marijuana and medical marijuana products and the batch number(s);
(E) The date and estimated time of arrival;
(F) The printed names, signatures, and transporter agent license numbers of the personnel accompanying the transport; and
(G) The printed names, titles, and signatures of any personnel accepting delivery on behalf of the receiving licensee.

(c) A separate inventory manifest shall be prepared for each licensee receiving the medical marijuana or medical marijuana products.
(d) Commercial transporters, processors, growers, and dispensaries shall also maintain copies of all inventory manifests in accordance with OAC 310:681-5-6(b).
(e) Inventory manifests should reflect a complete chain of custody of any and all medical marijuana and medical marijuana products being transported, including all instances in which the medical marijuana and medical marijuana products are stored at a commercial transporter warehouse.
(f) Originating and receiving licensees shall maintain copies of inventory manifests and inventory records logging the quantity of medical marijuana or medical marijuana products received for at least three (3) years from the date of receipt.
(g) An inventory manifest shall not be altered after departing from the originating licensee's premises, except for the addition of the printed names, titles, and signatures of any personnel accepting delivery on behalf of the receiving licensee.
(h) A receiving licensee shall refuse to accept any medical marijuana or medical marijuana products that are not accompanied by an inventory manifest.
(i) If a receiving licensee refuses to accept delivery of any medical marijuana and/or medical marijuana product or if delivery of the medical marijuana or medical marijuana is impossible:

(1) The medical marijuana and/or medical marijuana products shall be immediately returned to originating licensee who retains legal ownership of the products; and
(2) The refusal shall be fully documented in the inventory manifests, which should include, at a minimum:
(A) The license number, business name, address, and contact information of the licensee to which the medical marijuana or medical marijuana products were to be delivered;
(B) A complete inventory of the medical marijuana or medical marijuana products being returned, including batch number;
(C) The date and time of the refusal; and
(D) Documentation establishing the medical marijuana or medical marijuana products were returned in accordance with OAC 310:681-3-6(i)(1).

SUBCHAPTER 4. RESEARCH FACILITIES AND EDUCATION FACILITIES

310:681-4-2. Licenses
(a) Timeframe. Research facility and education facility licenses shall be issued for a twelve (12) month period expiring one (1) year from the date of issuance. The license may be issued upon receipt of a completed application, payment of application fee, and verification by the Department the individual or entity complies with the requirements set forth in Oklahoma law and this Chapter.
(b) Location. Research facility and education facility licenses shall only be valid for a single location at the address listed on the application. If a single research project will occur in multiple locations, a separate research facility or education facility license shall be required for each location.
(c) Renewal of license.

(1) It is the responsibility of the license holder to renew the license, with all applicable documentation, prior to the date of expiration of the license by following the procedures provided in OAC 310:681-4-3.
(2) Before renewing a license, the Department may require further information and documentation to determine the licensee continues to meet the requirements set forth in Oklahoma law and these Rules.
(3) If the research conducted by a research facility licensee includes a public institution or public money, the Department shall review any reports made by the licensee to determine if the research continues to meet qualifications in state law and these Rules.
(4) The Department may refuse to renew a license of a research or education facility for the following:
   (A) Failure to meet the requirements for licensure set forth in 63 O.S. § 420 et seq.; the Oklahoma Medial Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq.; or OAC 310:681.
   (B) Noncompliance with 63 O.S. § 420 et seq.; the Oklahoma Medial Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq.; the Oklahoma Medical Marijuana Waste Management Act, 63 O.S. § 427a et seq.; or OAC 310:681.
(5) Upon the determination that a licensee has not met the requirements for renewal, the Department shall provide written notice to the licensee. The notice shall provide an explanation for the denial of the renewal application.
(d) Liquidation of products. A research facility or education facility licensee whose license is not renewed, or whose license is revoked, suspended, or voluntarily surrendered, shall cease all operations immediately upon expiration of the license and shall liquidate or dispose of all medical marijuana and medical marijuana products in accordance with OAC 310:681-5-2(d).
(e) Change in information.
   (1) Licensees shall notify the Department in writing within fourteen (14) days of any changes in contact information by electronically submitting a change request in accordance with the Department's instructions.
   (2) Licensees shall obtain Department approval prior to any changes that affect the licensee's qualifications for licensure. Licensees shall notify the Department in writing in advance of any change that may affect the licensee's qualifications for licensure by electronically submitting a change request, along with any relevant documentation, in accordance with the Department's instructions. Except as is otherwise authorized by the Department, licensees are limited to one location change request and one ownership change request per year of licensure.
   (A) Medical marijuana research and education licensees submitting a location change request shall provide the information and documentation required in OAC 310:681-4-3 relating to locations, including but not limited to the following:
      (i) A certificate of compliance as required in OAC 310:681-4-3(e) on a form prescribed or otherwise authorized by the Department that is issued by the political subdivision where the licensed premises is to be located certifying compliance with the categories listed in 63 O.S. § 426.1(E); and
      (ii) Any further documentation the Department determines is necessary to ensure the business licensee is still qualified under Oklahoma law and this Chapter to obtain a business license.
   (B) Medical marijuana research and education licensees submitting an ownership change request must provide the information and documentation required in OAC 310:681-4-3 relating to owners, including but not limited to the following:
      (i) If applicable, a list of all owners and principal officers of the applicant and supporting documentation as set forth in OAC 310:681-4-3(e)(2);
      (ii) Documents required under OAC 310:681-4-3(e)(3) establishing that the applicant; and the members, managers, and board members if applicable; and seventy-five percent (75%) of the research facility's or education facility's ownership interests are Oklahoma residents as required in the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq.;
      (iii) For public institutions seeking a research facility license, a background check for each principal investigator and co-principal investigator;
      (iv) Any further documentation the Department determines is necessary to ensure the business licensee is still qualified under Oklahoma law and this Chapter to obtain a business license.
(3) Licensees shall notify the Department prior to any changes that affect the initial research project and/or curriculum, including funding, in a manner prescribed by the Department. If the research will be conducted with a public institution or public money, the licensee shall supply any documentation or information the Department determines is necessary to determine whether any change to the research project and/or curriculum constitutes a material change. If there is a material change, the Department may deny the change and require the licensee to submit a new application.
(f) Transfer of license.
   (1) Research facility and education facility licenses shall not be assigned or otherwise transferred from one person to another person or from one legal entity to another.
   (2) Licenses shall not be changed from one license type to another.
   (2) Licenses are limited to the research project(s) approved by the Department and shall not be transferred to any other research project, research, or curriculum.
(g) Surrender of license. A research facility or education facility licensee may voluntarily surrender a license to the Department at any time in accordance with 310:681-5-2(g).

310:681-4-5. Inventory tracking, records, and reports
(a) Monthly reports. Research facility licensees shall submit monthly reports to the Department, which shall include:
   (1) The amount of marijuana purchased from medical marijuana businesses and research facilities in pounds;
   (2) The amount of medical marijuana grown and used for research in pounds;
   (3) The amount of marijuana waste in pounds;
   (4) If necessary, a detailed explanation of why any marijuana cannot be accounted for as having been purchased, used for research, or maintained in current inventory; and...
(5) Any information the Department determines is necessary to ensure that all marijuana grown in Oklahoma is accounted for as required under 63 O.S. § 420 et seq. the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq.

(6) Upon implementation, submission of information and data to the Department through the State inventory tracking system will be required in accordance with the Oklahoma Medical Marijuana Protection Act, 63 O.S. § 427.1 et seq., and these Rules, and submission of information and data to the Department through the State inventory tracking system shall be sufficient to satisfy monthly reporting requirements.

(b) **Transfer or sale.** A research facility licensee and an educational facility licensee may only transfer, by sale or donation, marijuana grown within its operation to medical marijuana research licensees. Research facility and education facility licensees shall keep records for every transaction related to the donation or sale of marijuana. Records related to the donation or sale shall include at a minimum the following:

1. The name and license number of the medical marijuana research licensee that purchased or received the medical marijuana;
2. The address and phone number of each recipient;
3. The type of marijuana donated or sold;
4. The amount of marijuana donated or sold in pounds; and
5. The date of the donation or sale.

(c) **Records.** Pursuant to the Department's audit and inspection responsibilities, research facility and education facility licensees shall keep onsite and readily accessible, either in paper or electronic form, a copy of the records listed below. Except as otherwise specifically provided in Oklahoma law and this Chapter, all records shall be maintained for at least seven (7) years from the date of creation.

1. Business records, which may include but are not limited to employee records, organizational documents or other records relating to the governance and structure of the licensee, manual or computerized records of assets and liabilities, monetary transactions, tax records, journals, ledgers, and supporting documents, including agreements, checks, invoices, receipts, and vouchers.
2. As applicable, any documents related to the processing, preparation, and/or testing of medical marijuana and medical marijuana products, including but not limited to lab reports, testing records, equipment inspections, training materials, and standard operating procedures.
3. Documentation of every instance in which medical marijuana was sold or otherwise transferred to or purchased or otherwise obtained from another licensee, which shall include, but is not limited to:
   - The name, license number, address, and phone number of all licensees involved in each transaction; and
   - The quantity and type of medical marijuana or medical marijuana products involved in each transaction;

   (C) The batch number of the medical marijuana or medical marijuana products involved in each transaction;
   (D) The date of each transaction;
   (E) The monetary value of the medical marijuana or medical marijuana products involved in each transaction, including the total sale or purchase amounts;
   (F) All point-of-sale and tax records; and
   (G) All inventory manifests and other documentation relating to the transport of medical marijuana and medical marijuana products.

(4) Any and all documents relating to the disposal or destruction of medical marijuana, medical marijuana products, and medical marijuana waste.

(5) Written standard operating procedures outlining the manner in which the commercial licensee operates as prescribed by the Department.

(d) **Inventory tracking system.** Pursuant to 63 O.S. § 427.3(D)(8) and 63 O.S. § 427.13(B), each research facility and education facility commercial licensee shall use the State inventory seed to sale tracking system established by the Department by inputting inventory tracking data required to be reported to the Department directly into the State inventory tracking system or by utilizing a seed-to-sale tracking system that integrates with the Department-established system at the time of its implementation.

All commercial licensees must have an inventory tracking system account activated to lawfully operate and must ensure all information is reported to the Department accurately and in real time or after each individual sale in accordance with 63 O.S. § 427.13(B)(1) and these Rules. The system utilized by each licensee shall be a system that all commercial licensees shall ensure the following information and data are accurately tracked and timely reported to the Department through the State inventory tracking system:

1. Documents the chain of custody of all medical marijuana and medical marijuana products, including every transaction with another commercial licensee, patient, or caregiver including, but not limited to:
   - The name, address, license number and phone number of the medical marijuana business that cultivated, manufactured, sold, purchased, or otherwise transferred the medical marijuana or medical marijuana product(s);
   - The type, item, strain, and category of medical marijuana or medical marijuana product(s) involved in the transaction;
   - The weight, quantity, or other metric required by the Department, of the medical marijuana or medical marijuana product(s) involved in the transaction;
   - The batch number of the medical marijuana or medical marijuana product(s);
   - The total amount spent in dollars;
   - All point-of-sale records as applicable;
   - Transportation information documenting the transport of medical marijuana or medical marijuana product(s) as required under OAC 310:681-3-6(b);
   - Testing results and information;
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Subsection (f) Waste records and information: (J) Marijuana excise tax records, if applicable; (K) RFID tag number(s);
(2) Establishes ongoing inventory controls and procedures for the conduct of inventory reviews and comprehensive inventories of medical marijuana and medical marijuana products for traceability, which shall enable the licensee to detect any diversion, theft, or loss in a timely manner;
(3) Identifies and allows for tracking and documentation of the entire life span of a licensee's stock of medical marijuana and medical marijuana products, including, at a minimum, notifying the Department:
(A) when medical marijuana seeds or clones are planted;
(B) when medical marijuana plants are harvested and/or destroyed;
(C) when medical marijuana is transported, or otherwise transferred, sold, stolen, diverted, or lost;
(D) a complete inventory of all medical marijuana; seeds; plant tissue; clones; usable marijuana; trim; leaves; other plant matter and medical marijuana products. When medical marijuana changes form, including, but not limited to, when it is planted, cultivated, processed, and infused into a final product;
(E) all samples sent to a testing laboratory or used for internal testing or other purposes; a complete inventory of all medical marijuana; seeds; plant tissue; clones; usable marijuana; trim; shake; leaves; other plant matter; and medical marijuana products;
(F) All samples sent to a testing laboratory or used for internal quality testing or other purposes;
(4) In event of a serious adverse event or recall, is capable of tracking medical marijuana or medical marijuana product from a patient back to the source of the medical marijuana or medical marijuana product; and
(5) Tracks medical marijuana using an assigned batch number and barcode.

Appendix

Submission of an application for a research facility or education facility license constitutes permission for entry to any licensed premises and auditing of the licensee during hours of operation and other reasonable times. Refusal to permit the Department entry or refusal to permit the Department to inspect all books and records shall constitute grounds for the non-renewal, suspension, or revocation of a license.

(1) The Department may review any and all records and information of a research facility or education facility licensees and may require and conduct interviews with such persons or entities and persons affiliated with such licensees, for the purpose of determining compliance with Department rules and applicable laws. Failure to make documents or other requested information available to the Department and/or refusal to appear or cooperate with an interview shall constitute grounds for non-renewal, suspension, or revocation of a license, or any other remedy or relief provided under law. All records shall be kept on-site and readily accessible.

(2) Licensees shall comply with all written requests from the Department to produce or provide access to records and information within ten (10) business days.

(3) If the Department identifies a violation of 62 O.S. § 420 et seq., the Oklahoma Medical Marijuana and Patient Protection Act, 62 O.S. § 427.1 et seq.; or these rules during an audit of the licensee, the Department shall take administrative action against the licensee in accordance with Oklahoma law, including the Oklahoma Administrative Procedures Act, 75 O.S. § 250 et seq.

(4) The Department may refer all complaints alleging criminal activity or other violations of Oklahoma law that are made against a licensee to appropriate Oklahoma state or local law enforcement or regulatory authorities.

(5) If the Department discovers what it reasonably believes to be criminal activity or other violations of Oklahoma law during an audit, the Department may refer the matter to appropriate Oklahoma state or local law enforcement or regulatory authorities for further investigation.

(6) Except as is otherwise provided in Oklahoma law or these Rules, correctable violations identified during an audit shall be corrected within thirty (30) days of receipt of a written notice of violation.

(7) If a licensee fails to correct violations within thirty (30) days, the licensee will be subject to a fine of $500.00 for each violation and any other administrative action and penalty authorized by law.

Inventory tracking system requirements.

(1) At a minimum, commercial licensees shall track, update, and report inventory after each individual sale to the Department in the State inventory tracking system.

(2) All commercial licensees must reconcile all on-premises and in-transit medical marijuana and medical marijuana product inventories each day in the State inventory tracking system at the close of business.

(3) Commercial licensees are required to use RFID tags from a Department-approved supplier for the State inventory tracking system. Each Licensee is responsible for the cost of all RFID tags and any associated vendor fees.
(A) A commercial licensee shall ensure its inventories are properly tagged and that a RFID tag is properly assigned to medical marijuana, medical marijuana products, and medical marijuana waste as required by the Department.

(B) A commercial licensee shall ensure it has an adequate supply of RFID tags at all times. If a commercial licensee is unable to account for unused RFID tags, the commercial licensee must report to the Department and the State inventory tracking system vendor within forty-eight (48) hours.

(C) RFID tags must contain the legal name and correct license number of the commercial licensee that ordered them. Commercial licensees are prohibited from using another licensee's RFID tags.

(D) Prior to a plant reaching a point where it is able to support the weight of the RFID tag and attachment strap, the RFID tag may be securely fastened to the stalk or other similarly situated position approved by the Department.

(E) When the plant becomes able to support the weight of the RFID tag, the RFID tag shall be securely fastened to a lower supporting branch. The RFID tag shall remain affixed for the entire life of the plant until disposal.

(F) Mother plants must be tagged before any cuttings or clones are generated therefrom.

(G) If a RFID tag gets destroyed, stolen, or falls off of a medical marijuana plant, the licensee must ensure a new RFID tag is placed on the medical marijuana plant and the change of the RFID tag is properly reflected in the State inventory tracking system.

(H) Commercial licensees shall not reuse any RFID tag that has already been affixed to any regulated medical marijuana or medical marijuana products.

(4) Each wholesale package of medical marijuana must have a RFID tag during storage and transfer and may only contain one harvest batch of medical marijuana.

(5) Prior to transfer, commercial licensees shall ensure that each immature plant is properly affixed with an RFID tag if the plant was not previously tagged in accordance with these rules.

(6) Commercial licensees' inventory must have a RFID tag properly affixed to all medical marijuana products during storage and transfer in one of the following manners:

(A) Individual units of medical marijuana products shall be individually affixed with a RFID tag; or

(B) Medical marijuana products may only be combined in a single wholesale package using one RFID tag if all units are from the same production batch.

(7) If any medical marijuana or medical marijuana products are removed from a wholesale package, each individual unit or new wholesale package must be separately tagged.

(8) All packages of medical marijuana waste shall have a RFID tag affixed and the contents of the waste package shall be reported in the State inventory tracking system.

(g) **Inventory tracking system administrators and users.**

(1) A commercial licensee must have at least one owner, or manager, who is an inventory tracking system administrator.

(2) The inventory tracking system administrator must attend and complete all required inventory tracking system training.

(3) If at any point, the inventory tracking system administrator for a licensee changes, the commercial licensee shall change or assign a new inventory tracking system administrator within three business days.

(4) Commercial licensees shall maintain an accurate and complete list of all inventory tracking system administrators and employee users.

(5) Commercial licensees shall ensure that all owners and employees that are granted inventory tracking system account access for the purpose of conducting inventory tracking functions are trained and authorized before the owners or employees may access the State inventory tracking system.

(6) All inventory tracking system users shall be assigned an individual account in the State inventory tracking system.

(7) Any individual entering data into the State inventory tracking system shall only use the inventory tracking system account assigned specifically to that individual. Each inventory tracking system administrator and inventory tracking system user must have unique log-in credentials that shall not be used by any other person.

(8) Within three (3) business days, commercial licensees must remove access for any inventory tracking system administrator or user from their accounts if any such individual no longer utilizes the State inventory tracking system or is no longer employed by the commercial licensee.

(h) **Loss access to State inventory tracking system.** If at any time a commercial licensee loses access to the State inventory tracking system due to circumstances beyond the commercial licensee's control, the commercial licensee shall keep and maintain records detailing all inventory tracking activities that were conducted during the loss of access. Once access is restored, all inventory tracking activities that occurred during the loss of access must be immediately entered into the State inventory tracking system. If a commercial licensee loses access to the State inventory tracking system due to circumstances within its control, the commercial licensee may not perform any business activities that would be required to be reported into the State inventory tracking system until access is restored and reporting is resumed; any transfer, sale, or purchase of medical marijuana or medical marijuana products shall be an unlawful sale.

(i) **Audits.** The Department may perform on-site audits of all research facility and education facility licensees to ensure the accuracy of information and data reported to the Department and to ensure that all marijuana grown in Oklahoma is accounted for. Submission of an application for a research facility or education facility license constitutes permission for entry to any licensed premises and auditing of the licensee during hours of operation and other reasonable times. Refusal to
permit the Department entry or refusal to permit the Department to inspect all books and records shall constitute grounds for the nonrenewal, suspension, or revocation of a license.

(1) The Department may review any and all records and information of a research facility or education facility licensee and may require and conduct interviews with such persons or entities and persons affiliated with such licensees, for the purpose of determining compliance with Department rules and applicable laws. Failure to make documents or other requested information available to the Department and/or refusal to appear or cooperate with an interview shall constitute grounds for nonrenewal, suspension, or revocation of a license, or any other remedy or relief provided under law. All records shall be kept on-site and readily accessible.

(2) Licensees shall comply with all written requests from the Department to produce or provide access to records and information within ten (10) business days.

(3) If the Department identifies a violation of 63 O.S. § 420 et seq., the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq.; or these Rules during an audit of the licensee, the Department shall take administrative action against the licensee in accordance with Oklahoma law, including the Oklahoma Administrative Procedures Act, 75 O.S. § 250 et seq.

(4) The Department may refer all complaints alleging criminal activity or other violations of Oklahoma law that are made against a licensee to appropriate Oklahoma state or local law enforcement or regulatory authorities.

(5) If the Department discovers what it reasonably believes to be criminal activity or other violations of Oklahoma law during an audit, the Department may refer the matter to appropriate Oklahoma state or local law enforcement or regulatory authorities for further investigation.

(6) Except as is otherwise provided in Oklahoma law or these Rules, correctable violations identified during an audit shall be corrected within thirty (30) days of receipt of a written notice of violation.

(7) If a licensee fails to correct violations within thirty (30) days, the licensee will be subject to a fine of $500.00 for each violation and any other administrative action and penalty authorized by law.

### SUBCHAPTER 5. MEDICAL MARIJUANA BUSINESSES

#### 310:681-5-1.1 Responsibilities of the license holder

Upon acceptance of the license issued by the Department, the license holder in order to retain the license shall:

(1) Post the license or permit in a location in the licensed premises that is conspicuous;

(2) Comply with the provisions in this Chapter;

(3) Allow representatives of the Department access to the medical marijuana business as specified under OAC 310:681-5-4 and OAC 310:681-5-6(e);

(4) Comply with directives of the Department including time frames for corrective actions specified in inspection reports, audit reports, notices, orders, warnings, and other directives issued by the Department in regard to the license holder's medical marijuana business or in response to community emergencies;

(5) Accept notices issued and served by the Department according to law;

(6) Be subject to the administrative, civil, injunctive, and criminal remedies authorized in law for failure to comply with this Chapter or a directive of the Department, including time frames for corrective actions specified in inspection reports, audit reports, notices, orders, warnings, and other directives;

(7) Ensure that all information and records maintained in the licensee's online OMMA license account—including the hours of operation for all licensed premises and a valid mailing address, if applicable—are complete, accurate, and updated in a timely manner in accordance with these Rules; and

(8) If applicable, submit the annual renewal application and pay all renewal license and late fees, if any.

(9) Bear the financial responsibility for all compliance and inventory tracking obligations and responsibilities set forth in Oklahoma statutes and these Rules. The Department will not contribute to, fund, or subsidize any commercial licensee's compliance or tracking expenses. Nothing herein shall be construed to require the Department to contribute to, subsidize, or fund in any way a commercial licensee's compliance or tracking expenses.

#### 310:681-5-2. Licenses

(a) **Timeframe.** A medical marijuana business license shall be issued for a twelve (12) month period expiring one (1) year from the date of issuance. The license may be issued upon receipt of a completed application, payment of application fee, and verification by the Department the individual or entity complies with the requirements set forth in Oklahoma law and this Chapter.

(b) **Location.** A business license issued to a grower, processor, dispensary, or testing laboratory shall only be valid for a single location at the address listed on the application. A transporter license shall only be valid at the physical locations that have been submitted to and approved by the Department and are listed on the application.

(c) **Renewal of license.**

(1) It is the responsibility of the license holder to renew the license, with all applicable documentation, prior to the date of expiration of the license by following the procedures provided in OAC 310:681-5-3.

(2) Before renewing a license, the Department may require further information and documentation and may require additional background checks to determine the licensee continues to meet the requirements set forth in Oklahoma law and these Rules.

(3) The Department may refuse to renew a license of a medical marijuana business for the following:

(A) Failure to meet the requirements for licensure set forth in 63 O.S. § 420 et seq; the Oklahoma Medical
Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq.; or OAC 310:681.

(B) Noncompliance with 63 O.S. § 420 et seq.; the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq.; the Oklahoma Medical Marijuana Waste Management Act, 63 O.S. § 427a et seq.; or OAC 310:681.

(4) Upon the determination that a licensee has not met the requirements for renewal, the Department shall provide written notice to the licensee. The notice shall provide an explanation for the denial of the renewal application.

(d) Liquidation of products. A medical marijuana business licensee whose license is not renewed, or whose license is revoked, suspended, or voluntarily surrendered, shall cease all operations immediately upon expiration of the license.

(1) A medical marijuana business has thirty (30) days from date of expiration, revocation, suspension, or surrender of a business license to liquidate and transfer all medical marijuana or medical marijuana products to another medical marijuana business that (1) the medical marijuana business may lawfully sell to and (2) is licensed to possess such medical marijuana or medical marijuana products.

(2) Any medical marijuana or medical marijuana products not liquidated in accordance with OAC 310:681-5-2(d)(1) shall be disposed of as specified under OAC 310:681-5-10.

(e) Change in information.

(1) Licensees shall notify the Department in writing within fourteen (14) days of any changes in contact information by electronically submitting a change request in accordance with the Department's instructions.

(2) Licensees shall obtain Department approval prior to any changes that affect the licensee's qualifications for licensure. Licensees shall notify the Department in writing in advance of any change that may affect the licensee's qualifications for licensure by electronically submitting a change request, along with any relevant documentation, in accordance with the Department's instructions. Except as otherwise authorized by the Department, licensees are limited to one location change request and one ownership change request per year of licensure.

(A) Medical marijuana business licensees submitting a location change must provide the information and documentation required in OAC 310:681-5-3 relating to locations, including but not limited to the following:

(i) If applicable, proof as required in OAC 310:681-5-3(e)(7)(5) that the location of the dispensary is at least one thousand (1,000) feet from any public and private school;

(ii) A certificate of compliance as required in OAC on a form prescribed or otherwise authorized by the Department that is issued by the political subdivision where the licensed premises is to be located certifying compliance with the categories listed in 63 O.S. § 426.1(E); and

(iii) Any further documentation the Department determines is necessary to ensure the business licensee is still qualified under Oklahoma law and this Chapter to obtain a business license.

(B) Medical marijuana business licensees submitting an ownership change request must provide the information and documentation required in OAC 310:681-5-3 relating to owners, including but not limited to the following:

(i) An list of all owners and principal officers of the commercial applicant and supporting documentation as set forth in OAC 310:681-5-3(e)(1);

(ii) An affidavit of lawful presence for each new owner;

(iii) Documents required under OAC 310:681-5-3(e)(6) establishing that the applicant; and the members, managers, and board members if applicable; and seventy-five percent (75%) of the commercial applicant's ownership interests are Oklahoma residents as required in the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq.;

(iv) A background check in accordance with OAC 310:681-1-5; and

(v) Any further documentation the Department determines is necessary to ensure the business licensee is still qualified under Oklahoma law and this Chapter to obtain a business license.

(C) Medical marijuana growers, processors, or commercial transporters that have held a valid medical marijuana business license for at least eighteen (18) months and are operating in good standing may submit an ownership change request to add a publicly traded company as an owner. The publicly traded company shall not own more than forty percent (40%) of the equity in the existing medical marijuana grower, processor or commercial transporter. The following documentation must be provided:

(i) If applicable, a certificate of good standing from the Oklahoma Secretary of State issued within thirty (30) days of submission of the application.

(ii) A list of all owners, excluding all shareholders of the publicly traded company, and principal officers of the commercial applicant and supporting documentation as set forth in OAC 310:681-5-3(e)(1);

(iii) Document required under OAC 310:681-5-3(e)(6) establishing that the applicant; and the members, managers, and board members if applicable; and seventy-five percent (75%) of the grower, processor, or transporter applicant's ownership interests, excluding the publicly traded company, are Oklahoma residents as required in the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq. 

(iv) Documentation establishing that the publicly traded company does not own more that forty
percent (40%) of the equity interest of the licensed medical marijuana grower, processor or commercial transporter including, but not limited to: certificate of incorporation, bylaws, articles of organization, operating agreement, certificate of limited partnership, resolution of a board of directors, or other similar documents.
(v) Documentation establishing the publicly traded company was organized under the laws of the United States or Canada where the domicile for the business entity permits the sale of marijuana.
(vi) Documentation establishing what securities exchanges the publicly traded company is listed and traded on, as well as stock symbol information.
(vii) Any further documentation the Department determines is necessary to ensure the medical marijuana grower, processor, or commercial transporter licensee is still qualified under Oklahoma law and this Chapter to obtain a business license.

(f) Transfer of license.
(1) Business licenses may not be assigned or otherwise transferred from one person to another person, from one medical marijuana business to another, or from one legal entity to another.
(2) Licenses may not be changed from one license to another.

(g) Surrender of license.
(1) A licensee may voluntarily surrender a license to the Department at any time.
(2) If a licensee voluntarily surrenders a license, the licensee shall:
   (A) Return the license to the Department;
   (B) Submit on a form prescribed by the Department a report to the Department including the reason for surrendering the license; contact information following the close of business; the person or persons responsible for the close of the business; and where business records will be retained;
   (C) Submit proof of the licensee’s identity through submission of documentation identified in OAC 310:681-1-7 (relating to Proof of Identity); and
   (D) Liquidate or dispose of any medical marijuana or medical marijuana products remaining in the possession of the licensee in accordance with OAC 310:681-5-2(d) and OAC 310:681-5-10.

310:681-5-3. Applications
(a) Application fee. An applicant for a medical marijuana business, or renewal thereof, shall submit to the Department a completed application on a form and in a manner prescribed by the Department, along with the application fee as established in 63 O.S. § 420 et seq. and the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq.
(b) Submission. Applications for a business license will be accepted by the Department no earlier than sixty (60) days from the date that the State Question is approved by the voters of the State of Oklahoma. The application shall be on the Department prescribed form and shall include the following information about the establishment:
   (1) Name of the establishment;
   (2) Physical address of the establishment, including the county in which any licensed premises will be located;
   (3) GPS coordinates of the establishment;
   (4) Phone number and email of the establishment; and
   (5) Hours of operation for any licensed premises.
(c) Individual applicant. The application for a business license made by an individual on his or her own behalf shall be on the Department prescribed form and shall include at a minimum:
   (1) The applicant's first name, middle name, last name and suffix if applicable;
   (2) The applicant's residence address and valid mailing address;
   (3) The applicant's date of birth;
   (4) The applicant's telephone number and email address;
   (5) An attestation that the information provided by the applicant is true and correct;
   (6) An attestation that any licensed premises shall not be located on tribal lands;
   (7) An attestation that the business has obtained all applicable local licenses and permits for all licensed premises;

(8) An attestation that no individual with ownership interest in the business is a sheriff, deputy sheriff, police officer, prosecuting officer, an officer or employee of OMMA, or an officer or employee of a municipality in which the commercial entity is located; and

(9) A statement signed by the applicant pledging not to divert marijuana to any individual or entity that is not lawfully entitled to possess marijuana.

(d) **Application on behalf of an entity.** In addition to requirements of Subsection (c), an application for a business license made by an individual on behalf of an entity shall include:

1. An attestation that applicant is authorized to make application on behalf of the entity;
2. Full name of organization;
3. Trade name, if applicable;
4. Type of business organization;
5. Mailing address;
6. Telephone number and email address; and
7. The name, residence address, and date of birth of each owner and each member, manager, and board member, if applicable.

(c) **Supporting documentation.** Each application shall be accompanied by the following documentation:

1. A list of all owners and principal officers of the business applicant and supporting documentation, including, but not limited to: certificate of incorporation, bylaws, articles of organization, operating agreement, certificate of limited partnership, resolution of a board of directors, or other similar documents;
2. If applicable, a certificate of good standing from the Oklahoma Secretary of State issued within thirty (30) days of submission of the application;
3. If applicable, an electronic copy or digital image in color of a sales tax permit issued by the Oklahoma Tax Commission;
4. An Affidavit of Lawful Presence for each owner;
5. If a licensed dispensary, proof that the location of the dispensary is at least one thousand (1,000) feet from a public or private school. The distance specified shall be measured in a straight line from any entrance of any public or private school to the nearest point of the location of the dispensary; the school door nearest the front door of the medical marijuana dispensary to the front door of the medical marijuana dispensary; and
6. Documents establishing the applicant; and the members, managers, and board members if applicable; and seventy-five percent (75%) of the commercial applicant's ownership interests are Oklahoma residents as required in the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq.

(A) Applicants seeking to renew a commercial license issued prior to the enactment of the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq., shall submit documentation establishing proof of residency in accordance with OAC 310:681-1-6 (relating to proof of residency);

(B) All other applicants shall submit documentation establishing proof of residency in accordance with OAC 310:681-5-3.1 (relating to proof of residency for business licenses).

(7) A certificate of compliance on a form prescribed or otherwise authorized by the Department that is issued by the political subdivision where the licensed premises is to be located certifying compliance with the categories listed in 63 O.S. § 426.1(E);

(8) If applicable, accreditation documentation, including documentation of enrollment in analyte-specific proficiency testing results, showing applicants meet requirements stated in OAC 310:681-8-2(a);

(9) Any further documentation the Department determines is necessary to ensure the commercial applicant is qualified under the Oklahoma law and this Chapter to obtain a commercial license. If a licensed grower, processor or transporter has added or is seeking to add a publicly traded company as an owner, additional documentation as required under OAC 310:681-5-2(e)(2)(C) to show the grower, processor or transporter applicants meet the requirements stated in 63 O.S. § 427.15a.

(10) Any further documentation the Department determines is necessary to ensure the commercial applicant is qualified under Oklahoma law and this Chapter to obtain a commercial license.

(f) **Incomplete application.** Failure to submit a complete application with all required information and documentation shall result in a rejection of the application. The Department shall notify the applicant via email through the electronic application account of the reasons for the rejection, and the applicant shall have thirty (30) days from the date of notification to correct and complete the application without an additional fee. If the applicant fails to correct and complete the application within the thirty (30) day period, the application shall expire.

(g) **Status update letter.** If a delay in processing has occurred, the Department shall notify the applicant via email of the delay and the reason for the delay.

310:681-5-4. **Inspections**

(a) Submission of an application for a medical marijuana commercial license constitutes permission for entry to and inspection of any licensed premises and any vehicles on the licensed premises used for the transportation of medical marijuana and medical marijuana products during hours of operation and other reasonable times. Refusal to permit or impeding such entry or inspection shall constitute grounds for the nonrenewal, suspension, or revocation of a license.

(b) The Department may perform two on-site inspections per calendar year of each licensed grower, processor, dispensary, or commercial transporter to determine, assess, and monitor compliance with applicable Oklahoma law and these Rules.

(c) The Department shall conduct one on-site inspection of a testing laboratory applicant prior to initial licensure and one on-site inspection annually thereafter. The inspection prior to initial licensure may include proficiency testing, and shall be conducted to ensure all application materials are accurate and
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the applicant meets all requirements in 63 O.S. § 427.17 and these Rules.
(d) The Department may conduct additional inspections to ensure correction of or investigate violations of applicable Oklahoma law and these Rules. Such inspections may be unannounced if the Department believes notice will result in the destruction of evidence. The Department shall conduct one on-site inspection of each warehouse location of a medical marijuana transporter applicant or licensee prior to approving the location for use to ensure all information and documentation is true and correct and to determine if the proposed warehouse location meets all requirements of 63 O.S. § 427.16 and these Rules.
(e) The Department shall refer all complaints alleging criminal activity or other violations of Oklahoma law that are made against a licensee to appropriate Oklahoma state or local law enforcement or regulatory authorities. The Department may conduct additional inspections to ensure correction of or investigate violations of applicable Oklahoma law and these Rules. Such inspections may be unannounced if the Department believes notice will result in the destruction of evidence.
(f) If the Department discovers what it reasonably believes to be criminal activity or other violations of Oklahoma law during an inspection, the Department may refer the matter to appropriate Oklahoma state or local law enforcement or regulatory authorities for further investigation. The Department shall refer all complaints alleging criminal activity or other violations of Oklahoma law that are made against a licensee to appropriate Oklahoma state or local law enforcement or regulatory authorities.
(g) The Department may review any and all records of a licensee and may require and conduct interviews with such persons or entities and persons affiliated with such entities, for the purpose of determining compliance with Department rules and applicable laws. Licensees shall be afforded at least twenty-four hours’ notice to secure legal representation prior to any interviews. Failure to make documents or other requested information available to the Department and/or refusal to appear or cooperate with an interview shall constitute grounds for nonrenewal, suspension, or revocation of a license, or any other remedy or relief available under law. All records shall be kept on-site and readily accessible. If the Department discovers what it reasonably believes to be criminal activity or other violations of Oklahoma law during an inspection, the Department may refer the matter to appropriate Oklahoma state or local law enforcement or regulatory authorities for further investigation.
(h) If the Department identifies a violation of 63 O.S. § 420 et seq., the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq., and these Rules during an inspection of the licensed business, the Department shall take administrative action in accordance with Oklahoma law, including the Oklahoma Administrative Procedures Act, 75 O.S. § 250 et seq. The Department may review any and all records of a licensee and may require and conduct interviews with such persons or entities and persons affiliated with such entities, for the purpose of determining compliance with Department rules and applicable laws. Licensees shall be afforded at least twenty-four hours’ notice to secure legal representation prior to any interviews. Failure to make documents or other requested information available to the Department and/or refusal to appear or cooperate with an interview shall constitute grounds for nonrenewal, suspension, or revocation of a license, or any other remedy or relief available under law. All records shall be kept on-site and readily accessible.
(i) Except as otherwise provided in Oklahoma law or these Rules, correctable violations identified during an inspection shall be corrected within thirty (30) days of receipt of a written notice of violations. If the Department identifies a violation of 63 O.S. § 420 et seq., the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq., and these Rules during an inspection of the licensed business, the Department shall take administrative action in accordance with Oklahoma law, including the Oklahoma Administrative Procedures Act, 75 O.S. § 250 et seq.
(j) If a licensee fails to correct violations within thirty (30) days, the licensee will be subject to a fine of $500.00 for each deficiency and any other administrative action and penalty authorized by law. Except as otherwise provided in Oklahoma law or these Rules, correctable violations identified during an inspection shall be corrected within thirty (30) days of receipt of a written notice of violations.
(k) If a licensee fails to correct violations within thirty (30) days, the licensee will be subject to a fine of $500.00 for each deficiency and any other administrative action and penalty authorized by law.

310:681-5-4.1. Operational status visit
(a) Initial operational status visit for Growers, Processors, and Dispensaries. Effective September 1, 2021, the Department shall begin scheduling on-site visits at licensed growers, processors, and dispensaries for the purposes of verifying whether the licensed grower, processor, or dispensary is actively operating or is working towards becoming operational.
1) Initial operational status visits shall be scheduled and shall occur within the first one hundred eighty (180) days after issuance of a medical marijuana grower, medical marijuana processor, or medical marijuana dispensary license.
2) Each operational status visit shall be performed on-site at the licensed premises on file with the Department.
3) If, at the time of the initial operational status visit, the grower, processor, or dispensary being inspected fails to provide proof to the Department that the licensee is actively operating or working towards operational status, the Department shall grant the grower, processor, or dispensary a grace period of one hundred eighty (180) additional days from the date of their initial operational status visit to become operational.
(b) Follow-up operational status visits. Upon the expiration of an operational status visit grace period, the Department shall perform a follow-up inspection of the licensed grower, licensed processor, or licensed dispensary for the purposes of verifying whether the licensed grower, processor, or dispensary
has begun actively operating or is continuing to work towards becoming operational.

(1) Follow-up operational status visits shall be scheduled upon expiration of the grace period.

(2) Each follow-up operational status visit shall be performed on-site at the licensed premises on file with the Department.

(3) If, at the time of the follow-up operational status visit, the grower, processor, or dispensary fails to provide proof to the Department that the medical marijuana commercial licensee is actively operating or is continuing to work towards becoming operational, the Department may elect to grant an additional grace period of one hundred eighty (180) days to become operational. However, if granted, such grace period shall not extend beyond the one-year term of the license.

(A) If the Department does not grant a grower, processor, or dispensary a secondary grace period, the Department shall seek revocation of the grower, processor, or dispensary license.

(B) If, after conducting a follow-up visit, the Department grants a secondary grace period, a grower, processor, or dispensary shall be afforded an additional term of one hundred eighty (180) days to become operational. Upon expiration of the secondary grace period, if a grower, processor, or dispensary has failed to provide proof to the Department that operations have commenced, the Department shall seek revocation of the grower, processor, or dispensary license. A third operational status visit of the licensed premises shall be at the discretion of the Department in making such a determination but shall not be required.

310:681-5-6. Inventory tracking, records, reports, and audits

(a) Monthly reports. Licensed growers, processors, and dispensaries shall complete a monthly report on a form and in a manner prescribed by the Department. These reports shall be deemed untimely if not received by the Department by the fifteenth (15th) of each month for the preceding month.

(1) Dispensary reports shall include:

(A) The amount of marijuana purchased in pounds;

(B) The amount of marijuana sold or otherwise transferred in pounds;

(C) The amount of marijuana waste in pounds;

(D) If necessary, a detailed explanation of why any medical marijuana product purchased by the licensee cannot be accounted for as having been sold or still remaining in inventory;

(E) Total dollar amount of all sales to medical marijuana patients and caregivers;

(F) Total dollar amount of all taxes collected from sales to medical marijuana patients and caregivers; and

(G) Any information the Department determines is necessary to ensure that all marijuana grown in Oklahoma is accounted for as required under 63 O.S. § 420 et seq. and the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq.

(2) Grower reports shall include:

(A) The amount of marijuana harvested in pounds;

(B) The amount of marijuana purchased in pounds;

(C) The amount of marijuana sold or otherwise transferred in pounds;

(D) The amount of drying or dried marijuana on hand;

(E) The amount of marijuana waste in pounds;

(F) If necessary, a detailed explanation of why any marijuana cannot be accounted for as having been sold, disposed of, or maintained in current inventory;

(G) Total dollar amount of all sales; and

(H) Any information the Department determines is necessary to ensure that all marijuana grown in Oklahoma is accounted for as required under 63 O.S. § 420 et seq. and the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq.

(3) Processor reports shall include:

(A) The amount of marijuana purchased in pounds;

(B) The amount of marijuana sold or otherwise transferred in pounds;

(C) The amount of medical marijuana manufactured or processed in pounds;

(D) If necessary, a detailed explanation of why any marijuana cannot be accounted for as having been purchased, sold, processed, or maintained in current inventory;

(E) The amount of marijuana waste in pounds; and

(F) Any information the Department determines is necessary to ensure that all marijuana grown in Oklahoma is accounted for as required under 63 O.S. § 420 et seq. and the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq.

(4) Upon implementation submission submission of information and data to the Department through the seed to sale tracking system established by the Department, or a seed to sale tracking system that integrates with the Department-established system, State inventory tracking system will be required in accordance with the Oklahoma Medical Marijuana Protection Act, 63 O.S. § 427.1 et seq., and these Rules, and submission of information and data to the Department through the State inventory tracking system shall be sufficient to satisfy monthly reporting requirements.

(b) Records. Pursuant to the Department’s audit and inspection responsibilities, medical marijuana business shall keep onsite and readily accessible, either in paper or electronic form, a copy of the records listed below. Except as otherwise specifically provided in Oklahoma law and this Chapter, all records shall be maintained for at least seven (7) years from the date of creation.

(1) Business records, which may include but are not limited to employee records, organizational documents or other records relating to the governance and structure of the licensee, manual or computerized records of assets and liabilities, monetary transactions, tax records, journals,
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ledgers, and supporting documents, including agreements, checks, invoices, receipts, and vouchers.

(2) As applicable, any documents related to the processing, preparation, transportation, sampling, and/or testing of medical marijuana and medical marijuana products, including but not limited to sample field logs, lab reports, testing records, equipment inspections, training materials, and standard operating procedures.

(3) Documentation of every instance in which medical marijuana was sold or otherwise transferred to or purchased or otherwise obtained from another licensee, which shall include, but is not limited to:

(A) The name, license number, address, and phone number of all licensees involved in each transaction; and
(B) The quantity and type of medical marijuana or medical marijuana products involved in each transaction;
(C) The batch number of the medical marijuana or medical marijuana products involved in each transaction;
(D) The date of each transaction;
(E) The monetary value of the medical marijuana or medical marijuana products involved in each transaction, including the total sale or purchase amounts;
(F) All point-of-sale and tax records; and
(G) All inventory manifests and other documentation relating to the transport of medical marijuana and medical marijuana products.

(4) Any and all documents relating to the disposal or destruction of medical marijuana, medical marijuana products, and medical marijuana waste.

(5) Written standard operating procedures outlining the manner in which the commercial licensee operates as prescribed by the Department.

(c) **Patient information.** Records containing private patient information shall not be retained by a medical marijuana business for more than sixty (60) days without the patient's or caregiver's consent. "Private patient information" means personally identifiable information, such as the patient name, address, date of birth, social security number, telephone number, email address, photograph, and financial information. This term does not include the patient's medical marijuana license number, which shall be retained by the business and provided to the Department upon request for compliance and public health purposes, including the verification of lawful sales or patient traceability in the event of product recall.

(d) **Inventory tracking system.** Pursuant to 63 O.S. § 427.3(D)(8) and 63 O.S. § 427.13(B), each business-commercial licensee shall use the seed-to-sale State inventory tracking system established by the Department or by inputting inventory tracking data required to be reported to the Department directly into the State inventory tracking system or by utilizing a seed-to-sale tracking system that integrates with the State inventory tracking system. Department-established system at the time of its implementation. All commercial licensees must have an inventory tracking system account activated to lawfully operate and must ensure all information is reported to the Department accurately and in real time or after each individual sale in accordance with 63 O.S. § 427.13(B)(1) and these Rules. The system utilized by each licensee shall be a system that: All commercial licensees shall ensure the following information and data are accurately tracked and timely reported to the Department through the State inventory tracking system:

(1) The chain of custody of all medical marijuana and medical marijuana products, including every transaction with another commercial licensee, patient, or caregiver, including, but not limited to:

(A) The name, address, license number and phone number of the medical marijuana business that cultivated, manufactured, sold, purchased, or otherwise transferred the medical marijuana or medical marijuana product(s);
(B) The type, item, strain, and category of medical marijuana or medical marijuana product(s) involved in the transaction;
(C) The weight, quantity, or other metric required by the Department, of the medical marijuana or medical marijuana product(s) involved in the transaction;
(D) The batch number of the medical marijuana or medical marijuana product(s);
(E) The total amount spent in dollars;
(F) All point-of-sale records as applicable;
(G) Transportation information documenting the transport of medical marijuana or medical marijuana product(s) as required under OAC 310:681-3-6(b);
(H) Testing results and information;
(I) Waste records and information;
(J) Marijuana excise tax records, if applicable;
(K) RFID tag number(s);

(2) Establishes ongoing inventory controls and procedures for the conduct of inventory reviews and comprehensive inventories of medical marijuana and medical marijuana products for traceability, which shall enable the licensee to detect any diversion, theft, or loss in a timely manner.

(3) Identifies and allows for tracking and documentation of the entire life span of a licensee's stock of medical marijuana and medical marijuana products, including, at a minimum notifying the Department:

(A) When medical marijuana seeds or clones are planted;
(B) When medical marijuana plants are harvested and/or destroyed;
(C) When medical marijuana is transported, or otherwise transferred, sold, stolen, diverted, or lost;
(D) A complete inventory of all medical marijuana, seeds, plant tissue, clones, usable marijuana, trim, leaves, other plant matter, and medical marijuana products when medical marijuana changes form, including, but not limited to, when it is planted, cultivated, processed, and infused into a final form product.
(E) All samples sent to a testing laboratory or used for internal quality testing or other purposes; A complete inventory of all medical marijuana; seeds; plant tissue; clones; usable marijuana; trim; shake; leaves; other plant matter; and medical marijuana products;

(F) All samples sent to a testing laboratory or used for internal quality testing or other purposes;

(4) In event of a serious adverse event or recall, is capable of tracking medical marijuana or medical marijuana product from a patient back to the source of the medical marijuana or medical marijuana product; and

(35) Tracks medical marijuana using an assigned batch number and bar code. Any further information the Department determines is necessary to ensure all medical marijuana and medical marijuana products are accurately and fully tracked throughout the entirety of the life span of the plant and product.

(e) Seed-to-sale tracking system. A commercial licensee shall use a seed-to-sale tracking system or integrate its own seed-to-sale tracking system with the State inventory tracking system established by the Department. If a commercial licensee uses a seed-to-sale tracking system that does not integrate with the State inventory tracking system, or does integrate but does not share all required information, the commercial licensee shall ensure all required information is reported directly into the State inventory tracking system.

(f) Audits. The Department may perform on-site audits of all research facility and education facility licensees to ensure the accuracy of the research facility’s monthly reports and to ensure that all marijuana grown in Oklahoma is accounted for. Submission of an application for a research facility or education facility license constitutes permission for entry to any licensed premises and auditing of the licensee during hours of operation and other reasonable times. Refusal to permit the Department entry or refusal to permit the Department to inspect all books and records shall constitute grounds for the non-renewal, suspension, or revocation of a license.

(1) The Department may review any and all records and information of a research facility or education facility licensee and may require and conduct interviews with such persons or entities and persons affiliated with such licensees, for the purpose of determining compliance with Department rules and applicable laws. Failure to make documents or other requested information available to the Department and/or refusal to appear or cooperate with an interview shall constitute grounds for nonrenewal, suspension, or revocation of a license, or any other remedy or relief provided under law. All records shall be kept on-site and readily accessible.

(2) Licensees shall comply with all written requests from the Department to produce or provide access to records and information within ten (10) business days.

(3) If the Department identifies a violation of 63 O.S. § 420 et seq., the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq., or these Rules during an audit of the licensee, the Department shall take administrative action against the licensee in accordance with Oklahoma law, including the Oklahoma Administrative Procedures Act, 75 O.S. § 250 et seq.

(4) The Department may refer all complaints alleging criminal activity or other violations of Oklahoma law that are made against a licensee to appropriate Oklahoma state or local law enforcement or regulatory authorities.

(5) If the Department discovers what it reasonably believes to be criminal activity or other violations of Oklahoma law during an audit, the Department may refer the matter to appropriate Oklahoma state or local law enforcement or regulatory authorities for further investigation.

(6) Except as otherwise provided in Oklahoma law or these Rules, correctable violations identified during an audit shall be corrected within thirty (30) days of receipt of a written notice of violation.

(7) If a licensee fails to correct violations within thirty (30) days, the licensee will be subject to a fine of $500.00 for each violation and any other administrative action and penalty authorized by law.

Inventory Tracking System Requirements.

(1) At a minimum, commercial licensees shall track, update, and report inventory after each individual sale to the Department in the State inventory tracking system.

(2) All commercial licensees must reconcile all on-premises and in-transit medical marijuana and medical marijuana product inventories each day in the State inventory tracking system at the close of business.

(3) Commercial licensees are required to use RFID tags from a Department-approved supplier for the State Inventory Tracking System. Each Licensee is responsible for the cost of all RFID tags and any associated vendor fees.

(A) A commercial licensee shall ensure its inventories are properly tagged and that a RFID tag is properly assigned to medical marijuana, medical marijuana products, and medical marijuana waste as required by the Department.

(B) A commercial licensee shall ensure it has an adequate supply of RFID tags at all times. If a commercial licensee is unable to account for unused RFID tags, the commercial licensee must report to the Department and the State inventory tracking system vendor within forty-eight (48) hours.

(C) RFID tags must contain the legal name and correct license number of the commercial licensee that ordered them. Commercial licensees are prohibited from using another licensee’s RFID tags.

(D) Prior to a plant reaching a point where it is able to support the weight of the RFID tag and attachment strap. The RFID tag may be securely fastened to the stalk or other similarly situated position approved by the Department.

(E) When the plant becomes able to support the weight of the RFID tag, the RFID tag shall be securely fastened to a lower supporting branch. The RFID tag shall remain affixed for the entire life of the plant until disposal.

(F) Mother plants must be tagged before any cuttings or clones are generated therefrom.
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(G) If a RFID tag gets destroyed, stolen, or falls off of a medical marijuana plant, the licensee must ensure a new RFID tag is placed on the medical marijuana plant and the change of the RFID tag is properly reflected in the State inventory tracking system.

(H) Commercial licensees shall not reuse any RFID tag that has already been affixed to any regulated medical marijuana or medical marijuana products.

(4) Each wholesale package of medical marijuana must have a RFID tag during storage and transfer and may only contain one harvest batch of medical marijuana.

(5) Prior to transfer, commercial licensees shall ensure that each immature plant is properly affixed with an RFID tag if the plant was not previously tagged in accordance with these rules.

(6) Commercial licensees' inventory must have a RFID tag properly affixed to all medical marijuana products during storage and transfer in one of the following manners:

(A) Individual units of medical marijuana products shall be individually affixed with a RFID tag; or

(B) Medical marijuana products may only be combined in a single wholesale package using one RFID tag if all units are from the same production batch.

(7) If any medical marijuana or medical marijuana products are removed from a wholesale package, each individual unit or new wholesale package must be separately tagged.

(8) All packages of medical marijuana waste shall have a RFID tag affixed and the contents of the waste package shall be reported in the State inventory tracking system.

(g) Inventory tracking system administrators and users.

(1) A commercial licensee must have at least one owner, or manager, who is an inventory tracking system administrator.

(2) The inventory tracking system administrator must attend and complete all required inventory tracking system training.

(3) If at any point, the inventory tracking system administrator for a commercial licensee changes, the commercial licensee shall change or assign a new inventory tracking system administrator within three business days.

(4) Commercial licensees shall maintain an accurate and complete list of all inventory tracking system administrators and employees.

(5) Commercial licensees shall ensure that all owners and employees that are granted inventory tracking system account access for the purpose of conducting inventory tracking functions are trained and authorized before the owners or employees may access the State inventory tracking system.

(6) All inventory tracking system users shall be assigned an individual account in the State inventory tracking system.

(7) Any individual entering data into the State inventory tracking system shall only use the inventory tracking system account assigned specifically to that individual.

Each inventory tracking system administrator and inventory tracking system user must have unique log-in credentials that shall not be used by any other person.

(8) Within three (3) business days, commercial licensees must remove access for any inventory tracking system administrator or user from their accounts if any such individual no longer utilizes the State inventory tracking system or is no longer employed by the commercial licensee.

(h) Loss of use of the State inventory tracking system. If at any time a commercial licensee loses access to the State inventory tracking system due to circumstances beyond the commercial licensee's control, the commercial licensee shall keep and maintain records detailing all inventory tracking activities that were conducted during the loss of access. Once access is restored, all inventory tracking activities that occurred during the loss of access must be immediately entered into the State inventory tracking system. If a commercial licensee loses access to the State inventory tracking system due to circumstances within its control, the commercial licensee may not perform any business activities that would be required to be reported into the State inventory tracking system until access is restored and reporting is resumed; any transfer, sale, or purchase of medical marijuana or medical marijuana products shall be an unlawful sale.

(i) Audits. The Department shall perform on-site audits of all commercial licensees to ensure the accuracy of information and data reported to the Department and to ensure that all marijuana grown in Oklahoma is accounted for. Submission of an application for a medical marijuana commercial license constitutes permission for entry to any licensed premises and auditing of the commercial licensee during hours of operation and other reasonable times. Refusal to permit the Department entry or refusal to permit the Department to inspect all books and records shall constitute grounds for the nonrenewal, suspension, or revocation of a license.

(1) The Department may review any and all records and information of a commercial licensee and may require and conduct interviews with such persons or entities and persons affiliated with such licensees, for the purpose of determining compliance with Department rules and applicable laws. Failure to make documents or other requested information available to the Department and/or refusal to appear or cooperate with an interview shall constitute grounds for nonrenewal, suspension, or revocation of a license or any other remedy or relief provided under law. All records shall be kept onsite and readily accessible.

(2) Commercial licensees shall comply with all written requests from the Department to produce or provide access to records and information within ten (10) business days.

(3) If the Department identifies a violation of 63 O.S. § 420 et seq., the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq., or these Rules during an audit of the commercial licensee, the Department shall take administrative action against the licensee in accordance with the Oklahoma law, including the Oklahoma Administrative Procedures Act, 75 O.S. § 250 et seq.
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310:681-5-11. Attestation confirming or denying foreign financial interests.
(a) All licensed medical marijuana businesses shall submit an attestation to the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control ("OBNDD") confirming or denying the existence of any foreign financial interests in the medical marijuana business in accordance with 63 O.S. § 427.15 and OBNDD rules and regulations.
(b) The Department shall immediately revoke the medical marijuana business license of any medical marijuana business license that fails to submit such attestation to OBNDD in accordance with the law.
(c) A medical marijuana business that submits a complete and approved attestation to OBNDD within sixty (60) days of revocation of its license may be eligible to seek reinstatement of its license.

310:681-5-18. Prohibited acts
(a) No commercial licensee shall allow the consumption of alcohol or the smoking or vaping of medical marijuana or medical marijuana products on the premises.
(b) No commercial licensee shall employ any person under the age of eighteen (18).
(c) No dispensary shall allow for or provide the delivery of medical marijuana or medical marijuana products to licensed patients or caregivers.
(d) No dispensary shall allow any physician to be located, maintain an office, write recommendations, or otherwise provide medical services to patients at the same physical address as a dispensary.
(e) No commercial licensee shall engage in false advertising.
(f) No commercial licensee shall sell or offer to sell medical marijuana products by means of any advertisement or promotion that includes any statement, representation, symbol, depiction, or reference, directly or indirectly, which would reasonably be expected to induce minors to purchase or consume marijuana or medical marijuana products.
(g) No commercial licensee shall falsely or misrepresent any documents, forms, or other materials or information submitted to the Department.
(h) No commercial licensee shall threaten or harm a patient, medical practitioner, or an employee of the Department.
(i) No commercial licensee shall fail to adhere to any acknowledgment, verification, or other representation made to the Department.
(j) No licensee shall operate or otherwise use any extraction equipment or processes utilizing butane, propane, carbon dioxide or any potentially hazardous material in residential property.
(k) Licensees shall only sell or otherwise transfer, purchase, obtain, or otherwise accept the transfer of medical marijuana or medical marijuana products from an Oklahoma-licensed medical marijuana business. No licensee shall purchase or sell medical marijuana or medical marijuana products from any unlicensed or out-of-state individual or entity.
(l) After implementation of the State inventory tracking system, no licensee shall sell or otherwise transfer, purchase, obtain, or otherwise accept the transfer of medical marijuana or medical marijuana products that are not properly inputted and tracked in the State inventory tracking system in accordance with Oklahoma law and regulations.

SUBCHAPTER 7. PACKAGING, LABELING, AND ADVERTISING

310:681-7-1. Labeling and packaging
(a) Prohibition on sale or transfer. Commercial licensees shall not sell, distribute, or otherwise transfer medical marijuana and medical marijuana products that are not packaged and labeled in accordance with the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq., and these Rules.
(b) Nonacceptance or return. A dispensary shall refuse to accept or shall return to the licensee transferring medical marijuana or medical marijuana products to the dispensary, any medical marijuana or medical marijuana products that are not packaged and labeled in accordance with the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq., and these Rules. The business licensee who sold or otherwise transferred the nonconforming medical marijuana or medical marijuana products shall accept such return. If circumstances are such that the dispensary cannot return or refuse to accept the nonconforming medical marijuana or medical marijuana products, the dispensary shall dispose of the nonconforming medical marijuana and medical marijuana products in accordance with the Oklahoma Medical Marijuana Waste Management Act, 63 O.S. § 427a et seq., and these Rules.
(c) Documentation. A dispensary shall document any such return, nonacceptance, or disposal, and such documentation shall include at a minimum:
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(1) The license number, name, contact information, and address of the licensee who sold or otherwise transferred the nonconforming medical marijuana or medical marijuana products to the dispensary;
(2) A complete inventory of the medical marijuana and medical marijuana products to be returned or disposed, including the batch number;
(3) The reason for the nonacceptance, return, or disposal; and
(4) The date of the nonacceptance, return, or disposal.

d) General requirements. The following general label and packaging requirements, prohibitions, and exceptions shall apply to all medical marijuana and medical marijuana products being transferred or sold to a dispensary or by a dispensary:
(1) Labels, packages, and containers shall not be attractive to minors and shall not contain any content that reasonably appears to target children, including toys, cartoon characters, and similar images. Packages should be designed to minimize appeal to children and shall not depict images other than the business name logo of the medical marijuana producer and image of the product.
(2) Packaging must contain a label that reads: "Keep out of reach of children."
(3) All medical marijuana and medical marijuana products must be packaged in child-resistant containers at the point of sale or other transfer to a patient, a patient's parent or legal guardian if patient is a minor, or a caregiver.
(4) Label must contain a warning that states "Women should not use marijuana or medical marijuana products during pregnancy because of the risk of birth defects."
(5) Packages and labels shall not contain any false or misleading statements.
(6) No medical marijuana or medical marijuana products shall be intentionally or knowingly packaged or labeled so as to cause a reasonable patient confusion as to whether the medical marijuana or medical marijuana product is a trademarked product.
(7) No medical marijuana or medical marijuana products shall be packaged or labeled in a manner that violates any federal trademark law or regulation.
(8) Packages and labels shall not make any claims or statements that the medical marijuana or medical marijuana products provide health or physical benefits to the patient.
(9) Packages and labels shall not contain the logo of the Oklahoma State Department of Health or the Oklahoma Medical Marijuana Authority.

e) Label requirements for sales to dispensaries or by dispensers.
(1) Medical marijuana products, labels being transferred or sold to a dispensary or by a dispensary shall contain, at a minimum, the following information:
(A) The Oklahoma Uniform Symbol in the manner and form prescribed by the Department; the name and license number of the grower or processor who is selling or otherwise transferring the medical marijuana or medical marijuana products to the dispensary;
(B) THC potency; name of the medical marijuana or medical marijuana product;
(C) Terpenoid potency; and the batch number of the medical marijuana or medical marijuana product;
(D) The statement, "This product has been tested for contaminants." Net quantity or weight of contents;
(E) Ingredients list;
(F) The Oklahoma Uniform Symbol in the manner and form prescribed by the Department;
(G) THC potency;
(H) Terpenoid potency; and
(I) The statement, "This product has been tested for contaminants."

(2) Labels for edible medical marijuana products shall also meet the requirements set forth in OAC 310:681-5-8.1.
(3) As applicable, RFID tags shall not obscure required label and packaging requirements.

SUBCHAPTER 8. LABORATORY TESTING

310:681-8.3. Sampling requirements and procedures General requirements.
(a) Samples must be collected in accordance with OAC 310:681-8.3(a)-(c). Individuals collecting samples are called "Samplers."
(1) Samplers must:
(A) Follow the approved sampling policies and standard operating procedures of the laboratory that will be testing the samples collected. Samplers shall have access to a copy of the laboratory's standard operating procedures while they are collecting the samples; and
(B) Follow inventory manifest requirements set forth in these Rules.
(2) Samplers shall collect samples at the location of the grower or processor.
(3) A licensed laboratory must either utilize a licensed commercial transporter to transport samples or obtain a commercial transporter license in order to transport samples from the grower or processor to the laboratory.
(4) All commercial transporters, growers, or processors transporting samples to a laboratory shall be prohibited from storing samples at any location other than the laboratory facility. All samples must be delivered the day of collection.
(5) Samples shall only be collected from harvest batches and production batches in final form. For purpose of this Subsection, "final form" means the form medical marijuana or a medical marijuana product is in when sold or transferred.
(6) The sampler shall collect both a primary sample and a reserve sample from each harvest batch and production batch. The sample shall be clearly and conspicuously labeled and the label shall include at least the following information:

(A) Whether the sample is "Primary Sample" or "Reserve Sample";
(B) Name and license number of grower or processor from whom the sample was taken;
(C) The batch number of harvest batch or production batch from which the sample was taken.

(7) The primary sample and reserve sample shall be stored and analyzed separately. The reserve sample is used for quality control purposes only.

(8) Samples shall be transported and subsequently stored at the laboratory in a manner that prevents degradation, contamination, and tampering. If the medical marijuana or medical marijuana product specifies on the label how the product shall be stored, the laboratory shall store the sample as indicated on the label.

(9) The sampler shall create and use a sample field log to record the following information for each sample:

(A) Laboratory's name, address, and license number;
(B) Sampler's name(s) and title(s) and the names of others onsite; Title and version of the laboratory's standard operating procedure(s) followed when collecting the sample;
(C) Date and time sampling started and ended; Sampler's name(s) and title(s) and the names of others onsite;
(D) Grower's or processor's name, address, and license number; Date and time sampling started and ended;
(E) Batch number of the batch from which the sample was obtained; Grower's or processor's name, address, and license number;
(F) Sample matrix; Batch number of the batch from which the sample was obtained;
(G) Total batch size, by weight or unit count; Total weight or unit count;
(H) Total weight or unit count of the primary sample; Total batch size, by weight or unit count;
(I) Total weight or unit count of the reserve sample; Total batch size, by weight or unit count;
(J) The unique sample identification number for each sample; Total weight or unit count of the reserve sample;
(K) Name, business address, and license number of the person who transports the samples to the laboratory; The unique sample identification number for each sample;
(L) Requested analyses; Name, business address, and license number of the person who transports the samples to the laboratory;
(M) Sampling conditions, including temperature; Requested analyses;

(N) Problems encountered and corrective actions taken during the sampling process, if any;

(O) Any other observations from sampling, including major inconsistencies in the medical marijuana color, size, or smell. Problems encountered and corrective actions taken during the sampling process, if any;

(P) Any other observations from sampling, including major inconsistencies in the medical marijuana color, size, or smell.

(10) The laboratory shall maintain inventory manifest documentation listed in OAC 310:681-3-6 and utilize an electronic inventory management system that meets the requirements set forth in OAC 310:681-5-6(d) for each sample that the laboratory collects, transports, and analyzes.

(11) A laboratory must maintain the documentation required in these rules for at least two (2) years and must provide that information to the Department upon request. Commercial licensees shall document all employee training on a testing laboratory's standard operating procedures.

(12) Commercial licensees must maintain the documentation required in these rules for at least two (2) years and must provide that information to the Department upon request.

(b) Sample size.

(1) To obtain a representative sample of a harvest batch, a total of 0.5% of the batch is collected from different areas of the batch following the laboratory's approved protocol. The sample is then homogenized and aliquoted into a primary sample and reserve sample, which shall be equal in amounts. The primary sample and reserve sample shall be in the amounts specified in the laboratory's standard operating procedure. Any amounts left over after aliquoting may be returned to the harvest batch.

(2) To obtain a representative sample of a processed batch that is well mixed or homogeneous by its nature, obtain an amount sufficient to be aliquoted into a primary sample and a reserve sample, which shall be equal in amounts. If the batch is of not homogeneous or is of unknown homogeneity, then 0.5% of the batch shall be collected from different portions of the batch following the laboratory's approved protocol. The sample is then homogenized and aliquoted into a primary sample and reserve sample, which shall be equal in amounts. The primary sample and reserve sample shall be in the amounts specified in the laboratory's standard operating procedure. Any amounts left over after aliquoting may be returned to the harvest batch.

(c) Sampling standard operating procedures.

(1) Samples collected must be representative of the entire batch to ensure accurate microbiological analysis and foreign material assessments.

(2) Sample protocol shall be approved by the laboratory director. The laboratory shall develop and implement
written sampling policies and procedures that are appropriate for each test method and each type of matrix to be tested and that are consistent with these regulations. Sampling procedures must describe the laboratory's method for collection, preparation, packaging, labeling, documentation, and transport of samples from each matrix type the laboratory tests.

(3) The sampling standard operating procedures (SOP) shall include at least the following information:
   (A) A step-by-step guide for obtaining samples from each matrix type the laboratory samples;
   (B) Protocols for ensuring that contaminants are not introduced during sampling, including protocols relating to the sanitizing of equipment and tools, protective garb, and sampling containers;
   (C) Accepted test sample types;
   (D) Minimum test sample size;
   (E) Recommended test sample containers;
   (F) Test sample labeling;
   (G) Transport and storage conditions, such as refrigeration, as appropriate to protect the physical and chemical integrity of the sample;
   (H) Other requirements, such as use of preservatives, inert gas, or other measures designed to protect sample integrity; and
   (I) Chain-of-custody documentation for each sample in accordance with OAC 310:681-5-6.

(4) The sampling SOP shall be signed and dated by the medical laboratory director and shall include any revision dates and authors. The laboratory director's signature denotes approval of the plan.

(5) The laboratory shall retain a controlled copy of the sampling SOP on the laboratory premises and ensure that the sampling SOP is accessible to the sampler in the field during sampling.

(d) Sample handling, storage and disposal. A laboratory shall establish sample handling procedures for the tracking of test samples through the analytical process (by weight, volume, number, or other appropriate measure) to prevent diversion.

(1) The laboratory shall store each test sample under the appropriate conditions appropriate to protect the physical and chemical integrity of the sample.

(2) Analyzed test samples consisting of medical marijuana or medical marijuana products shall be held in a controlled access area pending destruction or other disposal.

(3) Any portion of a medical marijuana product test sample that is not destroyed during analysis shall be; Reserve samples shall be maintained and properly stored by the laboratory for at least thirty (30) days.

(4) After the required thirty (30) day storage period, any portion of a medical marijuana or medical marijuana product test sample that is not destroyed during analysis shall be;
   (A) Returned to the licensed individual or entity that provided the sample after the required retention period for reserve samples;
   (B) Transported to a state or local law enforcement office; or
   (C) Disposed of in accordance with OAC 310:681-5-10 (relating to medical marijuana waste disposal).

(e) Data reporting.

(1) The laboratory shall generate a certificate of analysis (COA) for each primary sample that the laboratory analyzes.

(2) The laboratory shall issue the COA to the requester within two (2) business days after technical and administrative review of analysis has been completed. A laboratory shall not withhold a COA reporting a failed test from the requester for any reason.

(3) The COA All COAs, whether in paper or electronic form, shall contain, at minimum, the following information:
   (A) The name, address, license number, and contact information of the laboratory that conducted the analysis;
   (B) If the laboratory sends a sample to another laboratory for testing, the reference laboratory must be identified as having performed that test;
   (C) The name, address, and license number of the requester;
   (D) The description of the type or form of the test sample (leaf, flower, powder, oil, specific edible product, etc.) and its total primary sample weight in grams, reported to the nearest gram;
   (E) The unique sample identifier;
   (F) Batch number of the batch from which the sample was obtained;
   (G) Sample history, including the date collected, the date received by the laboratory, and the date(s) of sample analyses and corresponding testing results, including units of measure where applicable;
   (H) The analytical methods used, including at a minimum identification of the type of analytical equipment used (e.g., GC, HPLC, UV, etc.);
   (I) The reporting limit for each analyte tested;
   (J) Any compounds detected during the analyses of the sample that are not among the targeted analytes and are unknown, unidentified, tentatively identified or known and injurious to human health if consumed, if any;
   (K) The identity of the supervisory or management personnel who reviewed and verified the data and results and ensured that data quality, calibration, and other applicable requirements were met; and
   (L) Definitions of any abbreviated terms.

(4) The laboratory shall report test results for each primary sample on the COA as follows:
   (A) When reporting quantitative results for each analyte, the laboratory shall use the appropriate units of measurement as required under this chapter and indicate "pass" or "fail";
   (B) When reporting qualitative results for each analyte, the laboratory shall indicate "pass" or "fail";
(C) When reporting results for any analytes that were detected below the analytical method limit of quantitation (LOQ), indicate "Pass" and "Fail" must be clear, conspicuous, and easily identifiable in a font size no less than the size of 12 pt font in Times New Roman and shall not be in fine print or footnotes;

(D) Indicate "NT" for not tested for any test that the laboratory did not perform. When reporting results for any analytes that were detected below the analytical method limit of quantitation (LOQ), indicate "<LOQ" and list the results for analytes that were detected above the LOQ but below the allowable limit; and

(E) Indicate "NT" for not tested for any test that the laboratory did not perform.

(5) Upon detection of any compounds during the analyses of the sample that are not among the targeted analytes and are unknown, unidentified, tentatively identified, or known and injurious to human health if consumed, laboratories shall notify the Department immediately and shall submit to the Department a copy of the COA containing those compounds as required in OAC 310:681-8-3(e)(3)(I). The Department may require a processor or grower to submit samples for additional testing, including testing for analytes that are not required by these Rules, at the licensee's expense.

(6) When a laboratory determines that a harvest batch or production batch has failed any required testing, the laboratory shall immediately notify the Department in the manner and form prescribed by the Department on its website and shall submit a copy of the COA to the Department within two (2) business days. Submission of this information to the Department through the seed-to-sale tracking system established by the Department or a seed-to-sale tracking system that integrates with the Department-established system shall be sufficient to satisfy this reporting requirement.

SUBCHAPTER 9. WASTE DISPOSAL FACILITIES

310:681-9-1. License or permit required

(a) No person or entity shall operate a medical marijuana waste disposal facility without first obtaining a license from the Department pursuant to the Oklahoma Medical Marijuana Waste Management Act, 63 O.S. § 427a et seq., other applicable Oklahoma law, including regulations of the Oklahoma Department of Environmental Quality, and the Rules in this Chapter. Only a person who is in compliance with the requirements of Oklahoma law and these Rules shall be entitled to receive or retain any license or permit.

(b) The Department shall not, for the first year of the license program until November 1, 2021, issue more than ten (10) waste disposal facility licenses. The Department shall have the authority to develop and utilize criteria, standards, and preferred qualifications for the selection of licensees and timing of licensure as it deems appropriate and reasonable.

Beginning November 1, 2021, there shall be no limit to the number of medical marijuana waste disposal licenses issues by the Department.

(c) All license and permit applications shall be complete and accurate in every detail, shall include all attachments or supplemental information required by the forms supplied by the Department, and shall be accompanied by full remittance of the entire application fee. Any misstatements, omissions, misrepresentations, or untruths made in the application shall be grounds for administrative action against the licensee by the Department.

(d) All licenses and permits shall be on forms prescribed by the Department.

(e) Application fees are nonrefundable.

(f) Upon issuance of a waste disposal facility license, each waste disposal facility licensee shall automatically receive a waste disposal transportation license. Medical marijuana waste disposal facility licensees shall ensure that a copy of the waste disposal transportation license is inside any vehicles used for transporting medical marijuana waste during transportation.

310:681-9-2. Licenses and permits

(a) Timeframe. Waste disposal facility licenses and permits shall be issued for a twelve (12) month period expiring one (1) year from the date of issuance. The license or permit may be issued upon receipt of a completed application, payment of application fee, and verification by the Department the individual or entity complies with the requirements set forth in Oklahoma law and this Chapter.

(b) Location. Waste disposal facility licenses and permits shall only be valid for a single location at the address listed on the application.

(c) Renewal of license or permit.

(1) It is the responsibility of the license holder to renew the license and any associated permits, with all applicable documentation, prior to the date of expiration of the license or permit by following the procedures provided in OAC 310:681-9-3 and OAC 310:681-9-4.

(2) Before renewing a license or permit, the Department may require further information and documentation to determine if the licensee continues to meet the requirements set forth in Oklahoma law and these Rules.

(3) The Department may refuse to renew a license or permit of a medical marijuana waste facility for the following:

(A) Failure to meet the requirements for licensure or permits set forth in the Oklahoma Medical Marijuana Waste Management Act, 63 O.S. § 427a et seq., or OAC 310:681.

(B) Noncompliance with 63 O.S. § 420 et seq.; the Oklahoma Medical Marijuana and Patient Protection Act, 63 O.S. § 427.1 et seq.; the Oklahoma Medical Marijuana Waste Management Act, 63 O.S. § 427a et seq.; or OAC 310:681.

(4) Upon the determination that a licensee has not met the requirements for renewal, the Department shall provide written notice to the licensee. The notice shall...
provide an explanation for the denial of the renewal application.

(d) **Disposal of waste upon termination of license/permit.**

(1) A waste disposal facility licensee whose license is not renewed, or whose license is revoked, suspended, or voluntarily surrendered, shall immediately cease all operations at all licensed and permitted locations upon expiration of the license and shall immediately either dispose of any medical marijuana waste remaining in its possession or transfer such medical marijuana waste to another licensed medical marijuana waste disposal facility licensee.

(2) A waste disposal facility licensee whose permit is not renewed, or whose permit is revoked, suspended, or voluntarily surrendered, shall cease all operations at the permitted location immediately upon expiration of the permit and shall immediately take one of the following actions:

(A) Dispose of any medical marijuana waste remaining in its possession at the permitted location;

(B) Transfer such medical marijuana waste to another permitted location belonging to the same licensed medical marijuana waste disposal facility licensee; or

(C) Transfer such medical marijuana waste to another licensed medical marijuana waste disposal facility licensee.

(e) **Change in information.**

(1) Licensee shall notify the Department in writing within fourteen (14) days of any changes in contact information by electronically submitting a change request in accordance with the Department's instructions.

(2) Licensees shall obtain Department approval prior to any changes that affect the licensee's qualifications to receive a license or permit. Licensees shall notify the Department in writing in advance of any change that may affect the licensee's qualifications for licensure by electronically submitting a change request, along with any relevant documentation, in accordance with the Department's instructions. Except as is otherwise authorized by the Department, licensees are limited to one location change request and one ownership change request per year of licensure.

(A) Medical marijuana waste licensees submitting a location change for any licensed or permitted location must provide the information and documentation required in OAC 310:681-9-3 relating to owners, including but not limited to the following:

(i) An list of all owners and principal officers of the commercial applicant and supporting documentation as set forth in OAC 310:681-9-3(e)(1);

(ii) An affidavit of lawful presence for each new owner;

(iii) Documents required under OAC 310:681-9-3(e)(5) establishing that the applicant; and

(iv) Background checks in accordance with OAC 310:681-1-5; and

(v) Any further documentation the Department determines is necessary to ensure the business licensee is still qualified under Oklahoma law and this Chapter to obtain a business license.

(f) **Transfer of license or permit.**

(1) Waste disposal facility licenses and permits may not be assigned or otherwise transferred from one person to another or from one legal entity to another.

(2) Licenses may not be changed from one license type to another.

(g) **Surrender of license or permit.** A waste disposal facility licensee may voluntarily surrender a license or permit to the Department at any time in accordance with OAC 310:681-5-2(g). If a waste disposal facility license is surrendered, all associated permitted locations will be surrendered.

(h) **Revocation of license or permit.** If a waste disposal facility license is revoked, all associated permitted locations will be revoked.

310:681-9-3. **License applications**

(a) **Application fee.** An applicant for a waste disposal facility license, or renewal thereof, shall submit to the Department a completed application on a form and in a manner prescribed by the Department, along with the application fee as established in 63 O.S. § 420 et seq. and the Oklahoma Medical Marijuana Waste Management Act, 63 O.S. § 427a et seq.

(b) **Submission.** The application shall be on the Department prescribed form and shall include the following information about the establishment:

(1) Name of the establishment;

(2) Physical address of the establishment, including the county in which any licensed premises will be located;

(3) GPS coordinates of the establishment;

(4) Phone number and email of the establishment;

(5) Hours of operation for any licensed premises;

(6) Type of waste facility; and

(7) Proposed number and location of additional waste disposal facilities associated with the applicant.

(c) **Individual applicant.** The application for a waste disposal facility license made by an individual on his or her own
behave shall be on the Department prescribed form and shall include at a minimum:

1. The applicant's first name, middle name, last name, and suffix if applicable;
2. The applicant's residence address and valid mailing address;
3. The applicant's date of birth;
4. The applicant's telephone number and email address;
5. An attestation that the information provided by the applicant is true and correct;
6. An attestation that any licensed premises shall not be located on tribal lands; and
7. A statement signed by the applicant pledging not to divert marijuana to any individual or entity that is not lawfully entitled to possess marijuana.

(d) Application on behalf of an entity. In addition to requirements of Subsection (c), an application for a waste facility license made by an individual on behalf of an entity shall include:

1. An attestation that applicant is authorized to make application on behalf of the entity;
2. Full name of organization;
3. Trade name, if applicable;
4. Type of business organization;
5. Mailing address;
6. Telephone number and email address; and
7. The name, residence address, and date of birth of each owner and each member, manager, and board member, if applicable.

(e) Supporting documentation. Each application shall be accompanied by the following documentation:

1. A list of all persons and/or entities that have an ownership interest in the entity;
2. A certificate of good standing from the Oklahoma Secretary of State, if applicable;
3. An Affidavit of Lawful Presence for each owner;
4. Proof that the proposed location of the waste disposal facility is at least one thousand (1,000) feet from a public or private school. The distance specified shall be measured from any entrance of the school to the nearest property line point of the facility;
5. Documents establishing the applicant, the members, managers, and board members, if applicable, and seventy-five percent (75%) of the ownership interests are Oklahoma residents as established in 63 O.S. § 420 et seq., and OAC 310:681-1-6 (relating to proof of residency);
6. Proof of sufficient liability insurance. Liability insurance or a letter of insurability from the insurance company shall be provided by the applicant and shall apply to sudden and non-sudden bodily injury and property damage on, below, and above the surface of the facility. Such insurance shall be maintained for the period of operation of the facility during operation and after closing. Such liability insurance means that the licensee shall maintain at all times insurance coverage with at least the following minimum limits:

   (A) Commercial General Liability: $5,000,000.00 each occurrence;
   (B) Pollution Legal Liability: $5,000,000.00 each occurrence;
   (7) Relevant waste permit(s) from the Oklahoma Department of Environmental Quality or the Oklahoma Department of Agriculture; and
   (8) Any other documentation the Department determines is necessary to ensure the applicant is qualified under Oklahoma law and this Chapter to obtain a waste disposal facility license.

(f) Incomplete application. Failure to submit a complete application with all required information and documentation shall result in a rejection of the application. The Department shall notify the applicant via email through the electronic application account of the reasons for the rejection.

310:681-9-4. Permit applications
(a) Application fee. An applicant for a waste disposal facility permit, or renewal thereof, shall submit to the Department a completed application on a form and in a manner prescribed by the Department, along with the application fee as established in 63 O.S. § 420 et seq. and the Oklahoma Medical Marijuana Waste Management Act, 63 O.S. § 427a et seq. A waste disposal facility permit application shall be submitted after and associated with an approved waste disposal facility license application.

(b) Submission. The application shall be on the Department prescribed form and shall include the following information about the establishment:

1. Name and license number of the waste disposal facility licensee associated with the permit;
2. Physical address of the establishment, including the county in which any licensed premises will be located;
3. GPS coordinates of the establishment;
4. Phone number and email of the establishment;
5. Hours of operation of the establishment.
6. Mailing address of the establishment;
7. An attestation that the information provided by the applicant is true and correct;
8. An attestation that any licensed premises shall not be located on tribal lands;
9. A statement signed by the applicant pledging not to divert marijuana to any individual or entity that is not lawfully entitled to possess marijuana; and
10. An attestation that applicant is authorized to make application on behalf of the entity.

(c) Supporting documentation. Each application shall be accompanied by the following documentation:

1. Proof that the proposed location of the waste disposal facility is at least one thousand (1,000) feet from a public or private school. The distance specified shall be measured from any entrance of the school to the nearest property line point of the facility;
2. Proof of sufficient liability insurance. Liability insurance shall be provided by the applicant and shall apply...
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to sudden and nonsudden bodily injury and property damage on, below, and above the surface of the facility. Such insurance shall be maintained for the period of operation of the facility and shall provide coverage for damages resulting from operation of the facility during operation and after closing. Sufficient liability insurance means that the licensee shall maintain at all times insurance coverage with at least the following minimum limits:

(A) Commercial General Liability: $5,000,000.00;
(B) Pollution Legal Liability: $5,000,000.00 each occurrence;

(3) Relevant waste permit(s) from the Oklahoma Department of Environmental Quality; and
(4) Any further documentation the Department determines is necessary to ensure the commercial applicant is qualified under Oklahoma law and this Chapter to obtain a waste disposal facility license.

(d) Incomplete application. Failure to submit a complete application with all required information and documentation shall result in a rejection of the application. The Department shall notify the applicant via email through the electronic application account of the reasons for the rejection.

310:681-9-7. Audits and inventory

(a) Audits. The Department may perform on-site audits of all waste disposal facility licensees and permitted locations to ensure that all marijuana grown in Oklahoma is accounted for. Submission of an application for a medical marijuana waste disposal facility license constitutes permission for entry to any licensed premises and auditing of the licensee during hours of operation and other reasonable times. Refusal to permit the Department entry or refusal to permit the Department to inspect all books and records shall constitute grounds for the nonrenewal, suspension, or revocation of a license or permit.

(1) The Department may review any and all records and information of a waste disposal facility licensee and may require and conduct interviews with such persons or entities and persons affiliated with such licensees, for the purpose of determining compliance with Department rules and applicable laws. Failure to make documents or other requested information available to the Department and/or refusal to appear or cooperate with an interview shall constitute grounds for nonrenewal, suspension, or revocation of a license or any other remedy or relief provided under law. All records shall be kept on-site and readily accessible.

(2) Waste disposal facility licensees shall comply with all written requests from the Department to produce or provide access to records and information within ten (10) business days.

(3) If the Department identifies a violation of the Oklahoma Medical Marijuana Waste Management Act, 63 O.S. § 427a et seq., other applicable Oklahoma law, or these Rules during an audit of the licensee, the Department shall take administrative action against the licensee in accordance with the Oklahoma law, including the Oklahoma Administrative Procedures Act, 75 O.S. § 250 et seq.

(4) The Department may refer all complaints alleging criminal activity or other violations of Oklahoma law that are made against a waste disposal licensee to appropriate Oklahoma state or local law enforcement or regulatory authorities.

(5) If the Department discovers what it reasonably believes to be criminal activity or other violations of Oklahoma law during an audit, the Department may refer the matter to appropriate Oklahoma state or local law enforcement or regulatory authorities for further investigation.

(6) Except as is otherwise provided in Oklahoma law or these Rules, correctable violations identified during an audit shall be corrected within thirty (30) days of receipt of a written notice of violation.

(7) If a licensee fails to correct violations within thirty (30) days, the licensee will be subject to a fine of $500.00 for each violation and any other administrative action and penalty authorized by law.

(b) Inventory tracking system. Each waste disposal facility pursuant to 63 O.S. § 427.3(D)(8) and 63 O.S. § 427.13(B), each commercial licensee shall use the seed to sale State inventory established by the Department or a seed to sale tracking system that integrates with the Department established system at the time of its implementation by inputting inventory tracking data required to be reported to the Department directly into the State inventory tracking system or by utilizing a seed-to-sale tracking system that integrates with the State inventory tracking system. All commercial licensees must have an inventory tracking system account activated to lawfully operate and must ensure all information is reported to the Department accurately and in real time or after each individual sale in accordance with 63 O.S. § 427.13(B)(1) and these Rules. The system utilized by each licensee shall be a system that all commercial licensees shall ensure the following information and data are accurately tracked and timely reported to the Department through the State inventory tracking system:

(1) Documents the chain of custody of all medical marijuana and medical marijuana products, including every transaction with another commercial licensee, patient or caregiver, including, but not limited to:

(A) The name, address, license number and phone number of the medical marijuana business that cultivated, manufactured, sold, purchased, or otherwise transferred the medical marijuana or medical marijuana product(s);

(B) The type, item, strain, and category of medical marijuana or medical marijuana product(s) involved in the transaction;

(C) The weight, quantity, or other metric required by the Department, of the medical marijuana or medical marijuana product(s) involved in the transaction;

(D) The batch number of the medical marijuana or medical marijuana product(s);

(E) The total amount spent in dollars;

(F) All point-of-sale records as applicable;

(G) Transportation information documenting the transport of medical marijuana or medical marijuana product(s) as required under OAC 310:681-3.6(b);
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(H) Testing results and information;
(I) Waste records and information;
(J) Marijuana excise tax records, if applicable;
(K) RFID tag number(s);

(2) Establishes ongoing inventory controls and procedures for the conduct of inventory reviews and comprehensive inventories of medical marijuana and medical marijuana products for traceability which shall enable the licensee to detect any diversion, theft, or loss in a timely manner;

(3) Identifies and allows for tracking and documentation of the entire life span of a licensee’s stock of medical marijuana and medical marijuana products, including, at a minimum, notifying the Department:
   (A) When medical marijuana seeds or clones are planted;
   (B) When medical marijuana plants are harvested and/or destroyed;
   (C) When medical marijuana is transported, or otherwise transferred, sold, stolen, diverted, or lost;
   (D) A complete inventory of all medical marijuana; seeds; plant tissue; clones; usable marijuana; trim; leaves; other plant matter; and medical marijuana products. When medical marijuana changes form, including, but not limited to, when it is planted, cultivated, processed, and infused into a final form product;
   (E) All samples sent to a testing laboratory or used for internal quality testing or other purposes. A complete inventory of all medical marijuana; seeds; plant tissue; clones; usable marijuana; trim; shake; leaves; other plant matter; and medical marijuana products; and
   (F) All samples sent to a testing laboratory or used for internal quality testing or other purposes;

(4) Tracks medical marijuana using an assigned batch number and bar code.

(3) Any further information the Department determines is necessary to ensure all medical marijuana and medical marijuana products are accurately and fully tracked throughout the entirety of the life span of the plant and product.

(c) Seed-to-sale tracking system. A commercial licensee shall use a seed-to-sale tracking system or integrate its own seed-to-sale tracking system with the State inventory tracking system established by the Department. If a commercial licensee uses a seed-to-sale tracking system that does not integrate with the State inventory tracking system, or does integrate but does not share all required information, the commercial licensee shall ensure all required information is reported directly into the State inventory tracking system.

(d) Inventory tracking system requirements.

(1) At a minimum, commercial licensees shall track, update and report its inventory after each individual sale to the Department in the State inventory tracking system.

(2) All commercial licensees must reconcile all on-premises and in-transit medical marijuana and medical marijuana product inventories each day in the State inventory tracking system at the close of business.

(3) Commercial licensees are required to use RFID tags from a Department-approved supplier for the State Inventory Tracking System. Each Licensee is responsible for the cost of all RFID tags and any associated vendor fees.
   (A) A commercial licensee shall ensure its inventories are properly tagged and that a RFID tag is properly assigned to medical marijuana, medical marijuana products, and medical marijuana waste as required by the Department.
   (B) A commercial licensee shall ensure it has an adequate supply of RFID tags at all times. If a commercial licensee is unable to account for unused RFID tags, the commercial licensee must report to the Department and the State inventory tracking system vendor within forty-eight (48) hours.
   (C) RFID tags must contain the legal name and correct license number of the commercial licensee that ordered them. Commercial licensees are prohibited from using another licensee's RFID tags.
   (D) Prior to a plant reaching a point where it is able to support the weight of the RFID tag and attachment strap, the RFID tag may be securely fastened to the stalk or other similarly situated position approved by the Department.
   (E) When the plant becomes able to support the weight of the RFID tag, the RFID tag shall be securely fastened to a lower supporting branch. The RFID tag shall remain affixed for the entire life of the plant until disposal.
   (F) Mother plants must be tagged before any cuttings or clones are generated therefrom.
   (G) If a RFID tag gets destroyed, stolen, or falls off of a medical marijuana plant, the licensee must ensure a new RFID tag is placed on the medical marijuana plant and the change of the RFID tag is properly reflected in the State inventory tracking system.
   (H) Commercial licensees shall not reuse any RFID tag that has already been affixed to any regulated medical marijuana or medical marijuana products.

(4) Each wholesale package of medical marijuana must have a RFID tag during storage and transfer and may only contain one harvest batch of medical marijuana.

(5) Prior to transfer, commercial licensees shall ensure that each immature plant is properly affixed with an RFID tag if the plant was not previously tagged in accordance with these rules.

(6) Commercial licensees’ inventory must have a RFID tag properly affixed to all medical marijuana products during storage and transfer in one of the following manners:
   (A) Individual units of medical marijuana products shall be individually affixed with a RFID tag; or
   (B) Medical marijuana products may only be combined in a single wholesale package using one RFID tag if all units are from the same production batch.
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(7) If any medical marijuana or medical marijuana products are removed from a wholesale package, each individual unit or new wholesale package must be separately tagged.

(8) All packages of medical marijuana waste shall have a RFID tag affixed and the contents of the waste package shall be reported in the State inventory tracking system.

(c) Inventory tracking system administrators and users.

(1) The inventory tracking system administrator must attend and complete all required inventory tracking system training.

(2) If at any point, the inventory tracking system administrator for a licensee changes, the commercial licensee shall change or assign a new inventory tracking system administrator within three business days.

(3) Commercial licensees shall maintain an accurate and complete list of all inventory tracking system administrators and employee users.

(4) Commercial licensees shall ensure that all owners and employees that are granted inventory tracking system account access for the purpose of conducting inventory tracking functions are trained and authorized before the owners or employees may access the State inventory tracking system.

(5) All inventory tracking system users shall be assigned an individual account in the State inventory tracking system.

(6) Any individual entering data into the State inventory tracking system shall only use the inventory tracking system account assigned specifically to that individual. Each inventory tracking system administrator and inventory tracking system user must have unique log-in credentials that shall not be used by any other person.

(7) Within three (3) business days, commercial licensees must remove access for any inventory tracking system administrator or user from their accounts if any such individual no longer utilizes the State inventory tracking system or is no longer employed by the commercial licensee.

(f) Loss of access to State inventory tracking system. If at any time a commercial licensee loses access to the State inventory tracking system due to circumstances beyond the commercial licensee's control, the commercial licensee shall keep and maintain records detailing all inventory tracking activities that were conducted during the loss of access. Once access is restored, all inventory tracking activities that occurred during the loss of access must be immediately entered into the State inventory tracking system. If a commercial licensee loses access to the inventory tracking system due to circumstances within its control, the commercial licensee may not perform any business activities that would be required to be reported into the State inventory tracking system until access is restored and reporting is resumed; any transfer, sale, or purchase of medical marijuana or medical marijuana products would be an unlawful sale.

[OAR Docket #21-697; filed 7-19-21]

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

[OAR Docket #21-690]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
Subchapter 11. Exemptions from Securities Registration
Part 5. Exempt Transactions
660:11-11-54. Intrastate offering exemption [NEW]

AUTHORITY:
Administrator, Oklahoma Department of Securities; 71 O.S. §§1-605, 1-608

ADOPTION:
June 2, 2021

EFFECTIVE:
Immediately upon Governor's approval

APPROVED BY GOVERNOR:
July 13, 2021

EXPIRATION:
Effective through September 14, 2022, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

FINDING OF EMERGENCY:
The rule is promulgated to comply with an amendment to the Oklahoma Uniform Securities Act of 2004, 71 O.S. §§1-101 through 1-701 (2011 and Supp. 2020) ("Securities Act"); specifically, a new exemption from registration at 71 O.S. 1-202.25, that was enacted by the Legislature and signed into law by the Governor of the State of Oklahoma on April 19, 2021. The Legislature and the Governor determined that the rule was "necessary for the public peace, health or safety," and required that the rule be promulgated within ninety (90) days of the effective date of the new statutory provision.

GIST/ANALYSIS:
The rule creates and clarifies the standards necessary to qualify for the new exemption for intrastate offerings as enacted by the Oklahoma Legislature (SB 568) and signed into law by the Governor of the State of Oklahoma on April 19, 2021.

CONTACT PERSON:
Gerri Kavanaugh, General Counsel, Oklahoma Department of Securities, (405) 280-7721

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

SUBCHAPTER 11. EXEMPTIONS FROM SECURITIES REGISTRATION

PART 5. EXEMPT TRANSACTIONS

660:11-11-54. Intrastate offering exemption

(a) Terms of the Exemption. Under the authority of Section 1-202.25 of the Securities Act, transactions meeting the following conditions are exempt from Sections 1-301 and 1-504 of the Securities Act:
1. **Intrastate offers and sales.** The issuer meets all of the requirements set forth in Section 2-202.25 of the Securities Act.

2. **Minimum offering amount.** Investors shall receive a return of all their subscription funds if the minimum offering amount is not raised by the time stated in the disclosure document. Non-cash contributions from control persons or other insiders shall not be considered in fulfilling the minimum offering amount.

3. **Initial notice filing.** The issuer, at least ten (10) business days prior to the first sale of the securities, shall file a notice of the proposed offering directly with the Department. The notice must include the following:
   - (A) the names and addresses of the issuer, all persons who will be involved in the offer or sale of securities on behalf of the issuer, and any bank or other depository institution in which investor funds will be deposited;
   - (B) a copy of the disclosure document to be provided to each prospective purchaser in connection with the offering within a reasonable period of time before the date of sale containing at least the following:
     - (i) the name, legal status, physical address, and website address of the issuer;
     - (ii) the names of the directors, officers, and any other control persons with descriptions of each person's background and qualification;
     - (iii) a description of the business of the issuer and the anticipated business plan of the issuer;
     - (iv) a description of the stated purpose and intended use of the proceeds of the offering sought by the issuer, including compensation paid to any officer, director, or control person;
     - (v) the target offering amount and the deadline to reach the target offering amount, and any minimum amount required to close the offering if such minimum is less than the target offering amount;
     - (vi) the amount of commission or other remuneration to be paid to any broker-dealer or agent involved in the offer or sale of the securities;
     - (vii) financial information about the issuer, certified by the issuer's chief executive officer and chief financial officer, or other individual serving in a similar capacity, to be true and complete in all material respects, including:
       - (I) annual financial statements, unless the issuer is newly organized and has not reached its first fiscal year end, that are dated as of the end of the issuer's most recently completed fiscal year; are prepared in accordance with generally accepted accounting principles in the United States; include a balance sheet, statement of income, statement of cash flows, statement of changes in stockholders' equity and notes to the financial statements; and comply with the applicable standards set forth in (4) of this subsection; and
   - (C) a description of any litigation, legal proceedings, or pending regulatory action involving the issuer, its officers, directors, or control persons;
   - (D) a statement that:
     - (i) sales will only be made to any one person in an amount up to $5,000.00 unless the persons are accredited investors as that term is defined in Rule 501 of Regulation D of the Securities Act of 1933 (17 C.F.R. 230.501);
     - (ii) sales will only be made to residents of the state of Oklahoma at the time of the sale of the security;
     - (iii) the securities have not been registered with or approved by the state of Oklahoma and are being offered and sold pursuant to an exemption from registration and, therefore, cannot be resold unless the securities are registered or qualify for an exemption from registration under federal and state law;
     - (iv) for a period of six (6) months from the date of the sale by the issuer of the securities, any resale of the securities (or the underlying securities in the case of convertible securities) shall be made only to persons resident within the state of Oklahoma;
     - (v) there is no ready market for the sale of the securities acquired from this offering and it may be difficult or impossible for a purchaser to sell or otherwise dispose of this investment;
   - (E) a copy of the escrow agreement;
   - (F) a consent to service of process on Form U-2 and (if applicable) Form U-2A; and
   - (G) the fee as set forth in Section 1-612 of the Securities Act.

4. **Annual financial statement standards.** The annual financial statements required in (3)(B)(vii)(I) of this subsection must meet the following applicable standard:
   - (A) For offerings that have an aggregate offering amount of $500,000 or less, the issuer may provide unaudited and unreviewed financial statements. However, if the issuer has obtained financial statements that have been compiled, reviewed, or audited by an independent certified public accountant, the issuer must provide those financial statements;
   - (B) For offerings that have an aggregate offering amount of more than $500,000 but less than $1,000,000, the financial statements must be compiled by an independent certified public accountant.
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However, if the issuer has obtained financial statements that have either been reviewed or audited by an independent certified public accountant, the issuer must provide those financial statements; or
(C) For offerings that have an aggregate offering amount of $1,000,000 or more, the financial statements must be reviewed by an independent certified public accountant. However, if the issuer has obtained financial statements that have been audited by an independent certified public accountant, the issuer must provide those financial statements.

(5) Continuing notice filings. For offerings that continue beyond one year from the commencement date of the offering, the issuer shall file with the Department, no later than thirty (30) days after the end of each quarter, updated interim financial statements including an unaudited balance sheet and statement of income for the issuer’s most recently completed fiscal quarter certified by the issuer’s chief executive officer and chief financial officer, or other individual serving in a similar capacity, to be true and complete in all material respects.

(6) Final notice filings. The issuer shall file with the Department, no later than thirty (30) days after the termination of the offering, a final notice that the offering has been terminated. The final notice must include the following:
(A) the Oklahoma exemption file number for the offering of securities to which the final notice relates;
(B) the commencement date of the offering and the termination date of the offering;
(C) a sales report that discloses the dollar amount of securities sold in Oklahoma in connection with the offering in the following format:
   (i) Beginning offering amount;
   (ii) Minus: Amount sold during the offering;
   (iii) Balance unsold at the termination of the offering; and
(D) If the offering did not achieve the minimum offering amount, the issuer shall provide written confirmation to the Department that all offering proceeds that were raised in the offering were returned to each purchaser and that each purchaser did receive their investment proceeds.

(7) Fees. There are no fees required to be paid for the continuing notices or the final notice.

(8) Piecemeal filings. Any notice required under this section is not considered filed if it is incomplete. Piecemeal filings shall not be accepted.

(9) Required legend. The issuer shall, in connection with any securities sold by it under this Section, place a prominent legend on the certificate or other document evidencing the security stating that: "Offers and sales of these securities were made under an exemption from registration and have not been registered under the Securities Act of 1933 or the Oklahoma Uniform Securities Act of 2004. For a period of six months from the date of the sale by the issuer of these securities, any resale of these securities (or the underlying securities in the case of convertible securities) shall be made only to persons resident within the state of Oklahoma."

(10) Evidence from purchaser. The issuer shall obtain from each purchaser a written representation of residency within the state of Oklahoma before a sale may be made. Such representation shall include an affirmation made by the purchaser that the purchaser is at least eighteen (18) years of age and purchasing the securities for investment. The issuer shall also obtain a copy of any one of the following from the purchaser:
(A) valid Oklahoma driver's license or official identification card issued by the State of Oklahoma;
(B) current Oklahoma voter registration card; or
(C) county property tax records showing the individual owns and occupies property in Oklahoma as his or her primary residence.

(b) Application of NASAA Statements of Policy and guidelines. The Department may apply the provisions of applicable Statement of Policy or guidelines adopted by NASAA to any offering of securities made pursuant to this exemption from registration. Failure to comply with any such provision may serve as the basis for withdrawing or further conditioning the exemption as to a particular offering.

[OAR Docket #21-690; filed 7-13-21]

TITLE 715. TEACHERS’ RETIREMENT SYSTEM
CHAPTER 10. GENERAL OPERATIONS

[OAR Docket #21-699]

RULEMAKING ACTION: EMERGENCY adoption

RULES:
      715:10-1-4. Optional TRS membership [AMENDED]
   Subchapter 5. Establishing Other Service Credits
      715:10-5-9. Re-establishing withdrawn service [AMENDED]
      715:10-5-38. Credit for service as an optional employee prior to July 1, 2021 [NEW]
   Subchapter 11. Withdrawal from Membership and Refund of Deposits
      715:10-11-2. Withdrawal of optional membership while still employed [AMENDED]
      715:10-11-4. Refunds of contributions [AMENDED]
   Subchapter 13. Contributions for Membership Service
   Subchapter 17. Post-Retirement Employment
      715:10-17-15. Salary limitations for certain returning classroom teachers [AMENDED]

AUTHORITY:
   70 O.S. Section 17-101, et seq., especially Section 17-106(10); Board of Trustees of Teachers' Retirement System

ADOPTION:
   June 2, 2021

EFFECTIVE:
   Immediately upon Governor's approval

APPROVED BY GOVERNOR:
   July 9, 2021

EXPIRATION:
   Effective through September 14, 2022, unless superseded by another rule or disapproved by the Legislature
253(F): limitations.

These amendments remove the one-year waiting period for optional personnel to join the System and also remove the ability for optional personnel to opt in and out of the System without terminating employment.

715:10-5-5 is being added to address the purchase of optional service to comply with amendments to 70 O.S. Section 17-103 enacted by Senate Bill 683 in the 2021 legislative session and effective July 1, 2021.

Section 17-103 enacted by Senate Bill 683 in the 2021 legislative session and effective July 1, 2021.

These amendments remove the one-year waiting period for optional personnel to join the System and also remove the ability for optional personnel to opt in and out of the System without terminating employment.

715:10-5-38 is being added to address the purchase of optional service to comply with amendments to 70 O.S. Section 17-103 enacted by Senate Bill 683 in the 2021 legislative session and effective July 1, 2021.

GIST/ANALYSIS:

715:10-5-3 is being amended to comply with amendments to 70 O.S. Section 17-103 enacted by Senate Bill 683 in the 2021 legislative session and effective July 1, 2021.

These amendments remove the one-year waiting period for optional personnel to join the System and also remove the ability for optional personnel to opt in and out of the System without terminating employment.

715:10-5-5 is being added to address the purchase of optional service to comply with amendments to 70 O.S. Section 17-103 enacted by Senate Bill 683 in the 2021 legislative session and effective July 1, 2021.

These amendments remove the one-year waiting period for optional personnel to join the System and also remove the ability for optional personnel to opt in and out of the System without terminating employment.

715:10-5-11 is being amended to comply with amendments to 70 O.S. Section 17-103 enacted by Senate Bill 683 in the 2021 legislative session and effective July 1, 2021.

These amendments remove the one-year waiting period for optional personnel to join the System and also remove the ability for optional personnel to opt in and out of the System without terminating employment.

715:10-17-7 is being amended to comply with amendments to 70 O.S. Section 17-103 enacted by Senate Bill 683 in the 2021 legislative session and effective July 1, 2021.

These amendments remove the one-year waiting period for optional personnel to join the System and also remove the ability for optional personnel to opt in and out of the System without terminating employment.

GIST/ANALYSIS:

715:10-5-1 is being amended to comply with amendments to 70 O.S. Section 17-103 enacted by Senate Bill 683 in the 2021 legislative session and effective July 1, 2021.

These amendments remove the one-year waiting period for optional personnel to join the System and also remove the ability for optional personnel to opt in and out of the System without terminating employment.

715:10-5-9 is being amended to comply with amendments to 70 O.S. Section 17-103 enacted by Senate Bill 683 in the 2021 legislative session and effective July 1, 2021.

These amendments remove the one-year waiting period for optional personnel to join the System and also remove the ability for optional personnel to opt in and out of the System without terminating employment.

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SUBCHAPTER 5. ESTABLISHING OTHER SERVICE CREDITS

715:10-5-9. Re-establishing withdrawn service

After returning to employment in the public schools of Oklahoma a member may redeposit a withdrawn account to re-establish service previously withdrawn from the system. For purposes of this section the following shall apply:

(1) A "classified" and "non-classified" member (except as noted in paragraph 2 of this section) who has returned to public education employment and has established one full year (twelve calendar months) of creditable Oklahoma service, is eligible to redeposit withdrawn contributions. A redeposit of withdrawn contributions must include all applicable interest, which shall be computed at a simple interest rate of ten percent (10%) per annum from the date of the withdrawal to the date repayment is made.

(2) Any member absent from the teaching service who is eligible to continue membership under special provisions of 70 O.S. 17-116.2, provided that such employee continues to be employed by a governmental agency.

(3) A visiting professor from another state or nation.

(4) Classified and Non-Classified members employed after retirement. (See OAC 715:10-17-13).

(5) Full-time, non-classified optional personnel who previously have opted out of TRS without terminating employment prior to July 1, 2021 under OAC 715:10-11-2 may revoke their election and return to TRS participation by filing a written irrevocable election on a form provided by TRS with the System no later than July 31, 2021, electing to opt in and return to TRS participation. Providing, however, that such member is not eligible to redeposit the account withdrawn under OAC 715:10-11-2 or purchase credit for service performed after termination of membership and re-instatement of membership.

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GIST/ANALYSIS:

715:10-1-4. Optional TRS membership

The following employees are eligible to be members of the Teachers' Retirement System at their option:

(A) Any non-classified optional employee employed on July 1, 2021, shall make an irrevocable election on a form provided by TRS to participate in or opt out of the System. If the employee fails to make an election by July 31, 2021, the employee shall be deemed to participate in the System.

(B) A non-classified optional employee employed after July 1, 2021, shall have thirty (30) days from the date of hire to make a one-time written irrevocable election on a form provided by TRS to opt out of the System. If an eligible employee fails to make an election within the thirty-day period, the eligible employee shall be deemed to participate in the System.

(C) A non-classified optional employee who opts out of participation in the System shall be ineligible for future participation in the System; provided, however, that if the employee is hired for a classified position, he or she shall become a member of the System, but shall not be eligible for prior service credit for service performed while employed in a non-classified position during which time the employee opted out of participation in the System.
withdrawn account and the date of return to membership in TRS.

(3) Non-classified members who voluntarily cease monthly contributions to TRS while continuing to be employed in an eligible position shall be considered to have withdrawn from membership.

(4) Requests for redeposits should be made to TRS in writing. The request must include the name in which the service was rendered, the TRS Member ID number or Social Security number, and the number of years withdrawn.

(5) Documentation of this service is on file with TRS and will be verified by the staff. Service that cannot be verified must be purchased under the rule for establishing service prior to membership.

(6) Repayments of withdrawn accounts may be made by active contributing members of TRS in a single lump sum, which includes the withdrawn contributions and all applicable interest, or in installment payments. Such installment payments may be paid in 12-month increments but shall be completed within 60 months. The member shall be responsible for maintaining the payment schedule. Payments are due on the first day of each month. A monthly installment not paid within sixty (60) days of the due date will result in termination of the installment payment schedule. The member will be given the option of paying the remaining balance within six (6) months. If the balance is not paid in full in the remaining six (6) month period, the redeposit will be canceled. Installment payments shall include interest based upon actuarial assumptions adopted by the TRS Board of Trustees. Such installment payments shall be completed before the member's effective retirement date. No proration is allowed for partial payments. If payments terminate prior to completion of the installment agreement, the amount paid by the member shall be refunded without interest.

(7) Redepositing of withdrawn accounts must be completed, and payment made to TRS, ninety (90) days prior to the effective date of a member's official retirement date.

(8) No person may make a redeposit to a member's account after the death of the member.

Any other public retirement system of this state, the United States government, or any other state or territory of the United States.

(3) The purchase price for eligible non-classified optional service credit shall be based upon actuarial cost as defined in OAC 715:10-5-4. All payments for such service credit must be made while the member is an active contributing member or within sixty (60) days after the end of the member's employment in the public schools in Oklahoma. No person may purchase service credit for such employment after the member's death.

(4) The payments for such service credit may be made in one lump sum or in equal monthly installments for up to sixty (60) months, as provided in OAC 715:10-5-4 and may be made as a picked-up service credit purchase in compliance with OAC 715:10-5-35.

(5) The purchase of service must be completed, and payment made to TRS, no later than ninety (90) days prior to the effect date of a member's official retirement date.

**SUBCHAPTER 11. WITHDRAWAL FROM MEMBERSHIP AND REFUND OF DEPOSITS**

**715:10-5-38. Credit for service as an optional employee prior to July 1, 2021**

Non-classified optional personnel who were employed prior to July 1, 2021, and who make an election to join the System by July 31, 2021, or within thirty (30) days of their date of hire, or who become classified mandatory personnel, may obtain service credit for qualified employment in public educational institutions in the State of Oklahoma for work performed as an optional, non-classified employee, prior to July 1, 2021, under certain circumstances.

(1) The member shall not be eligible to purchase withdrawn service as described in OAC 715:10-5-9(2) or service for which the member had ceased monthly contributions on at any prior date as described in OAC 715:10-5-9(3).

(2) The member is not receiving and is not eligible to receive retirement credit or benefits from the service in any other public retirement system of this state, the United States government, or any other state or territory of the United States.

Prior to July 1, 2021, a non-classified optional member may voluntarily terminate TRS membership while continuing employment in the public schools of Oklahoma, if:

(1) Proper application is made to TRS. Withdrawal may be made no earlier than two (2) months after date of application and no earlier than the receipt by TRS of the final deposit to the member's account.

(2) The financial officer of the employing school certifies the member's election to stop contributions and the date the member's last contributions will be remitted to TRS.

(3) Any member who withdraws under the conditions listed here may rejoin the Teachers' Retirement System, under the provision of OAC 715:10-1-4(4)(5). A member who terminates membership under this section cannot redeposit contributions withdrawn under this section at a later date, even if the individual returns to membership in TRS. The member will also forfeit any right to purchase service performed from the date of termination of membership under this section and prior to the re-entry date, and will forfeit any unused sick leave accumulated from the date of termination of membership under this section and prior to the re-entry date.

(4) A member's contributions cannot be terminated, by either the member or the employer, without termination of TRS membership. Any member who ceases contributions while still employed in an optional position shall be deemed to have become an ineligible member of TRS and will have forfeited all rights to retirement benefits provided by TRS for the service prior to the date the member ceased contributions.
(5) An employer may prevent its employees from withdrawing, under this rule, if the employer has a negotiated labor agreement, or formalized IRS plan, prohibiting such terminations and withdrawals.

(6) After-tax contributions can be refunded to an optional member prior to separation from service. Pre-tax contributions cannot be refunded until the member terminates employment or turns 62. Following termination of employment, TRS should be contacted for the proper form to be completed for return of pre-tax contributions. Upon completion of mandatory four-month waiting period, payment of the balance of the account will be made at the same time as regular withdrawals.

715:10-11-4. Refunds of contributions

(a) Refunds for overpayment of employer annual contributions, ineligible service purchases, or membership service contributions of less than six (6) months shall be made upon request by the employing school if the payment of contributions or service purchase was made based on mistake of fact or law.

1. Refunds to members who are terminating accounts will not be made until the final contributions of the withdrawing member is received and posted to his account. The required application must be completed and on file. The amount to be returned to the employer is the excess of the amount contributed or paid over the amount that would have been contributed or paid had no mistake been made.

2. No interest shall be paid on refunds for this purpose.

3. Contributions reported by the employer as "prefunded" will be refunded to the employer.

(b) Refunds of excess employee contributions shall be distributed to the member as soon as practical through a lump sum payment for all past overpayments with appropriate interest under OAC 715:10-11-1. The distribution shall be reported on IRS Form 1099-R for the year of the distribution.

SUBCHAPTER 13. CONTRIBUTIONS FOR MEMBERSHIP SERVICE


The Teachers’ Retirement System contribution deduction shall start with the payment for the first month of a “classified” employee's contract, or the first month of membership for an optional “non-classified” member. This contribution shall be based on the total compensation for the month, but shall not apply to the compensation of a substitute teacher or any employee working on a less than one-half time basis. Individuals who join the Teachers’ Retirement System during the school year, and who have been employed prior to becoming a member, must make retroactive contributions from the beginning of that school year. The membership date of such a member is the date of first payment not the beginning of the school year. The member shall not receive credit for a year of service until the balance of contributions, including any contributions required by the employer, are received by TRS. Interest compounded annually at ten percent (10%) per annum shall be levied against the balance due until paid.

1. The total deductions in any one school year shall not exceed the maximum limit prescribed by statutes as defined in OAC 715:10-13-3.

2. In determining the amount of the contribution for a member in any payroll period, the employer shall consider the total compensation earned from all sources. The contribution shall be calculated on the gross compensation before any deductions, such as tax-sheltered annuity, income taxes, Social Security, etc. Deductions shall be made at the statutory contribution rate on each month’s compensation until the maximum annual compensation level is reached. Total monthly compensation shall be reported in the monthly salary column of the remittance report. Monthly compensation includes gross wages and fringe benefits paid or provided by the remitting agency.

3. Monthly contributions for employees of a comprehensive university, whose maximum compensation level is less than the member's regular annual compensation, may be remitted in twelve equal payments to the member’s account during the school year. It shall be the responsibility of the employer to insure any required adjustment in contributions is made if a member terminates employment or the member's salary changes during the school year.

4. Contributions must be remitted monthly as long as the individual is employed in a position for which membership is a condition of employment. No member, including non-classified optional employees, may terminate contributions and retain membership in Teachers' Retirement System, except as expressly provided elsewhere in the statutes or TRS rules.

5. As of July 1, 1979, members who signed a waiver to contribute on a maximum annual salary of $7,800 are required by law to contribute on their total compensation not to exceed any current maximum contribution level.

6. The Department of Corrections shall contribute the employer's share to the Teachers' Retirement System. The contribution shall be the same dollar amount required of the member.

SUBCHAPTER 17. POST-RETIREMENT EMPLOYMENT

715:10-17-15. Salary limitations for certain returning classroom teachers

Legislation enacted during the 2017 legislative session allows members teachers who retired on or before July 1, 2017 to return to employment as a classroom teacher for a public school or career technology district with no earnings limitations in certain circumstances. Members seeking to return to employment as a classroom teacher under this provision must meet all of the following requirements:

1. The member must have been employed as an active classroom teacher as is defined in 70 O.S. § 17-101(27) for at least one full school year immediately prior to their date
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of retirement. Members employed as superintendents, admin-
istrators, or in other non-classroom teacher positions
during the school year immediately preceding retirement
are ineligible;
(2) The member can only be employed as an active
classroom teacher as defined in 70 O.S. § 17-101(27)
when they return to employment;
(3) The member must have been retired and drawing a
TRS retirement benefit and not be employed by any pub-
lic school or career technology district in any capacity for
the twelve (12) consecutive months immediately follow-
ing the last day of employment prior to their retirement
date; and
(4) Prior to the member’s return to employment the
member must provide to TRS on forms prescribed by
TRS, documentation establishing their eligibility under
this provision. This documentation must be accepted by
and approved by TRS prior to the member commencing
employment under this provision.

Legislation enacted during the 2021 legislative session al-

lows members who retired on or before July 1, 2020, to re-
turn to employment as an active classroom teacher for a public
school or career technology district with no earnings limita-
tions in certain circumstances. Members seeking to return to
employment as an active classroom teacher under this provi-
sion must meet all of the following requirements:

(1) The member must have been retired as of July 1,
2020;
(2) The member must have been retired and drawing a
TRS retirement benefit and not be employed by any pub-
lic school or career technology district in any capacity for
a period of twelve (12) consecutive months immediately
following the last day of employment prior to their retire-
ment date;
(3) The member can only be employed as an active
classroom teacher as defined in 70 O.S. § 17-101(27)
when they return to employment; and
(4) Within sixty (60) days of the member’s return to
employment the member’s employer must provide to TRS
on a form prescribed by TRS, documentation establishing
the member’s eligibility under this provision.

[OAR Docket #21-699; filed 7-20-21]

TITLE 777. STATEWIDE VIRTUAL
CHARTER SCHOOL BOARD
CHAPTER 15. OKLAHOMA
SUPPLEMENTAL ONLINE COURSE
CERTIFICATION

[OAR Docket #21-698]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
777:15-1-1. Purpose [AMENDED]
777:15-1-3. Application for course certification [AMENDED]
777:15-1-5. Course review requirements [AMENDED]
777:15-1-6. Course review and certification process [AMENDED]
777:15-1-7. Certified courses remaining in good standing [AMENDED]
777:15-1-9. SVCSB responsibilities [AMENDED]

AUTHORITY:
Statewide Virtual Charter School Board; 70 O.S. § 3-145.8(D).

ADOPTION:
June 24, 2021

EFFECTIVE:
Immediately upon Governor's approval.

APPROVED BY GOVERNOR:
July 19, 2021

EXPIRATION:
Effective through September 14, 2022, unless superseded by another rule or
disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

SUPERSUED RULES:
777:15-1-1. Purpose [AMENDED]
777:15-1-3. Application for course certification [AMENDED]
777:15-1-5. Course review requirements [AMENDED]
777:15-1-6. Course review and certification process [AMENDED]
777:15-1-7. Certified courses remaining in good standing [AMENDED]
777:15-1-9. SVCSB responsibilities [AMENDED]

Gubernatorial approval:
October 19, 2020

Register publication:
38 OK Reg 840

Docket number:
21-674

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:
The Statewide Virtual Charter School Board affirmed the finding of an
emergency for the proposed rule changes at its public meeting on September
1, 2020 because the rule changes are necessary to address a compelling public
interest.

More specifically, the amendments are necessary to prevent the expiration
of the rules in place from last year's finding of emergency and the inability to
complete the follow-up permanent rulemaking process due to the pandemic
and weather issues.

GIST/ANALYSIS:
The Statewide Virtual Charter School Board makes publicly available
a list of supplemental online courses which it has reviewed and certified to
ensure that the courses are high quality options and are aligned with the subject
matter standards approved by the State of Oklahoma. In conjunction with
the Office of Management and Enterprise Services, the SVCSB negotiates
with online course providers to offer a state rate price to school districts for
supplemental online courses. These rules have been proposed for the purpose
of implementing policy and procedures pursuant to Oklahoma Statute Title 70,
Section 3-145.3.

CONTACT PERSON:
Dr. Rebecca Wilkinson, Executive Director, (405) 522-3240,
Rebecca.Wilkinson@svcsb.ok.gov.

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(F):

777:15-1-1. Purpose
The Statewide Virtual Charter School Board (SVCSB)
makes publicly available a list of supplemental online courses
which it has reviewed and/or certified to ensure that the courses
are high quality options and are aligned with the subject matter
standards approved by the State of Oklahoma. In conjunction
with the Office of Management and Enterprise Services
(OMES), the SVCSB negotiates with online course providers
to offer a state rate price to school districts for supplemental
online courses. These rules have been adopted for the purpose

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Oklahoma Register (Volume 38, Number 23)  August 16, 2021
of implementing policy and procedures pursuant to Oklahoma Statute Title 70, Section 3-145.3.

777:15-1-3. Application for course certification
(a) To have a course(s) listed in the Oklahoma Online Course Catalog, Course Providers must first be approved as vendors through the Oklahoma Management and Enterprise System (OMES) and enter into a contract with the state. Potential vendors must respond to the Request for Proposals (RFP) released by the SVCSCB through OMES and provide all required documentation according to the deadline listed in the RFP solicitation.
(b) Once the solicitation period has closed, online provider is registered as a state vendor, OMES and the SVCSCB will negotiate and enter into a contract with the approved vendor to provide online courses at a state rate. All submitted materials will be reviewed for compliance by the SVCSCB and OMES. Entities meeting the minimum criteria established in the RFP will be approved as vendors for the State of Oklahoma.

777:15-1-5. Course review requirements
(a) Online Course Providers must supply the following at the time of course review:
(1) The name of the institution or organization providing the online content;
(2) Course title and subject code (using appropriate course title and subject code as established by the Oklahoma State Department of Education's approved Subject Codes for the appropriate academic year);
(3) Number of students who may be admitted to the course per instructor;
(4) Explanation of the alignment between Oklahoma content standards and course content and assignments;
(5) Protocols established to monitor student engagement and course progression, including guidelines to address non-responsive students;
(6) Description of procedures for reporting students' course progression, grade and other student information to the local school district;
(7) Instructor credentials and qualifications; and
(8) Course NCAA eligibility status. Recognition of course by external entity (e.g., NCAA, College Board Authorized, Advanced Placement certification); and
(9) Course syllabus that includes:
   (A) course title;
   (B) course description;
   (C) course credits;
   (D) objectives that clearly statements in measurable terms what the students will know or be able to do at the end of the course;
   (E) assignments/assessments;
   (F) instructional strategies and student expectations, including any synchronous attendance requirements;
   (G) time requirements;
   (H) grading policy;
   (I) contact policies for communication between teacher and students and teacher and parents;
   (J) resources and materials required;
   (K) technology requirements, including the Learning Management System (LMS) utilized;
   (L) accommodation and accessibility statement; and
   (M) course outline (i.e., list of units/modules in sequential order).
(b) At the time of the course review, guest access to the course will be required for the reviewers. If substantive changes are made to a course since its last certification, it must be submitted for review regardless of its current status in the review cycle. Substantive changes would include altering the intended course outcomes, significantly changing instructional strategies or assessment protocols used in the course as a whole, or any revision that impacts standards alignment. Only courses certified (or pending review) by the Statewide Virtual Charter School Board will be accepted into the Oklahoma Online Course Catalog.
(c) Course Providers whose courses have undergone review and approval by a recognized third-party entity must provide the results of those reviews. Depending on the results of the external review, a course may be recommended for state certification with no additional review or with a modified review process (e.g., review only for alignment to state standards).
(ed) Course Providers of Advanced Placement (AP) courses must provide the results of their College Board AP Course Audit and Authorization. No other course evaluation will be conducted for AP Courses. If a course is authorized by the College Board as an AP course, it is automatically listed as "state-certified" in the Oklahoma Online Course Catalog. Online Providers must provide evidence annually of AP Authorization Renewal.

777:15-1-6. Course review and certification process
(a) All approved vendors will have the online courses they submitted as part of the RFP published on the OSOCR website, the Oklahoma Online Course Catalog, and reviewed according to the schedule adopted by the SVCSCB.
(b) Course reviews will be conducted by content experts and pedagogical experts selected by the SVCSCB. Courses will be evaluated using rubrics to determine alignment with the current academic standards approved by the State of Oklahoma (or nationally/ internationally accepted content standards set for courses whose content is not included in state standards) and national standards for quality in online course design. The International Association for K-12 Online Learning (iNACOL) National Standards for Quality Online Courses. The rubric published in the most current National Standards for Quality Online Courses will be used as part of the Course Review, along with a rubric to measure the presence of each of the academic standards for the content area. Course Providers whose courses have undergone review and approval by a recognized third-party entity must provide the results of those reviews. Depending on the results of the external review, a course may be recommended for state certification with no additional review or with a modified review process (e.g.,
review. Online Course Providers of Advanced Placement (AP) courses must provide the results of the AP Course Audit and Authorization. No other course evaluation will be conducted for AP Courses. Online Providers must provide evidence annually of AP Authorization Renewal.

(c) If results of the initial review suggest that a course will not be recommended for certification, the Course Provider will be contacted with the review results and have fifteen (15) calendar days to revise material or provide additional information pertinent to the review. These revisions will be examined by the course reviewers and, if appropriate, the rubric scores will be modified. Once the course review is complete, results of the evaluation will be presented to the Statewide Virtual Charter School Board (SVCSB). The SVCSB will consider the evidence and vote whether to certify or not certify the course. The decision will be made on a simple majority vote. If the SVCSB votes to not certify a course, the course will be removed from the Oklahoma Online Course Catalog and the Course Provider will be notified of the reasons the course was not certified. The Course Provider may revise the course and resubmit for additional Course Review and certification consideration. Resubmitted courses will be reviewed after all submitted courses have undergone an initial review. Courses approved will be certified for a five-year period. After which, Course Providers must apply for renewal. Certified courses will be identified as such and have their course review ratings published in the Oklahoma Online Course Catalog available on the OSOCP website. Courses pending review will be identified as such and have the date of their scheduled review published in the Oklahoma Online Course Catalog.

777:15-1-7. Certified courses remaining in good standing

(a) To remain in good standing and have a course(s) continuously listed in the Oklahoma Online Course Catalog through the entirety of the approval period, Course Providers agree to:

1. Maintain their vendor status.
2. Notify the SVCSB of any additions, deletions or changes to certified courses by completing the online form located on the OSOCP website.
3. Serve all enrolled students, regardless of number enrolled in a section so that Receiver Districts have reliable course options for students.
4. Provide online instructors who are 1) certified in Oklahoma or another state to teach in the content area of the course offered; or 2) a faculty member at an accredited institution of higher education, possessing the specific content expertise necessary to teach the course. Additionally, the Course Provider shall supply certification or applicable credentialing documentation to the SVCSB as part of the course review process and within ten (10) working days upon the hire of any new instructors for any certified course. The Course Provider shall be responsible for such obligation regardless of whether instructors are employees of the Course Provider, independent contractors, or employees of a third-party course vendor. Course Providers shall take all steps necessary to verify the qualifications of non-employee instructors.
5. Notify SVCSB in writing within ten (10) working days if for any reason an online instructor no longer meets the requirements to teach a course offered. The name and credentials of the replacement instructor must also be provided at that time.
6. Refer only to courses currently certified and listed in the Oklahoma Online Course Catalog as "Statewide Virtual Charter School Board approved."
7. Own, secure, and/or maintain licensure and copyright for all courses offered in the Oklahoma Online Course Catalog.
8. Maintain a current course syllabus including key information such as examinations requiring proctoring and other supporting information (see syllabus requirements in Course Review Requirements).
9. Course Providers of Advanced Placement (AP) courses must provide evidence annually of AP Authorization Renewal.
10. Ensure that each certified course is maintained throughout the duration that the course is offered and continues to meet the current academic standards approved by the State of Oklahoma; national standards for quality in online course design (International Association for K-12 Online Learning (INACOL)) National Standards for Quality Online Courses; and Oklahoma's Information Technology Accessibility Standards.
11. Employ the appropriate course title and subject code as established by the Oklahoma State Department of Education's approved Subject Codes for the appropriate academic year for the purpose of data collection.
12. Report aggregate student success data to the SVCSB in the requested format and by the timeline set. The SVCSB does not collect individual student information. By August 1 of each year, the Course Provider will report the following aggregate student success data to the SVCSB:
   (A) Total number of unique Oklahoma students;
   (B) Total number of courses taken by Oklahoma students;
   (C) Number of students in each course (both overall number and Oklahoma students); and
   (D) Successful completion rate (number and percent) of each course (i.e. X% of students enrolled in X successfully completed the course). Include both overall rates and Oklahoma-specific rates.

(b) Course providers will be notified if a course(s) is found to be noncompliant and will have fifteen (15) business days after notification to bring the course(s) into compliance. If
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the course(s) is still noncompliant at the end of this period, the course certification will be revoked and the course will be removed from the Oklahoma Online Course Catalog.

777:15-1-9. SVCSB responsibilities

The SVCSB shall:

1. Ensure that all courses listed in the Oklahoma Online Course Catalog are reviewed according to the stated requirements.
2. Notify the Course Providers of changes in current academic standards approved by the State of Oklahoma; national standards for quality in online course design, the International Association for K-12 Online Learning (IN-ACOL) National Standards for Quality Online Courses; and Oklahoma's Information Technology Accessibility Standards, or other standards that prompt the need for course revisions. Such notification is a courtesy and does not negate the responsibility of the Course Providers to maintain currency with regard to these standards.
3. Maintain accurate information in the Oklahoma Online Course Catalog.

[OAR Docket #21-698; filed 7-20-21]
Permanent Final Adoptions

An agency may promulgate rules on a permanent basis upon "final adoption," as defined in 75 O.S., Section 250.3(5), of the proposed rules.
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 cites the Register publication of the finally adopted rules in the permanent rule document.
For additional information on the permanent rulemaking process, see 75 O.S., Sections 303, 303.1, 308, 308.1 and 308.3.

TITLE 25. OKLAHOMA AERONAUTICS
COMMISSION
CHAPTER 1. COMMISSION OPERATIONS

[OAR Docket #21-373]

RULEMAKING ACTION:
PURSUANT TO THE ACTIONS DESCRIBED HEREIN,
THE FOLLOWING RULES ARE CONSIDERED
FINALY ADOPTED AS SET FORTH IN 75 O.S.,
SECTIONS 250.3(5) AND 308(5), WITH AN EFFECTIVE
DATE OF AUGUST 26, 2021:

The rules of this chapter shall govern all proceedings
before and dealings with the Oklahoma Aeronautics Com-
mission, except as provided in Chapter 10, "Airport Zoning".
Hearings and appellate proceedings shall be governed by the
rules of this chapter and all applicable Oklahoma statutes,
including, but not limited to, the Administrative Procedures
Act, Title 75, Oklahoma Statutes 1981, Section 301 et seq.

25:1-1-3. Definitions
The following words and terms, when used in this chapter,
shall have the following meaning unless the context clearly in-
dicates otherwise:
"Aeronautical hazard" means any structure, object of
natural growth, or use of land, which obstructs the airspace
required for the flight of aircraft in landing or taking off at
an airport or that is otherwise hazardous to the operation and
navigation of aircraft.
"Aeronautics" means the science, art and practice of
flight, including, but not limited to, transportation by aircraft
and matters relating to air commerce; the operation, construc-
tion, repair, or maintenance of aircraft, aircraft power plants
and accessories, including the repair, packing, and mainte-
nance of parachutes; the design, establishment, construction,
extension, operation, improvement, repair, or maintenance of
airports, restricted landing areas, or other air navigation facil-
ties; and instruction in flying or ground subjects pertaining
thereto.
"Air navigation facility" means any facility used in,
available for use in, or designed for use in, aid of air navigation,
including landing areas, any structures, mechanisms, lights,
beacons, markers, communicating systems, or other instru-
mentalities or devices used or useful as an aid, or constituting
an advantage or convenience, to the safe taking off, navigation,
and landing of aircraft, or the safe and efficient operation or
maintenance of an airport, and any combination of any or all of
such facilities.
"Aircraft" means any contrivance now known, or here-
after invented, used, or designed for navigation or flight in
the air or airspace.
"Airman" means any individual who engages, as the
person in command, or as pilot, mechanic, or member of the
crew, in the navigation of aircraft while under way, and any
individual who is directly in charge
"Airport" means any area of land or water which is used,
or intended for use, for the landing and take-off of aircraft,
and any appurtenant areas which are used, or intended for use,
for airport buildings, clear zones, or other airport facilities or

AUTHORITY:
Oklahoma Aeronautics Commission; 3 O.S. Section 85
DATE OF AUGUST 26, 2021:
FINALLY ADOPTED AS SET FORTH IN 75 O.S.,
The FOLLOWING RULES ARE CONSIDERED
FINALLY ADOPTED AS SET FORTH IN 75 O.S.,
SECTIONS 250.3(5) AND 308(5), WITH AN EFFECTIVE
DATE OF AUGUST 26, 2021:

PERMANENT final adoption
PUBLIC HEARING:
March 4, 2021
ADOPTION:
March 10, 2021
SUBMISSION OF ADOPTED RULES TO GOVERNOR AND
LEGISLATURE:
March 10, 2021
LEGISLATIVE APPROVAL:
Approved June 11, 2021 by HJR 1046
FINAL ADOPTION:
June 11, 2021
EFFECTIVE:
August 26, 2021
SUPERSEDED EMERGENCY ACTIONS:
N/A
INCORPORATIONS BY REFERENCE:
N/A
GIST/ANALYSIS:
The proposed permanent rules will revoke the scope of the chapter which
references a previously revoked chapter. It will also modify the definition
of Commission. A change made to organization and responsibilities will
update the election of officers’ timeline and a change made to Director
responsibilities will modify the definition of eligible workforce. These
changes to the permanent rules are to help clarify and ensure efficiency
within the Commission’s operations pursuant to the Governor’s Executive
Order 2020-3, which asked agencies to identify all unnecessary and outdated
regulations.
CONTACT PERSON:
Michelle Bouziden, Grants Administrator, Oklahoma Aeronautics
Commission, 110 N. Robinson, Suite 200, Oklahoma City, OK 73102, (405)
604-6912.
right-of-ways, together with all airport buildings and facilities located thereon.

"Airspace" means the portion of the atmosphere overlying a designated geographical area considered as subject to territorial jurisdiction or international law in respect to its use by aircraft, guided missiles, and rockets.

"Commission" means the Oklahoma Aeronautics Commission as created in Title 3 Section 84 of the Oklahoma Statutes.

"Director" means the Director of the Oklahoma Aeronautics Commission.

"Designated Emergency Management Use Landing Site" means any area of land which has been designated for the landing and take-off of aircraft for emergency management use, including, but not limited to law enforcement, search and rescue, and medical.

"Municipality" means any incorporated city, village, or town of this state and any county or political subdivision or district in this state which is, or may be authorized by law to acquire, establish, construct, maintain, improve, and operate airports, airstrips, and aeronautical navigation facilities.

"Operation of aircraft" or "operate aircraft" means the use, navigation, or piloting of aircraft in the airspace over this state or upon any airport within this state of the inspection, maintenance, overhauling, or repair, of aircraft, aircraft engines, propellers, and appliances.

"Person" means any individual, firm, partnership, corporation, company, association, joint stock association or body politic; and includes any trustee, receiver, assignee, or other similar representative thereof.

"Resources" means services, facilities, funds, equipment, property, personnel, and such other activities as are customarily included within the term.

"State" means the State of Oklahoma.

25:1-1-4. Organization and responsibilities of Commission

(a) At the next last regular scheduled meeting after at the first end of June of each calendar year, the Commission shall organize itself by electing a Chairman, Vice-Chairman, and Secretary. The Chairman shall be the presiding officer at all official meetings and shall execute all documents, requiring the Commission's approval. The Vice-Chairman shall act in the capacity of the Chairman, in the absence of the Chairman. The Secretary shall be responsible for written recording of the Commission's actions and shall attest to the signature of the Chairman as required. The Secretary shall act in the capacity of Chairman or Vice-Chairman during their absence providing there is a quorum.

(b) The Commission shall meet as prescribed by law, and all meetings of the Commission shall be in conformance with the "Oklahoma Open Meeting Act", Title 25, Oklahoma Statutes 1981, Section 301 et seq.

(c) The Commission shall prescribe the basic rules, regulations, policies, and procedures by which the Oklahoma Aeronautics Commission operates.

(d) The Commission shall coordinate, develop, and maintain a comprehensive airport systems plan for the State of Oklahoma, develop measurable goals and objectives designed to carry out such a plan, and cooperate with local governments in the planning and development of airport related activities, when consistent with the goals and objectives of the State master system plan for airports and the laws of the State of Oklahoma.

(e) The Commission shall formulate and adopt a program of airport construction, improvements, and maintenance throughout the entire state. Its purpose shall be to monitor the construction and maintenance of the statewide system of airports with emphasis on current and future needs while considering the impact of population centers, traffic volume requirements, traffic data, and industrial development areas on these needs.

(f) The Commission shall appoint, by a majority vote of the entire Commission, a State Aeronautics Director to be the principal officer of the Oklahoma Aeronautics Commission in accordance with Title 3, Oklahoma Statutes 1985 Supp., Section 84.B.(1).

25:1-1-5. Director

The Director is hereby granted all the powers and authority necessary for the orderly operation of the Oklahoma Aeronautics Commission, not in conflict herewith or prohibited by law, including, but not limited to the following:

1. General duties.
   (A) To approve claims for all lawful expenses of the Commission.
   (B) To act as the claims and request officer for the Oklahoma Aeronautics Commission.
   (C) To appoint an Assistant Director and to delegate to him/her the appropriate authority and responsibility.
   (D) To keep the Commission informed on operations and official actions.
   (E) To appoint and employ, supervise, and discharge such professional, clerical, and skilled and semiskilled help, labor, and other employees as may be deemed necessary for the proper and lawful discharge of the duties of the Commission.
   (F) To establish and maintain training and educational programs.
   (G) To keep files and to record therein such matters as he/she may deem necessary or advisable, or which the Commission may direct.
   (H) To be the keeper of the official seal of the Commission.
   (I) To make budgetary transfers within the Commission, within the limits of statutory control and Commission authorization.
   (J) To cooperate with governing bodies of cities and towns, boards of the various counties, and other entities, on the basis prescribed by state and federal laws, to the end that joint efforts will be coordinated to attain a maximum of airport development and service; and to execute any appropriate contracts and
agreements necessary toward the accomplishment of the Commission's approved program.

(K) Contracts:
(i) To execute all contracts and agreements on behalf of the Commission as provided by law, and in accordance with Commission policy.
(ii) To approve necessary contract extensions or modifications made necessary by unexpected developments as allowed by law.

(L) Federal Aid:
(i) To act for and represent the Oklahoma Aeronautics Commission in all official matters involving the Federal Aviation Administration or any other agency of the United States government, for the purpose of executing Federal Grant Programs.
(ii) To make or withhold commitments, execute contracts and agreements, and to bind the Commission by any other action which the Commission may lawfully do.

(2) Administration. To develop forms and to issue more detailed instructions, not inconsistent with the rules of this Chapter, or applicable state and federal laws, by appropriate orders and memoranda for the general guidance and administration of the Commission.

[OAR Docket #21-373; filed 6-14-21]

TITLE 38. OKLAHOMA BOARD OF LICENSED ALCOHOL AND DRUG COUNSELORS
CHAPTER 10. LICENSURE AND CERTIFICATION OF ALCOHOL AND DRUG COUNSELORS

[OAR Docket #21-486]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 3. Rules of Professional Conduct
38:10-3-2 [AMENDED]
38:10-3-4 [AMENDED]
Subchapter 5. Fitness of Applicants
38:10-5-4 [NEW]
Subchapter 7. Application
38:10-7-2 [AMENDED]
38:10-7-8 [AMENDED]
38:10-7-9 [AMENDED]
Subchapter 11. Fees
38:10-11-1 [AMENDED]
Subchapter 13. Continuing Education Requirements
38:10-13-2 [AMENDED]

AUTHORITY:
Oklahoma Board of Licensed Alcohol and Drug Counselors; 59 O.S., § 1875-1 and § 1884 (B).

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
November 3, 2020

COMMENT PERIOD:
December 1, 2020 until the conclusion of the public hearing on January 5, 2021

PUBLIC HEARING:
January 5, 2021
ADOPTION:
January 25, 2021

SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:
January 27, 2021

LEGISLATIVE APPROVAL:
Approved June 11, 2021 by HJR 1046

FINAL ADOPTION:
June 11, 2021

EFFECTIVE:
August 26, 2021

SUPERSEDED EMERGENCY ACTIONS:

INCORPORATIONS BY REFERENCE:

GIST/ANALYSIS:
Subchapter 3 revisions clarify romantic and sexual relationships between the counselor and their clients. These amendments are to clarify professional boundaries regarding romantic or sexual relationships.

Subchapter 5 addictions establish rules for applicants with criminal convictions to be able to request a review of the criminal convictions to determine the potential eligibility for application acceptance. This addition allows the Board to charge a fee for this review and develop a list of criminal offenses that would disqualify an individual from obtaining a license. This addition is in response to HB 1373.

Subchapter 7 is amended to eliminate subjective language regarding good moral character in 38:10-7-8 and changes in reciprocity rules in 10-7-9 for military personnel and their spouses.

Subchapter 11 clarifies the renewal fee for CADCs and LADCs at $125.00 and the LADC/MH renewal fee at $175.00. The former language in the fee schedule for the co-occurring credential is eliminated and replaced by the LADC/MH fee. Late renewal fees are adjusted to accommodate a renewal fee increase in 2018. A new fee of $95.00 is added as allowed by HB 1373 for a Criminal History Initial Determination Fee.

Subchapter 13 amends language requiring candidates to acquire 6 hours of continuing education after one year of candidacy. The continuing education will be submitted each December along with the Application Maintenance Fee.

CONTACT PERSON:
Richard D. Pierson, Executive Director, (405) 521-0779, or rpierson@okdrugcounselors.org.

ADDITIONAL INFORMATION:
Any additional information desired will be supplied upon request.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 3. RULES OF PROFESSIONAL CONDUCT

38:10-3-2. Code of ethics
(a) It shall be the responsibility of Licensed and Certified Alcohol and Drug Counselors to value objectivity and integrity, and in providing services, to strive to maintain the highest standards of their profession.
(b) LADCs and CADCs shall accept responsibility for the consequences of their work and make every effort to ensure their services are used appropriately.
(c) LADCs and CADCs shall be alert to personal, social, organizational, financial, and political situations or pressures that might lead to the misuse of their influence.
(d) LADCs and CADCs shall not participate in, condone, or be associated with dishonesty, fraud, sexual harassment, deceit or misrepresentation.

(e) LADCs and CADCs shall not exploit their relationships with current or former clients, supervisees, students, employees, or research participants, sexually or otherwise, for personal advantage, profit, satisfaction, or interest.

(1) LADCs and CADCs shall not ever engage in any romantic or sexual relationship with a current client.
(2) LADCs and CADCs shall not ever engage in any romantic or sexual relationship with a former client.
(3) LADCs and CADCs shall not accept as a client anyone with whom they have ever had a romantic or sexual relationship.

(f) LADCs and CADCs shall not solicit the clients of one’s employing agency for private practice.

(g) LADCs and CADCs shall terminate service to clients, and professional relationships with them when such service and relationships are no longer required or in which a conflict of interest arises.

(h) LADCs and CADCs shall not accept as a client anyone with whom they have engaged in a romantic or sexual relationship.

(i) The LADC and CADC shall give precedence to his or her professional responsibility over personal interests.

(j) The LADC and CADC shall not represent that he or she performed services which he or she did not perform.

(k) LADCs and CADCs shall not divide a fee or accept or give anything of value for receiving or making a referral.

(l) LADCs and CADCs shall provide clients at the beginning of service written, accurate and complete information regarding the extent and nature of the services available to them, to include fees and manner of payment.

(m) In addition to the above stated provisions each LADC and CADC shall sign and adhere to the written code of ethics as set forth in Appendix A of this Chapter.

(n) LADC/MH applicants will need to sign the Code of Ethics for Co-Occurring Disorders as found in Appendix B.

(dg) Updating. LADCs and CADCs shall notify the Board of any changes in address, telephone number, and employment within fourteen (14) days of the change.

**SUBCHAPTER 5. FITNESS OF APPLICANTS**

**38:10-5. Criminal history initial determination**

(a) An individual with a criminal history record may request an initial determination of whether the criminal history would potentially disqualify the individual from obtaining a license or certificate issued by the Board. The individual may request the determination at any time, including prior to obtaining the required education necessary for licensing or certification, and prior to making the application with the Board.

(b) The request shall be in writing, accompanied by a fee found in the fee schedule, and shall include either a copy of the person’s criminal history record with explanation of each conviction mentioned in the criminal history record or a statement describing each criminal conviction, including the date of each conviction, the court of jurisdiction and the sentence imposed.

(c) The individual may include a statement with his or her request describing additional information for consideration by the Board including, but not limited to, information about his or her current circumstances, the length of time since conviction, what has changed since the conviction, evidence of rehabilitation, testimonials or personal reference statements.

(d) The Board shall consider the written request and make an initial determination based upon the information provided as to whether the criminal history is disqualifying. A written notice of initial determination shall be issued to the requestor within sixty (60) days from the date such request was received by the Board and mailed to the requestor at the address provided in the request. The notice shall contain the following statements:

(1) Whether the person appears eligible for licensure or certification at the current time;

(2) If there is a disqualifying offense prohibiting the person’s licensure or certification;

(A) a statement identifying the offense(s) in the criminal history record or information submitted for consideration;

(B) any actions the person may take to remedy what appears to be temporary disqualification, if any; and

(C) the earliest date the person may submit another request for consideration, if any; and licensure or certification based upon the information provided by the requestor.

(e) The Board shall maintain and make available to applicants and others upon request a list of criminal offenses that would disqualify an individual from obtaining a license or certification. Any disqualifying offense shall substantially relate to the duties and responsibilities of the profession, and pose a reasonable threat to public safety as defined in 59 O.S. § 4000.1(A).
SUBCHAPTER 7. APPLICATION

38:10-7-2. Requirements for licensure or certification

(a) Licensed Alcohol and Drug Counselor.

(1) An application for a license to practice as a LADC shall be made to the Oklahoma Board of Licensed Alcohol and Drug Counselors in writing. Such application shall be on a form and in a manner prescribed by the Board. The application shall be accompanied by the fee required by the act, which shall be retained by the Board and not returned to the applicant.

(2) Each applicant shall:

(A) Be of good moral character;

(B) Pass an oral and written examination;

(C) Be at least twenty-one years of age;

(D) Not have engaged in, nor be engaged in, any practice or conduct which would be grounds for denying, revoking or suspending a license pursuant to the provisions of the Act;

(E) Otherwise comply with the rules promulgated by the Board pursuant to the provisions of the Act.

(3) In addition to the requirements in subsection (a) (2), each applicant shall:

(A) Have at least a master's degree in alcohol and substance abuse counseling or other clinical counseling field recognized by the Oklahoma Board of Licensed Alcohol and Drug Counselors from a college or university accredited by an accrediting body recognized by the U.S. Department of Education. The degree program must include, at a minimum, the courses and the practicum/internship listed in 59 O.S. § 1876 (D) (1) and;

(B) Have successfully completed at least one (1) year of full-time work experience. For the purpose of the Act, "One (1) year of full-time work experience" shall be defined as two thousand (2000) hours of work experience, of which at least one thousand (1000) hours shall consist of direct client contact providing behavioral health services to an individual and/or the individual's family. At least five hundred (500) hours of the one thousand (1000) direct client contact hours must be the provision of alcohol and drug counseling services; or

(C) Be a licensed mental health professional as defined in Section 1-103 of Title 43A of the Oklahoma Statutes and have completed a minimum of fifteen (15) hours of master's level substance abuse specific coursework, including, but not limited to, chemical addiction, counseling, alcohol/drug counseling theory, pharmacology of drugs and abuse, assessment and treatment of alcohol and drug problems, theories in family addiction and family addiction counseling. An applicant who qualifies under this subsection is not required to complete the supervised work experience.

(D) An applicant must complete all requirements for licensure, including passing the exams, within three (3) years of the date the application was accepted.

(E) Persons who meet the requirements in subsection (a) may include the assessment, diagnosis and treatment of mental health disorders within the LADC scope of practice. The designation LADC/MH (licensed alcohol and drug counselor/mental health) shall be noted on their license and wallet card.

(F) Persons who were licensed as LADC or made application prior to January 1, 2012 and who meet the requirements in subsection (a) may make application for the LADC/MH designation. Applicants must submit a completed application on the form prescribed by the Board and pay a fee of one hundred forty dollars ($140.00) which shall be retained by the Board and not returned to the applicant. The application must include;

(i) An official transcript in a sealed envelope showing that the applicant has obtained the educational requirement;

(ii) Proof that the applicant holds a valid license in good standing in one of the behavioral health professions listed in 59 O.S. § 1876 (F) (1);

(iii) For applicants who do not meet the requirements in (a) (3) (A) or (a) (3) (B), proof that the applicant has a valid co-occurring disorders certification from a certification entity approved by the Board.

(G) The scope of practice of a LADC who does not have the MH designation may not include provision of services that focus solely on mental health disorders. The LADC may provide services for a client with no independent substance use disorder if services are focused on the client's exposure to a family member's substance abuse.

(b) Certified Alcohol and Drug Counselor.

(1) An application for certification as a CADC shall be made to the Oklahoma Board of Licensed Alcohol and Drug Counselors in writing. Such application shall be on a form and in a manner prescribed by the Board. The application shall be accompanied by the fee required by the Act, which shall be retained by the Board and not returned to the applicant.

(2) Each applicant for certification shall:

(A) Be of good moral character;

(B) Pass an oral and written examination;

(C) Be at least twenty-one years of age;

(D) Not have engaged in, nor be engaged in, any practice or conduct which would be grounds for denying, revoking or suspending a license pursuant to the provisions of the Act;

(E) Otherwise comply with the rules promulgated by the Board pursuant to the provisions of the Act.

(F) At a minimum, a bachelor's degree in a behavioral science field that is recognized by the Oklahoma Board of Licensed Alcohol and Drug Counselors as appropriate to practice as a certified drug and alcohol counselor in this state;
permanent final adoptions

(c) Direct Client Contact Hours. Direct client contact hours, as referenced above in (a) and (b), are defined as activities in which a counselor provides services to a client or group of clients. These must be activities within the scope of the alcohol and drug counselor, such as assessment, intervention, screening, counseling, education. This does not include observation of others providing these services. Direct client contact also includes activities in which services are provided to the client’s family members/caregiver/guardian, with or without the client physically present, such as family education and/or family counseling. This includes review of assessment and treatment results with these stakeholders, either individually or during group meetings. Direct client contact also includes communication with the client and/or family members/caregiver/guardian via email or telephone. Activities that DO NOT count as direct contact include speaking or consulting with other professionals regarding the client, without the client and/or family member/caregiver/guardian present; collaborating with other professionals without the client and/or family member/caregiver/guardian present; time spent preparing materials, writing reports, planning for assessment or intervention, and so forth. Administrative duties without the client and/or family member/caregiver/guardian present, while important, are NOT direct contact. Observation of treatment or assessment sessions are NOT considered direct contact, of the counselor is only observing others providing services.

(d) Post-Military Service Applicants. The Board shall consider the equivalent education, training and experience completed by an applicant for certification or licensure while the applicant was a member of the United States Armed Forces or Reserves, National Guard of any state, the Military Reserves of any state, or the Naval militias of any state, and apply it in the manner most favorable toward satisfying the qualifications for certification or licensure. To determine whether education, training and experience completed by an applicant for certification or licensure while the applicant was a member of the military as described in the preceding paragraph, the Board may consider, but is not limited to, determinations made by institutions of higher education based on the Guide to the Evaluation of Educational Experience in the Armed Services, published by the American Council on Education.

38:10-7-8. Renewal of license or certification

(a) Renewal timeline. All licenses or certifications shall expire at the end of each fiscal year (June 30) and shall be subject to renewal on the first day of the next fiscal year (July 1st).

(b) Renewal package. All licensed or certified persons must submit a complete renewal package, including fee, postmarked by June 30 of the fiscal year. Only renewals submitted on the most current forms provided by the Board will be accepted.

(c) Individual responsibility. Each LADC or CADC is responsible for renewing the license or certification and specialty designation before the expiration date.

(d) Renewal notification. The Board shall mail a written notice of expiration to LADC or CADC at least forty-five (45) days prior to the expiration date of the license or certification.

(e) Failure to renew. If the licensee or certified person fails to timely renew his or her license or certification by the expiration date, the Board shall notify him or her in writing that:

(1) suspension of the license and/or certification, and forfeiture of rights and privileges granted by the license or certification; the license or certificate holder is no longer authorized to practice alcohol and drug counseling;

(2) The license or certificate holder may be subject to disciplinary action for practicing with an expired license or certificate.

(3) For up to one (1) year following the expiration of the license, the LADC or CADC has the right to renew the license by making application for renewal, payment of the renewal fee and the late renewal fee and fulfillment of all other renewal requirements, for up to one (1) year following the suspension of the license; and

(4) Licenses or certifications not renewed within the one (1) year renewal period shall not be reinstated and the license or certification shall be returned to the Board.

(f) Any LADC or CADC whose license or certification is active and in good standing is a member of the Armed Forces of the United States and is on active duty at the time of renewal is exempt from payment of the renewal fee. Upon receipt of notice of assignment to active duty from the LADC or CADC, the Board shall automatically renew the license without fee each year thereafter of active duty military service, and for up to one year after the date of discharge from active duty.

38:10-7-9. Reciprocity

(a) Any person who becomes a resident of Oklahoma and who is or has been, immediately preceding his residency in this state, licensed or certified in good standing to practice alcohol and drug counseling by another state and who meets
the testing, educational and work experience qualifications for licensure or certification in Oklahoma may, upon payment of the necessary fee and submission of documents as required by the Board, be licensed or certified under these provisions.

(b) Reciprocity shall be based upon an evaluation of the licensing or certification criteria of the other state to determine if criteria are equal to or more stringent than Oklahoma licensing or certification requirements.

(c) The Board shall expedite the process of licensure or certification by reciprocity for applicants who are former military service members, active duty military members or spouses of active duty military members. If the applicant's out-of-state license or certification is in good standing and the requirements for obtaining the out-of-state license or certification are reasonably equivalent to Oklahoma's requirements, the Board will issue the license or certificate within thirty (30) days of receipt of the completed application. The application fee shall be waived and whose spouse is an active duty member of the armed forces of the United States if:

(1) the military service member is on active duty within Oklahoma or claims permanent residency within Oklahoma for the six (6) months prior to assignment to active duty or during the period of active duty and;

(2) the applicant left employment in another state to accompany the military service member spouse to Oklahoma.

(d) The Board may authorize an applicant whose spouse is an active duty military service member as described in subsection (c) of this Section to practice under supervision while completing Oklahoma exam requirements for licensure that were not required in the state in which the applicant is licensed or certified. The applicant is subject to the rules governing supervision of applicants who are not seeking licensure or certification by reciprocity.

**SUBCHAPTER 11. FEES**

38:10-11-1. Schedule of fees

Fees are non-refundable and include:

(1) **Application fee.** One-hundred and seventy-five ($175.00) dollars and shall be submitted with the application form.

(2) **Examination fee.** The fee shall be the amount set by the examination provider, and is paid by the applicant directly to the examination provider.

(3) **Initial license or certification fee.** One-hundred and twenty-five ($125.00) dollars shall be submitted prior to the receipt of license or certificate. The initial license or certification notices shall invoice the licensed or certified person for the interim period between the original license or certification date and the following June 30 so that subsequent renewals shall be on July 1 annual basis.

(4) **Renewal fee. CADC or LADC.** One-hundred and twenty five dollars ($125.00). Shall be submitted upon notification by the Board on or before June 30, and validates the license or certification for twelve (12) months.

(5) **Renewal fee. LADC/MH.** One-hundred and seventy five dollars ($175.00). Shall be submitted upon notification by the Board on or before June 30, and validates the license or certification for twelve (12) months.

(6) **Late renewal fee.** Twenty-five dollars ($25.00) will be charged each month, if the license or certification is not renewed by June 30. This fee combined with the renewal fee shall not exceed ($200.00)($25.00) for CADC or LADC or ($275.00) for LADC/MH. The licensed or certified person must submit this fee as well as the renewal fee on or before the following June 30 to avoid revocation.

(7) **Replacement fee.** Twenty-five dollars ($25.00). Shall be submitted for the issuance of a license or certification to replace a license which has been lost, damaged, or is in need or revision.

(8) **Inactive license or certification fee.** Twenty-five dollars ($25.00). Payment of this fee renders the license or certification inactive and suspends all rights and privileges granted by the license or certification for a period of no more than two (2) years. If not renewed within the two (2) year period, license or certification is considered lapsed.

(9) **Mailing list of licensed and certified counselors.** Thirty-five dollars ($35.00).

(10) **Written verification of licensure or certification.** Five dollars ($5.00).

(11) **Duplication of public records.** Twenty-five cents ($ .25) per page for un-certified copies; one dollar per page ($1) for certified copies.

(12) **Search fee for public records.** $25 per hour.

(13) **Investigation or prosecution.** At cost incurred.

(14) **Returned check processing fee, or denied or non-payment of credit card fees.** Fifty dollars ($50.00).

(15) **Probation.** Twenty-five dollars ($25.00) per month.

(16) **Board approved supervisor status designation.** Thirty-five dollars ($35.00) for initial application fee.

(17) **Supervisor status designation annual renewal fee.** Twenty-five dollars ($25.00).

(18) **LADC/MH application fee.** One Hundred Seventy-Five Dollars ($175.00).

(19) **Co-occurring disorder Certification renewal fee.** Criminal history initial determination fee. Fifty dollars ($50.00). Ninety-five dollars ($95.00).

(20) **Application maintenance fee.** A candidate for certification or licensure shall pay an annual application maintenance fee of twenty-five dollars ($25.00). The purpose of the fee is to defray costs of monitoring the application for compliance with the supervision requirements. The fee shall be due and payable on or before December 31 of each year until the license is issued. The fee shall not be imposed until the following year for applications accepted by the Board from December 1 to December 31. An additional twenty-five dollar ($25.00) late fee will be charged for each month the maintenance fee is past due for up to three months. If the maintenance fee and late fees are not paid in full on or before April 1, the application shall be void. Persons whose applications are void must
submit a new application, pay the application fee, and shall be subject to the licensure and certification requirements currently in effect. The following requirements may carry over to the new application: (1) supervised work experience hours and continuing education hours completed within 2 years prior to the application void date; (2) practicum. This fee shall apply to all applications on file with the Board as of the effective date of the rule.

(2021) Continuing education provider application fee-$200
(2422) Licensee application fee for approval of continuing education Program-$25

SUBCHAPTER 13. CONTINUING EDUCATION REQUIREMENTS

38:10-13-2. Continuing education standards
(a) Continuing education hours required. As a requirement for license or certification renewal, twenty (20) clock hours of continuing education units shall be required for each license or certification held. These hours must have been obtained during the previous renewal period July through June and approved by the Board. At least three (3) hours must be categorized as ethics training as defined by the Board. At least ten (10) hours must be alcohol and drug specific as defined by the Board and only half or 10 hours can be done through online sources. For LADC/MH, the twenty (20) hours of continuing education hours must be on topics categorized by the Board as Co-Occurring, or consist of (10) hours on Mental Health topics and ten (10) hours on alcohol and drug specific topics as defined by the Board.
(b) Candidate requirements for continuing education. Candidates who have been in the licensure process for more than one year must have at least three hours of continuing education in ethics each successive year until licensed. For each year of candidacy after the first year, the candidate must also obtain three hours of continuing education in addition to the three hours of ethics. Proof of completion of the continuing education required for applicants shall be submitted with the application maintenance fee. Continuing education must be from approved providers to avoid additional fees and must meet all other requirements for continuing education.
(c) Continuing education approval. Approval of continuing education shall be at the discretion of the Oklahoma Board of Licensed Alcohol and Drug Counselors and shall be in accordance with standards acceptable to the profession of alcohol and drug counseling. Requirements for the providers of continuing education are addressed in OAC 38:10-13-7.
(d) Armed services. A licensed or certified person called to active duty in the Armed forces of the United States for a period of time exceeding one hundred and twenty (120) days during a calendar year shall be exempt from obtaining the continuing education required during that calendar year.
(e) Exemption. A licensed or certified person experiencing physical disability, illness, or other extenuating circumstances may request partial or complete exemption from the continuing education requirements. The licensee or certified person shall provide supporting documentation for the Board’s review. Such hardship cases will be considered by the Board on an individual basis.
(f) Prorating. Licensees or certified persons upon initial certification will have their CEU hours prorated according to the date of their initial certification.

[OAR Docket #21-486; filed 6-15-21]

TITLE 45. ALCOHOLIC BEVERAGE LAWS
ENFORCEMENT COMMISSION
CHAPTER 10. PROVISIONS AND PENALTIES APPLICABLE TO ALL LICENSEES

[OAR Docket #21-490]
SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 11, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS

45:10-1-1. Purpose [REVOKED]

The rules in this Chapter provide procedures and penalties which are applicable to all alcoholic beverage licensees.

SUBCHAPTER 3. PROVISIONS APPLICABLE TO ALL LICENSEES

45:10-3-2. Felony conviction or previous revocation [REVOKED]

All applications for employee or agent's license shall be denied by the Commission or Director if it is found that the applicant has been convicted of a felony. Application for an employee or agent's license shall be denied if it is found that the applicant has been the holder of a license previously revoked for cause by the Commission or the Director within twelve (12) months preceding the date of the application.

45:10-3-29. Restriction on licensing relatives [REVOKED]

No license of any type shall be issued to any person or any partnership containing any partner who is related by affinity or consanguinity within the third (3rd) degree to any licensee after the date of the issuance of any contemplated suspension, revocation or denial of any application for a renewal of the license of said licensee. This provision shall remain in full force and effect during the pendency of the disciplinary proceedings and throughout the time during which there has been no final determination of the action of the Commission or Director under such Notice of Suspension, Revocation or Denial of the Renewal of a License. PROVIDED, that no license shall be issued to any person or any partnership containing any partner who is related to any licensee by affinity or consanguinity within the third (3rd) degree of the licensee during the period of suspension, revocation or the period of time during which the licensee would not be permitted to operate under his existing license or denial thereof.

[OAR Docket #21-490; filed 6-15-21]

TITLE 45. ALCOHOLIC BEVERAGE LAWS ENFORCEMENT COMMISSION CHAPTER 20. RETAIL SPIRIT STORES, MIXED BEVERAGE, CATERERS, SPECIAL EVENTS AND BOTTLE CLUBS

[OAR Docket #21-491]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

45:20-1-1. Purpose [REVOKED]
45:20-1-3-1. Licensees Authorized to utilize curbside and delivery methods [NEW]
45:20-1-2. Signature required [NEW]
45:20-1-3-2. Maintaining records of delivery [NEW]
45:20-1-3-3. Delivery vehicle requirements [NEW]
45:20-1-3-4. Curbside and delivery hours [NEW]
45:20-1-3-5. Curbside and delivery area [NEW]
45:20-1-3-6. Restriction on delivery area [NEW]
45:20-1-3-7. Invoice or receipt required on board [NEW]

AUTHORITY:

Oklahoma Alcoholic Beverage Control Act, 37A O.S. §1-101 et seq.; and Alcoholic Beverage Laws Enforcement Commission, 37A O.S. §1-107(2).

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:

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n/a

INCORPORATIONS BY REFERENCE:

n/a

GIST/ANALYSIS:

Senate Bill 1928 was passed during the 2020 legislative session and subsequently signed into law by Governor J. Kevin Stitt on May 21, 2020. Senate Bill 1928 authorizes curbside and delivery sales by certain licensees and authorizes the ABLE Commission to promulgate rules for its implementation. The purpose of the new rules is to provide a regulatory framework for retailers engaging in these types of alcohol sales to consumers.

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., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 11, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS

45:20-1-1. Purpose [REVOKED]

The rules in this Chapter provide procedures which are applicable to Retail Spirit, Retail Beer, Retail Wine, Mixed Beverage, Caterer, Special Event and Bottle Club licensees.
Permanent Final Adoptions

SUBCHAPTER 9. RETAIL BEER LICENSEES

45:20-9-1. Restriction on certain sales [REVOKED]
No Retail Beer licensee shall sell beer containing more
than 8.99% alcohol by volume.

SUBCHAPTER 11. RETAIL WINE LICENSEES

45:20-11-1. Restriction on certain sales [REVOKED]
No Retail Wine licensee shall sell wine containing more
than 14.99% alcohol by volume.

SUBCHAPTER 13. CURBSIDE AND DELIVERY SALES

45:20-13-1. Licenses authorized to utilize curbside and delivery methods
(a) Small Brewers and Small Farm Winery license holders
are authorized to sell alcoholic beverages they produce on the
licensed premises at their curbside to consumers age 21 years
or older in accordance with Title 37A O.S. §2-161.
(b) Retail Spirit license holders are authorized to sell sealed
original containers of beer, wine, and spirits at their curbside
or delivered to consumers age 21 years or older in accordance
with Title 37A O.S. §2-161.
(c) Retail Beer, Retail Wine, Mixed Beverage, Caterer/Mixed Beverage, and Beer and Wine license holders
are authorized to sell sealed original containers of beer or
wine only at their curbside or delivered to consumers age 21
years or older in accordance with Title 37A O.S. §2-161.
(d) For purposes of this section, "curbside" shall mean the
immediate outdoor area of the licensed premises that is owned,
leased, or controlled by such licensee. Further, "delivery" shall
mean the physical transportation of authorized alcoholic bev-
erages to a consumer's physical location.

45:20-13-2. Signature required
A valid signature of the person 21 years of age or older
receiving the alcoholic beverages shall be obtained at the time
of each delivery.

(a) All licensees authorized to engage in alcoholic beverage
delivery to consumers provided for in Title 37A O.S. §2-161
shall maintain a record of each sale completed using delivery
that includes the following information:
(1) The purchaser's name, date of birth, and delivery
location;
(2) The name and license number of the licensee's em-
ployee completing the delivery; and
(3) The signature receipt of the consumer receiving the
delivery of alcoholic beverages.
(b) These records shall be available for inspection by the
ABLE Commission upon request, and shall be held for a period
of twelve (12) months.

45:20-13-4. Delivery vehicle requirements
All vehicles used for retail delivery of alcoholic beverages
shall have displayed on the outside of the vehicle, a sign in
letters at least three (3) inches in height and one and one-half
(1 1/2) inches in width, giving the name of the licensee and its
Alcoholic Beverage Laws Enforcement Commission license
number.

45:20-13-5. Curbside and delivery hours
Any licensee engaged in authorized curbside or delivery
sales may do so during any such time the licensee is authorized
to engage in the sale of alcoholic beverages. For all purposes
including hours of operating delivery sales, all such delivery
sales shall be considered completed at the time the alcoholic
beverages being delivered are in the physical possession of the
end consumer.

45:20-13-6. Restriction on delivery area
Any licensee engaged in authorized delivery sales may
only do so within the county the licensed premise is located,
and any immediately contiguous county sharing a county line
border with the licensee's home county.

45:20-13-7. Invoice or receipt required on board
Any employee licensee making authorized retail alcohol
deliveries on behalf of a licensed establishment must carry on
board the delivery vehicle an invoice or physical receipt reflect-
ing the following:
(1) the name of the licensee selling the alcoholic bev-
erages;
(2) the name and location of the consumer purchasing
the alcoholic beverages;
(3) the date and time the transaction occurred; and
(4) the price charged for the alcoholic beverages.

[OAR Docket #21-491; filed 6-15-21]

TITLE 45. ALCOHOLIC BEVERAGE LAWS ENFORCEMENT COMMISSION
CHAPTER 25. WINEMAKERS, SELF-DISTRIBUTION, DIRECT SHIPMENT

[OAR Docket #21-492]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 5. Direct Shipment of Wine
45:25-5-5. Direct consumer's permit [REVOKED]

AUTHORITY:
Oklahoma Alcoholic Beverage Control Act, 37A O.S. §1-101 et seq.; and
Alcoholic Beverage Laws Enforcement Commission; 37A O.S. §1-107(2).
Permanent Final Adoptions

TITLe 45. ALCOHOLIC BEVERAGE LAWS
ENFORCEMENT COMMISSION
CHAPTER 30. MANUFACTURERS, WINE
AND SPIRIT WHOLESALERS, BREWERS,
NONRESIDENT SELLERS AND BEER
DISTRIBUTORS

[OAR Docket #21-493]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
45:30-1-1. Purpose [REVOKED]
Subchapter 5. Brewers, Nonresident Sellers, and Beer Distributors
45:30-5-16. Employees and agents must be licensed [REVOKED]
45:30-5-25. Quality Control [REVOKED]

AUTHORITY:
Oklahoma Alcoholic Beverage Control Act, 37A O.S. §1-101 et seq.; and
Alcoholic Beverage Laws Enforcement Commission, 37A O.S. §1-107(2).

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INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
During the 2020 legislative session, the Oklahoma Legislature passed Senate Bill 1928, which Governor Stitt signed into law effective May 21, 2020. The Oklahoma ABLE Commission adopted emergency rules in response, which are set to expire September 14, 2021. In compliance with Executive Order 2020-3 ("one in two out rule"), Chapter 25, Subchapter 5, Section 45:25-5-5 provides for a direct consumer permit as originally provided for in Senate Bill 383 (2016). Before the effective date of Senate Bill 383, the legislature removed this permit from statute deeming this rule as unnecessary.

CONTACT PERSON:
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Subchapter 5. Direct Shipment of Wine

45:25-5-5. Direct consumer’s permit [REVOKED]
A Direct Consumer’s Permit may be applied for in person or by mail at the ABLE Commission headquarters by completing an application form and providing a State issued photo identification card proving the applicant is over the age of 21 years. A Direct Consumer’s Permit shall be required of all residents receiving wine from a direct shipper’s permit holder.

[OAR Docket #21-492; filed 6-15-21]
Permanent Final Adoptions

45:30-1-1. Purpose [REVOKED]
The rules in this Chapter provide procedures which are applicable to Manufacturers, Wine and Spirits Wholesalers, Brewers, Nonresident Sellers and Beer Distributors of alcoholic beverages.

SUBCHAPTER 5. BREWERS, NONRESIDENT SELLERS, AND BEER DISTRIBUTORS

45:30-5-16. Employees and agents must be licensed [REVOKED]
(a) A Brewer, Nonresident Seller or Beer Distributor shall have any person employed in connection with his licensed business in this State who physically handles alcoholic beverages, unless the employer and/or employee have filed by certified United States mail or in person an application for license for such employee or agent.
(b) Any Brewer, Nonresident Seller or Beer Distributor having an unlicensed person performing any duties of an employee or agent in connection with his licensed business will be subject to a suspension of license for such time as the Director or Commission deems appropriate.

45:30-5-25. Quality Control [REVOKED]
(a) Beer Distributors, Small Brewer Self-Distributors and Brewpub Self-Distributors may withdraw, from a retail licensee's stock, with the permission of the retail licensee and at the time of regular delivery, a quantity of beer or cider in undamaged original packaging if the following conditions are met:

1. The beer or cider is withdrawn before, or immediately after the date for recommended use stamped on the beer or cider by the Brewer; and
2. The beer or cider is replaced with beer or cider of identical brands, quantities, packaging and alcohol by volume as the beer or cider withdrawn.

(b) The provisions of this Section shall not apply to beer or cider that:

1. Has suffered damage at the retail licensee's location. Beer Distributors, Small Brewer Self-Distributors and Brewpub Self-Distributors are prohibited from giving a refund for or replacing beer or cider that was damaged while in the possession of the retail licensee. Retail licensees are prohibited from requesting or requiring the Beer Distributor, Small Brewer Self-Distributor and Brewpub Self-Distributor to remove such damaged product as a condition of continued business with the retail licensee.
2. Has a date for recommended use that expired on or before October 1, 2018. Retail licensees and Brewers are prohibited from requesting or requiring a Beer Distributor to remove such expired beer or cider as a condition of continued business with the retail licensee or Brewer.

[OAR Docket #21-493; filed 6-15-21]

TITLE 45. ALCOHOLIC BEVERAGE LAWS ENFORCEMENT COMMISSION CHAPTER 50. CHARITY GAMES

[OAR Docket #21-494]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
45:50-1-1. Purpose [REVOKED]
Subchapter 11. Administrative Hearings and Penalties
45:50-11-3. Petition for rule change or declaratory ruling [REVOKED]

AUTHORITY:
Oklahoma Alcoholic Beverage Control Act, 37A O.S. §1-101 et seq.; and Alcoholic Beverage Laws Enforcement Commission, 37A O.S. §1-107(2).

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INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
During the 2020 legislative session, the Oklahoma Legislature passed Senate Bill 1928, which Governor Stitt signed into law effective May 21, 2020. The Oklahoma ABLE Commission adopted emergency rules in response, which are set to expire September 14, 2021. In compliance with Executive Order 2020-3 (“one in two out rule”), Chapter 50, Subchapter 1, Section 45:50-1-1 provides a purpose statement which is not necessary. Further, Chapter 50, Subchapter 11, Section 45:50-11-3 is duplicative with another provision in Chapter 10 and unnecessary.

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., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 11, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS

45:50-1-1. Purpose [REVOKED]
The rules in this Chapter have been promulgated for the purpose of administering and enforcing the Oklahoma Charity Games Act, Section 401 et seq., of Title 3A, of the Oklahoma Statutes.
SUBCHAPTER 11. ADMINISTRATIVE HEARINGS AND PENALTIES

45:50-11-3. Petition for rule change or declaratory ruling [REVOKED]

(a) Interested persons may petition the Commission for the promulgation, amendment, or repeal of a rule or petition the Commission for declaratory ruling in the following manner:

(1) All petitions for promulgation, amendment, or repeal of rules shall set out in its entirety the requested rule or the suggested amendment or repeal of any rule in effect.

(2) All petitions filed for declaratory rulings by the Commission concerning any ruling or order by said Commission shall set out fully the views of the petitioner giving the reasons he has in support of such views.

(3) All petitions filed with the Commission on or before the 29th day of the month shall be set for hearing on the Agenda of the Commission at its next regular meeting of the following month; PROVIDED, That for good cause shown to the Director or the Commission by mutual agreement between the petitioner and the legal representative of the Commission, the hearing of the petition may be postponed.

(4) The following forms shall be used in petitioning the Commission for promulgation, amendment, or repeal of any rule or declaratory ruling:

(A)

BEFORE THE OKLAHOMA ALCOHOLIC BEVERAGE LAWS ENFORCEMENT COMMISSION

In the Matter of the Petition for Promulgation, Amendment or Repeal of a Rule

PETITION

Comes now, the undersigned petitioner and respectfully requests the Commission to: __________ and in furtherance hereof asks that this petition be set for hearing before the Commission on the date of its next regular meeting.

WHEREFORE, petitioner asks that upon the hearing of the above requested that such relief be granted by the Commission.

________________________
PETITIONER

(B)

BEFORE THE OKLAHOMA ALCOHOLIC BEVERAGE LAWS ENFORCEMENT COMMISSION

In the Matter of the Petition for a Declaratory Ruling

PETITION

[OAR Docket #21-494; filed 6-15-21]
Permanent Final Adoptions

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

GIST/ANALYSIS:
The amendments revoke rules related to technology no longer used by state agencies for the management of records, a report no longer required, and microfilming services no longer provided by the agency.

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., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 7. MICROFILM [REVOKED]

60:10-7-1. Authenticity and photographic quality [REVOKED]
The Archives and Records Commission requires, prior to authorization for destruction of original records previously microfilmed, that state agencies seeking such destruction must first obtain certification of the identity and photographic quality of such film from the Micrographics Section of the Records Management Division of the Oklahoma Department of Libraries, or personnel in other micrographics laboratories certified by the State Records Administrator. The Commission suggests ANSI/AIIM MS 23-1991, “Practice for Operational Procedures/Inspection and Quality Control of First Generation Silver Gelatin Microfilm of Documents,” as a guide for agency microfilming programs [67 O.S., Sections 305-306].

60:10-7-2. Quality control standards [REVOKED]
The following are quality control standards for microfilm of state records:

(1) Records and Microfilm Identification Declarations must be completed and signed by the official who has legal custody of the original records and by the camera operator, and filmed at the beginning and end of each roll of film thus identifying the records on that particular roll. The Commission suggests ANSI/AIIM MS 10-1993, “Recommended Practice for Identification of Microforms,” as a guide for completing Microform Identification Declarations.

(2) Documents in a condition making it impossible to reproduce them in a legible and readable condition, as displayed on a microfilm reader or reproduced in paper copy, should be marked with a target to that effect, such as “The following document is below standards for microfilm.” After being filmed, such documents must be withdrawn from the sequence and retained in the original for the same length of time as the applicable microfilm. Legibility is defined as the quality of a letter or numeral which enables the observer to identify it positively and quickly to the exclusion of all other letters and numerals. Readability is defined as the quality of a group of letters or numerals which makes them recognizable as words or whole numbers.


(A) The required master record on microfilm (camera negative) shall be permanent record film as specified in ANSI/NAPM IT9.1 1992, “Imaging Media (Film) Silver Gelatin Type Specifications for Stability (revision and redesignation of ANSI PH 9.1-1989).”

(B) In addition to the master record, a working copy of the microfilm may be provided. The working copy may be silver, diazo or vesicular type on a safety base of cellulose ester or polyester materials.

(4) In clear-base, negative appearing microfilm of paper documents, the gross background density shall be between 0.8 and 1.50, depending on the type of original document and the reduction ratio. The base plus fog density of unexposed, processed, clear-base film must not exceed 0.10. When a tinted-base film is used, the density will increase by 0.1 or 0.2 which must be added to the 0.10 value. The Procedures for density measurement are described in ANSI/AIIM MS 23-1991, “Practice for Operational Procedures/Inspection and Quality Control of First Generation Silver Gelatin Microfilm of Documents.” On negative microfilm produced by Computer Output Microfilm (COM), the background density shall be a minimum 1.1. These requirements apply only to the master records.

(5) Every master record shall have density measurements taken at five (5) separate locations listed in (a) through (e) of this paragraph. Whenever possible, the areas selected for recording density measurement shall be free of information. The locations for density measurement are:

(A) at the beginning of the reel (within the first ten (10) frames);

(B) one quarter (1/4) of the way through the reel;

(C) one half (1/2) of the way through the reel;

(D) three quarters (3/4) of the way through the reel; and

(E) at the end of the reel (within the last ten (10) frames).

(6) The maximum residual thiosulfate ion concentration for the master record shall not exceed 0.014 grams per square meter for records of permanent value or 0.030 grams per square meter for microfilm that the Archives and Records Commission has authorized for destruction within fifty years as determined by the methylene blue method for measuring thiosulfate as specified in ANSI/NAPM IT 9.1-1992, “Imaging Media (Film) Silver Gelatin Type Specifications for Stability (revision and redesignation of ANSI PH 9.1-1989).” The
residual thiosulfate ion test shall be performed in accordance with procedures outlined in ANSI/ISO 417-1993, ANSI/NAPM IT9.17-1993, "Determination of Residual Thiosulfate and other Related Chemicals in Processed Photographic Materials-Methods Using Iodine Amylose, Methylene Blue and Silver Sulfide" (revision and redesignation of ANSI PH 4.8-1985), whenever any change in film, chemicals, or processing is made. Regular test periods should be observed, and if any reading of more than 0.014 grams per square meter occurs, the test shall be performed on a daily basis until the condition is corrected. The silver densitometric method, as outlined in ANSI/ISO 417-1993, ANSI/NAPM IT9.17-1993, "Determination of Residual Thiosulfate and other Related Chemicals in Processed Photographic Materials-Methods Using Iodine Amylose, Methylene Blue and Silver Sulfide" (revision and redesignation of ANSI PH 4.8-1985), may be used for routine daily analysis providing the density stain differential produced in this method is no greater than 0.02, but this test is not a sufficiently reliable substitute for the methylene blue method required by this section.

(7) Archival quality as defined in ANSI/NAPM IT9.1-1992, "Imaging-Media-(Film)-Silver Gelatin Type Specifications for Stability (revision and redesignation of ANSI PH19.1-1989)" is required for records with a retention requirement greater than ten (10) years except that thermally processed silver film (TPS) is acceptable as the master negative for microfilm that the Archives and Records Commission has authorized as permanent. The master record must be stored in accordance with ANSI IT9.11, "Imaging-Media Processed Safety Photographic Film-Storage (revision and redesignation of ANSI PH1.43-1985)."

(8) Retakes, properly identified, may be spliced to either the beginning or end of the reel containing the images for which the retakes are necessary. Splices shall be butt welded or by use of photographic splicing tape or ultrasonic splicer. Retakes, properly identified, may be produced as a separate reel. Splices within the sequence of filmed documents are not acceptable.

(9) Requests for destruction of records that have been microfilmed must include quality evaluation forms from the Micrographics Section of the Records Management Division of the Oklahoma Department of Libraries or authorized personnel in other micrographics laboratories certified by the State Records Administrator certifying that the microfilm meets the above standards for identification, photographic quality, and storage.

60:10-7.3. Computer output microfilm (COM) [REVOKED]

The master Records produced by computer output microfilm (COM) technology shall meet the same standards for storage delineated in 60:10-7.2(7). For microfilm that the Archives and Records Commission has authorized as permanent, either wet processed silver film or thermally processed silver film (TPS) is acceptable COM output.

60:10-7.4. Micrographics laboratory certification [REVOKED]

The State Records Administrator, in conjunction with the Archives and Records Commission, shall establish criteria for, and certify, agency and other micrographics programs that provide microfilming services for state records, in accordance with approved records disposition schedules. Microfilm and microfiche produced by programs that are not certified shall be quality evaluated by laboratories that are certified. All certified laboratories shall submit copies of all microform quality evaluation forms and a five percent (5%) sample of microforms they have created and/or quality evaluated to the Micrographics Section of the Records Management Division. Program certification shall be for one (1) year, and may be revoked at any time by the State Records Administrator, on written notice to the agency head or applicable private firm official stating the reason for certification revocation.

SUBCHAPTER 8. OPTICAL IMAGING

60:10-8.6. Annual compliance report [REVOKED]

(a) Every agency, board, commission, or institution maintaining records in optical imaging format with an approved retention period of ten (10) years or more in accordance with approved records disposition schedules shall file annually each July with the State Records Administrator a report stating that it is in compliance with all statutory provisions and Archives and Records Commission Rules pertaining to maintaining records in optical imaging format. Upon receipt and acknowledgment of the report, the State Records Administrator or his/her designee shall transmit a copy of the report to the submitting agency, board, commission, or institution. The report shall be in a reporting form provided by the Records Management Division that contains the following information:

(1) The name of the agency, board, commission, or institution filing the report.
(2) The year covered by the report.
(3) The name and signature of the person who compiled the report.
(4) The date the report was compiled.
(5) The name of the optical-imaging system administrator.
(6) The schedules, records series numbers, and records series titles of all records with a retention period of ten (10) years or more maintained in optical imaging format.
(7) The name and signature of the person submitting the compliance report.
(8) The date the report was received by the State Records Administrator and the name of the person acknowledging receipt.

(b) The State Records Administrator shall notify the Archives and Records Commission of any agency, board, commission, or institution that fails to file an annual report.

SUBCHAPTER 11. SERVICE FEES
Permalink Final Adoptions

60:10-11-2. Archival microfilming service fees [REVOKED]
The Department of Libraries is authorized to provide microfilming services to state agencies or subdivisions of Oklahoma government and to be paid for these services on the basis of fee schedules established by the Archives and Records Commission [47 O.S., Section 301].

(1) **Microfilm.** The following fees shall be charged for microfilm:

(A) **16mm microfilm.** Providing duplicates of 16mm film by photographic duplication of original: $25.00 per 100 ft. roll; $27.50 per 215 ft. roll.

(B) **35mm microfilm.** Providing duplicates of 35mm film: $30.00 per 100 ft. roll.

(C) **105mm microfilm.** Providing duplicates of 105mm fiche: $0.50 for first copy plus $0.25 for additional copies of the same fiche.

(2) **Security film storage.** There shall be no charge for storing master negatives of state agency and local government microfilm and microfiche in the Department of Libraries microform security vaults.

(3) **Other micrographics services.** The fee for any services in addition to basic processing, duplicating and automatic-feed filming shall be $15 per hour of staff time.

60:10-11-3. Charges for special equipment and supplies [REVOKED]

Rental charges for special equipment and costs of special supplies in addition to filming, processing and duplicating procedures will be paid by the agency for whom filming is being done. Before a filming project is begun, a maximum cost amount must be agreed to by the Records Management Division and the agency for whom the filming is being done.

[OAR Docket #21-447; filed 6-15-21]

TITLE 175. STATE BOARD OF COSMETOLOGY AND BARBERING

CHAPTER 10. LICENSURE OF COSMETOLOGISTS, BARBERS, SCHOOLS AND RELATED ESTABLISHMENTS

[OAR Docket #21-445]

RULEMAKING ACTION:
PERSISTENT final adoption

RULES:

Subchapter 3. Licensure of Schools

Part 3. Student registration and entrance requirements

175:10-3-16. Student entrance requirements [AMENDED]

Part 5. Equipment and curriculum requirements

175:10-3-31. Training equipment requirements [AMENDED]

175:10-3-37. Master cosmetology instructor course entrance and curriculum requirements [AMENDED]

175:10-3-40. Curriculum and training requirements for cosmetology and barbering courses [AMENDED]

175:10-3-41. Cosmetician course entrance and curriculum requirements [AMENDED]

175:10-3-45. Barber course entrance and curriculum requirements [AMENDED]

Subchapter 7. Sanitation, Disinfection and Safety Standards for Establishments and Schools

175:10-7-12. Towels/Linens [AMENDED]

175:10-7-18. Disinfection precautions before and after each patron service [AMENDED]

Subchapter 9. Licensure of Cosmetologists, Barbers and Related Occupations

Part 1. Apprenticeship

175:10-9-1. Apprentice training [AMENDED]

Part 5. Demonstrators; cosmetic studios; trade shows; guest artists; wig dressing; other practices of cosmetology and barbering

175:10-9-53. Wig dressing requirements [AMENDED]

Subchapter 15. Inspections, Violations and Enforcement

175:10-15-2. Board inspection of Establishments and schools [AMENDED]

AUTHORITY:

59 O.S. § 199.3(B)(1) and § 199.7; State Board of Cosmetology and Barbering

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n/a

GIST/ANALYSIS:

The proposed rules clarify existing rules, correct typographical errors, reduce redundancy and streamline and simplify student entrance requirements for the study of cosmetology. The proposed rules also reorganize the training equipment requirements by specialty. The proposed rules further reflect prior legislative changes.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 3. LICENSURE OF SCHOOLS

PART 3. STUDENT REGISTRATION AND ENTRANCE REQUIREMENTS

175:10-3-16. Student entrance requirements

Student entrance requirements for the Basic Cosmetologist, Manicurist/Nail Technician, Cosmetician, Esthetician/Facialist/Facial Operator, Barber and Barber Instructor courses are as follows:
175:10-3-31. Training equipment requirements
(a) The following minimum equipment is considered by the Board to be adequate for the appropriate and safe training of no more than thirty-seven (37) students. The minimum equipment shall be required for all schools with one (1) to and including thirty-seven (37) students.

(1) One (1) school seal
(2) One (1) Chart of Anatomy to include:
   (A) bones
   (B) muscles
   (C) nerves
   (D) circulatory system
   (E) skin
(3) One (1) blackboard
(4) Three (3) large wet sanitizers (pan-type with covers)
(5) One (1) large dry sanitizer with airtight cabinet (without fumigant) to keep instruments, combs, and brushes after they have been taken from wet sanitizer
(6) One (1) small dry sanitizer for each student (closed dry cabinet, drawer or other covered box-type container)
(7) One (1) container with cover for each student to store soiled brushes/combs etc. until such time as all items shall be cleaned and sanitized according to approved rules and methods
(8) Four (4) shampoo basins equipped with shampoo sprays and connected with hot and cold water (one shampoo basin for each additional 15 students or major fraction thereof)
(9) Four (4) shampoo chairs (one for each additional 15 students or major fraction thereof)
(10) Two (2) facial chairs, considered adequate for patron service, reclining, styling or shampoo are acceptable for student practice (one for each additional 15 students or major fraction thereof)
(11) Four (4) hair dryers - hood or chair type
(12) Twelve (12) blow-dryers (one for each additional 15 students or major fraction thereof)
(13) Twelve (12) blow dryers (one for each additional 15 students or major fraction thereof)
(14) Twelve (12) curling irons (one for each additional 15 students or major fraction thereof)
(15) One (1) mannequin for each student
(16) Twenty (20) styling chairs
(17) Five (5) covered waste receptacles
(18) One (1) large closed cabinet for clean towels
(19) Twenty (20) work/styling stations with mirrors
(20) Twenty (20) styling chairs
(21) Four (4) vented, covered containers provided for soiled linens (towels, capes, sheets) (one for each additional 15 students or major fraction thereof)
(22) One (1) large dispensary cabinet
(23) Five (5) covered waste receptacles
(24) One (1) large dispensary cabinet
(25) Five (5) wet
(26) Four (4) manicure tables and chairs considered adequate for patron service. A long narrow (18") folding
Permanent Final Adoptions

...table is acceptable for student practice. This is a requirement for a cosmetology school and not a barber school.

(24) One (1) covered hair pin or clipper container for each student. This is a requirement for a cosmetology school and not a barber school.

(25) Two (2) facial chairs, considered adequate for patron service; reclining, styling or shampoo are acceptable for student practice (one for each additional 15 students or major fraction thereof) This is a requirement for a cosmetology school and not a barber school.

(26) One (1) facial supply cabinet (one for each additional 15 students or major fraction thereof) This is a requirement for a cosmetology school and not a barber school.

(27) Subscriptions to at least three (3) professional cosmetology-related periodicals (electronic periodicals are acceptable).

(28) Four (4) heaters and irons and/or four (4) electric pressing combs.

(29) Four (4) manicure tables and chairs considered adequate for patron service. A long narrow (18") folding table is acceptable for student practice. This is a requirement for a cosmetology school and not a barber school.

(30) One (1) covered hair pin or clipper container for each student. This is a requirement for a cosmetology school and not a barber school.

(31) Five (5) head forms

(32) Five (5) wefts

(b) Other additional equipment shall be required if the Boards Inspector shall show evidence that the need for additional equipment is necessary to the appropriate and safe training in all phases of cosmetology and barbering to each student enrolled in the school.

175:10-3.37. Master cosmetology instructor course entrance and curriculum requirements

(a) Entrance requirements.

(1) Student registered in the master cosmetology instructor course must:

(A) hold an Oklahoma Cosmetologist license or be registered for the Basic Cosmetologist examination. If any person enrolled prior to examination shall fail to appear or fail to pass Basic Cosmetologist, he/she shall immediately cease master cosmetology instructor training until such time as he shall again register for and show proof of achieving a passing score on the cosmetologist examination.

(B) hold a High School Diploma or General Education Development Certificate.

(C) file registration application for master cosmetology instructor course including fee of $5.00 with the Board.

(2) Each student shall be provided with an approved textbook or manual before commencing training.

(b) Curriculum requirements. The 1000 clock hour Master Cosmetology Instructor course curriculum is prescribed as follow: (Note: Hours may be measured in credits and ratio as recognized by the United States Department of Education or by a regional or national accreditation entity recognized by the United States Department of Education.)

(1) Orientation 60 clock hours

(2) Introduction to teaching and curriculum 120 clock hours

(3) Course outlining and development; lesson planning; teaching techniques; teaching aids; developing and administering and grading examinations 330 clock hours

(4) Cosmetology Law, cosmetology school management and record keeping 90 clock hours

(5) Teaching - assisting in the classroom and clinic 150 clock hours

(6) Practice teaching - classroom and clinic 250 clock hours

(7) Total hours 1000 hours

(c) Master Cosmetology Instructor students are assigned practice in classes actually scheduled by the school. Practice teaching by master cosmetology instructor students will be in the Basic, Manicurist/Nail Technician, Cosmetician, Hair Braiding - Technician and/or Esthetician/Facialist/Facial Operator course. Practice teaching must be supervised by a licensed master cosmetology instructor.

(d) A master cosmetology instructor student is not allowed to perform patron services. The master cosmetology instructor student shall only demonstrate for or otherwise assist student under his supervision.

(e) Minimum training supplies. A master cosmetology instructor shall be provided the following:

(1) textbook or manual

(2) workbook

(3) board Statute, Rules and Regulations Book

175:10-3.40. Curriculum and training requirements for cosmetology and barbering courses

(a) Curriculum training shall include the study of electricity, safety measures and chemistry and must be carried through all classes in which it is used. Mannequin practice must be given to each student.

(b) A student who has completed the training in the Basic courses in a cosmetology and/or barbering school or as an apprentice who completed the course in an Establishment, must have had required amount of patron practice by working under actual cosmetology/barbering Establishment conditions to that he should be able to:

(1) perform any ordinary operation satisfactorily and in the same amount of time customarily allotted to that operation in an Establishment.

(2) conduct a consultation on any ordinary cosmetology or barbering subject and prescribe proper treatment.

(3) mix any preparation used in an Establishment.

(c) Establishment management must include purchasing, price determination, selling, appointment scheduling, dispensing of supplies and personal management.

(d) The teaching of wig styling and hairpieces shall consist of training in the proper fitting, dressing, styling and arranging of wigs and hairpieces.

(e) State Cosmetology and Barbering Law and Board rules and regulations must be taught in all courses.
A school owner shall maintain an adequate dispensary room with supplies necessary for school operation and student training.

A student enrolled in a school shall not be allowed to work on the public until such time as he has received at least 150 clock hours or equivalent number of credit hours of training spent in classroom theory and in mannequin or student practice under the direct supervision of a licensed instructor.

A Basic Cosmetology or Barber student who fails to complete the course and registers in the Manicurist, Cosmetician, Hairbraiding Technician, or Facialist course may be credited with 10% of the previously accumulated hours. A Manicurist, Cosmetician, Hairbraiding Technician, Facialist or Barber student who fails to complete the course and registers in the Basic Cosmetology or Barber course may be credited with 10% of the previously accumulated hours.

If a person who holds a current Board license and registers in any course other than a Master Instructor course, credit of 224 clock hours is allowed.

Cosmetology and Barber schools must teach the curriculum for each course approved by the Board. A copy of current curriculum must be on file with the Board. The curriculum must be proven by a schedule which must be posted, followed and made available to students. The schedule may be interrupted for a period not to exceed more than eight (8) hours per month for assembly purposes.

If a school stays open more than eight (8) hours per day, a curriculum and schedule must be submitted to the Board covering extra hours.

An evening school cannot be approved unless information as to the instructors in charge and a curriculum and schedule for each course to be taught is submitted to the Board before beginning evening classes. A student may attend both day and evening classes provided the entire time does not exceed eight (8) hours daily. A schedule must be submitted to each student training in such manner.

Each manager, instructor or other person shall exercise the greatest care in keeping his person, all instruments used in school in the cleanest possible condition. Each must be knowledgeable of the more communicable diseases and the techniques necessary to prevent the transmission of disease.

175:10-3-41. Cosmetician course entrance and curriculum requirements

(a) Entrance requirements. Cosmetician course entrance requirements are the same as for a Basic course.

(1) Each student shall be provided an approved textbook or manual before commencing classroom training.
(2) A Cosmetician student shall not be allowed to perform patron services until such time as he/she has received at least 80 clock hours of practice and classroom instruction under the direct supervision of a licensed instructor.
(3) Kit is required on or before completion of practice and classroom instruction hours.

(b) Curriculum requirements. The 600 clock hour curriculum is prescribed as follows: (Note: Hours may be measured in credits and ratio as recognized by the United States Department of Education or by a regional or national accreditation entity recognized by the United States Department of Education.)

(1) Bacteriology, disinfection and sanitation 60 clock hours
(2) Make-up application (includes application of make-up, lipstick, eye shadow, eyeliner, mascara and rouge) 200 clock hours
(3) Hair arranging (includes arranging of the hair using curling irons, hot rollers, combs, brushes and any necessary product and accessories) 200 clock hours
(4) Establishment development (includes business administration and law, insurance, professional ethics, record keeping, business telephone techniques, salesmanship, displays, advertising, hygiene and public health) 90 clock hours
(5) Board rules, regulations and statutes 50 clock hours
(6) Total hours 600 hours

(c) Minimum training supplies. Cosmetician minimum training supplies are required as follows:

(1) Textbook or manual
(2) Make-up with disposable applicators
(3) Lipstick with disposable applicators
(4) Eye shadow with disposable applicators
(5) Mascara with disposable applicators
(6) Eyeliner with disposable applicators
(7) Rouge/blush with disposable applicators
(8) Set of five (5) make-up brushes
(9) Hairspray
(10) Minimum of twelve (12) combs
(11) Minimum of twelve (12) hairbrushes
(12) Disposable make-up sponges
(13) Hot rollers
(14) Curling iron
(15) One (1) comb-out cape
(16) An adequate supply of protective gloves (disposable)
(17) An adequate supply of neck strips
(18) Visual aid equipment in addition to the chalk or marker board.

175:10-3-45. Barber course entrance and curriculum requirements

(a) Entrance requirements. A Barber course entrance requirements are the same as for a Basic cosmetology course pursuant to OAC 175:10-3-16.

(1) Each student shall be provided an approved textbook or manual before commencing classroom training.
(2) A Barber student shall not be allowed to perform patron services until such time as he/she has been trained in safety and disinfection procedures on the clinic services performed under the direct supervision of a licensed instructor.

(b) Curriculum requirements. The 1500 clock hour curriculum for the barber course is prescribed as follows: (Note: Hours may be measured in credits and ratio as recognized by the United States Department of Education or by a regional or
Temporary Final Adoptions

national accreditation entity recognized by the United States Department of Education.)

(1) Safe work practices, infection control, bacteriology, implements, tools, equipment, sterilization, disinfection and safety 155 clock hours
(2) Barbershop, job search, job management, history of barbering and professional image 175 clock hours
(3) Anatomy, physiology, chemistry, electricity and light therapy, properties and disorders of skin, scalp and hair, hair and scalp treatments 200 clock hours
(4) Facial massage and treatment 40 clock hours
(5) Haircutting and styling 580 clock hours
(6) Chemical relaxing, soft curl perms, permanent waving 95 clock hours
(7) Hair coloring 150 clock hours
(8) Men's hairpieces, mustache, beard design and shaving 65 clock hours
(9) Board rules, regulations and statutes 40 clock hours
(10) Total hours 1500 hours
(c) Public barber school. The 1500 clock hour curriculum (1000 hours pure barber plus 500 hours of barber related high school subjects) is prescribed for public school, parochial school, private school or home schooled students in the following situations:
(1) Barber students that are currently attending high school, parochial, private school or a home school.
(2) Persons that did not otherwise complete their barber training while registered as a barber student in high school, parochial school, or a home school.
   (A) Students who shall qualify for training in this matter must complete 1000 clock hours in a Basic barber course and 500 hours of approved related subjects. The official parochial, private school or home school high school transcript shall serve as documentation for the 500 hours of related instruction. The transcript must show passing grades in related subjects and completion of at least the first semester of the twelfth (12th) grade. Related subjects shall run concurrently with and shall be in no instance older than three (3) years at time of enrollment in a barber school course. The curriculum as follows has a recommended completion time of two (2) school years.
   (B) Adult students registered in a barber school are not eligible to train under the 1000 hours pure barber plus 500 hours of barber related high school subjects unless qualified under (c) (1) and (2) of this rule.
(d) Minimum barber student training supplies. Barber training supplies are required as follows:
   (1) one (1) approved text on theory of barbering
   (2) one (1) razor-type hair shaper and shaper blades
   (3) one (1) pair each hair cutting shears and thinning shears
   (4) one (1) tweezer
   (5) six (6) assorted hair brushes
   (6) twelve (12) combs (including tail, all purpose and/or barber-type)
   (7) one (1) shampoo cape
   (8) permanent wave rods
   (9) other hair restructuring supplies
   (10) an adequate supply of applicator bottles or chemical bowl and brush
   (11) an adequate supply of protective gloves (disposable)
   (12) an adequate supply of neck strips
   (13) an adequate supply of hair clippers
   (14) an adequately supplied products dispensary to appropriately train students in classes
   (15) visual aid equipment in addition to the chalk or marker board
   (16) straight razors

SUBCHAPTER 7. SANITATION, DISINFECTION AND SAFETY STANDARDS FOR ESTABLISHMENTS AND SCHOOLS

175:10-7-12. Towels/linens
(a) Clean towels shall be used for each patron.
(b) Clean towels and other linens shall be kept in a closed container, cabinet or drawer that is free from contamination.
(c) A suitable hamper-type container shall be provided for soiled towels.
(d) The headrest of the facial chair shall be covered with a clean towel for each patron.
(e) An appropriate supply of clean towels, linens and neck strips shall be maintained in the Establishment.
(f) All linens (towels, sheets, robes, etc.) cannot be re-used and must be laundered prior to use.
(g) Linens shall be washed on hot with detergent and dried until "hot to the touch".
(h) There shall be 1 vented, covered container provided for soiled linens (towels, capes, sheets) in salons, barber shops, spa and nail salons and each individual room used for services and any customer changing area.
(i) Containers for used linens must be covered and have vented sides to reduce the growth of pathogens.
(j) Towel warmers must be disinfected daily with a disinfectant wipe or spray.
(k) Salons using hot steamed towels in services must meet these requirements;
   (1) Towels used in a warmer must be washed with detergent and bleach and dried using a hot dryer setting.
   (2) Practitioners preparing towels for the warmer must first wash their hands or wear gloves.
   (3) Wet towels used in services must be prepared fresh each day. At the end of the day, unused steamed towels must be removed and laundered.
   (4) Towel warmers must be left open overnight to allow unit to dry completely.

175:10-7-18. Disinfection precautions before and after each patron service
(a) The hands of the licensee, student or apprentice shall be washed and the integrity of the skin carefully examined before and after performing a service for any person. If any
abrasion, cut, scratch, open lesion or infection is evidenced, protective or disposable gloves shall be worn while performing services in order to reduce risk or transmission of infectious bacteria/virus/disease.

(b) All licensees are required to wash hands prior to any service, following eating, smoking or the use of the restroom. Hands must be washed with running water and soap and then dried with a disposable towel. Antibacterial soap is not recommended.

(c) Styptic pencils and lump alum are prohibited. Liquid or powdered astringent shall be used to check bleeding and shall be applied with separate, clean, sterile gauze or cotton which shall be disposed of immediately after use.

(d) Any licensee who can reasonably anticipate, as the result of performing any cosmetology or barbering service, contact with blood and other potentially infectious material, shall use universal precautions, and shall wear protective disposable gloves while performing the services. Gloves shall not be re-used and shall be disposed of properly immediately after use.

(e) Implements and tools that cannot be disinfected must be disposed of after one use.

SUBCHAPTER 9. LICENSURE OF COSMETOLOGISTS, BARBERS AND RELATED OCCUPATIONS

PART 1. APPRENTICESHIP

175:10-9-1. Apprentice training

(a) An apprentice must train under the direct supervision of a currently licensed instructor or an instructor that is licensed in the particular field of practice. Only one (1) apprentice per Establishment shall be approved to be trained at any given time.

(b) A currently licensed instructor who wishes to train an apprentice shall make written application to the Board. The application shall include apprenticeship inspection fee of $20.00 (includes purchase of Rules, Regulations and Law book, apprentice registration and inspection fee).

(c) An inspection will be made by the Board for approval of required equipment, textbooks, and theory tests.

(d) An interview will be conducted with the instructor and the proposed apprentice to assure that both parties fully understand the apprenticeship program.

(e) When all requirements are met, an equipment affidavit will be signed by the inspector and the instructor. Apprentice registration forms will be completed at time of inspection.

(f) Equipment required to train an apprentice is based on course of study as follows:

(1) One (1) facial chair (reclining styling or shampoo chairs are acceptable).

(2) One (1) facial supply cabinet.

(3) One (1) work/styling station.

(4) One (1) mannequin.

(5) Other Establishment equipment as shall be required for course of training.

(g) Textbooks must be approved by the Board that adequately cover the prescribed curricula and prepares students for State Board testing. Other textbooks and reference material may be used to enhance the apprentice course.

(h) Entrance requirements for apprentice training:

(1) Apprenticeship must be approved by the Board before apprentice attends class.

(2) Apprentice must be at least sixteen (16) years of age.

(3) Apprentice must show proof of at least 8th grade education or equivalency (8th grade diploma or transcript). The Board may accept a statement from a school official who states, upon interview with applicant, that applicant has the equivalency of at least 8th grade potential and ability to learn.

(4) Apprentice must be able to benefit from instruction.

(5) Apprentice must submit copy of birth certificate or other legal proof of age if under the age of 18 years of age.

(i) Minimum equipment and supplies content requirements for an apprentice kit are the same as for students registered in a school.

(j) In addition to requirements of a kit, the apprentice shall have available for apprentice training:

(1) At least one set of appropriately disinfected manicuring implements immediately available for use on each patron (not required for barber or esthetician apprentices).

(2) Adequately supplied dispensary to appropriately train apprentice in cosmetology practices, barber, esthetician, manicuring, practices depending on program; and

(3) Visual aid equipment in addition to the chalk or marker board.

(k) Apprentice training may be approved for all courses except Instructor. Apprentice training may be approved for courses of review when required for expired license.

(l) The instructor shall not charge the apprentice for training. The instructor may charge for services rendered by the apprentice while in apprentice training.

(m) If the apprentice performs extra-curricular work for the shop owner for compensation, the work shall in no way interfere with the eight (8) hours per day of training for an apprentice.

(n) The instructor shall instruct the apprentice in all subjects as outlined in the curricula prescribed by the Board to be taught in a school. The instructor shall give the apprentice weekly tests and a final examination in both the practical skills and theory work.

(o) Apprenticeship training shall be under the direct supervision of the approved licensed instructor at all times.

PART 5. DEMONSTRATORS; COSMETIC STUDIOS; TRADE SHOWS; GUEST ARTISTS; WIG DRESSING; OTHER PRACTICES OF COSMETOLOGY AND BARBERING

175:10-9-53. Wig dressing requirements

(a) The dressing, cleaning, styling, fitting or arranging of wig/wiglet/hair-piece of synthetic or human hair and the
performing of these services to the public is a practice of cosmetology and barbering. The person performing these services upon head/hair or the public consumer must be appropriately licensed as a Cosmetologist, Barber or Instructor. The requirements for a Hairbraiding Technician at 175:10-7.42 do not apply to this subsection.

(b) Wig dressing services must be performed in a licensed school or Establishment. Sanitation rules and regulations must be observed.

(c) Retailing of wig, wiglet or hairpiece is exempt from licensing requirements. However the seller shall not engage in the practice of cosmetology or barbering as described in subsection (a) of this rule or as otherwise defined in the Oklahoma Cosmetology and Barbering Act.

SUBCHAPTER 15. INSPECTIONS, VIOLATIONS AND ENFORCEMENT

175:10-15-2. Board inspection of Establishments and schools
(a) The Board's Inspector and/or its authorized representative shall have the authority and right to enter into Establishments and schools during reasonable business hours in order to perform inspection and investigatory duties necessary to the responsibility and functions of the Board. The inspection duties shall include all sanitation and licensing rules compliance as pertains to any licensed facility where cosmetology and barbering services are performed for the public.

(b) Inspectors shall list the names of persons working in each Establishment and school, license type, file number and expiration date.

(c) Inspectors shall make inspections and investigations and shall file a report on any alleged violation and unlawful practice of the Oklahoma Cosmetology and Barbering Act.

(d) Refusal to permit, or otherwise interfering with an inspection shall constitute cause for disciplinary action and could lead to revocation or suspension of license(s).

(e) Schools are to be inspected every ten (10) to twelve (12) weeks and establishments a minimum of two times a year.

[OAR Docket #21-445; filed 6-15-21]

TITLE 175. STATE BOARD OF COSMETOLOGY AND BARBERING

CHAPTER 20. MASSAGE THERAPY

[OAR Docket #21-446]

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PERMANENT final adoption

RULES:
Subchapter 9. Standards of Professional Conduct
175:20-9-3. Sanitation and safety standards [AMENDED]

AUTHORITY:
59 O.S. § 199.3(B)(1) and § 199.7; State Board of Cosmetology and Barbering

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n/a

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n/a

GIST/ANALYSIS:
The proposed rule clarifies sanitation standards regarding the storage of soiled linens and makes the verbiage consistent with the same standards for cosmetologists.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(S) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 9. STANDARDS OF PROFESSIONAL CONDUCT

175:20-9-3. Sanitation and safety standards
(a) All client contact items and work areas must be cleaned and disinfected between client therapy sessions.

(b) Disinfectants shall only be used if registered with the Environmental Protection Agency for use as a disinfectant to achieve its intended purpose in accordance with the product label. Licensees shall be responsible for product knowledge.

(c) Licensees shall wash their hands, forearms and above the elbows after each client session.

(d) Clean towels, gowns, linens and sheets shall be used for each client.

(e) Clean towels, gowns, linens and sheets shall be kept in a closed area that is free from contamination.

(f) A suitable hamper type container shall be provided for soiled towels, gowns, linens or sheets. There shall be 1 vented, covered container provided for soiled linens (towels, capes, sheets) in each individual room used for services and any customer changing area.

(g) All liquids, creams and other products shall be kept in clean, closed containers.

(h) All products used on a client must be dispensed by a spatula, scoop, spoon, squeeze bottle, pump, dropper or similar dispenser so that the remaining product is not contaminated.
(i) Products applied to one client cannot be removed and reused on another client.
(j) Licensees shall observe universal precautions as published by the Centers for Disease Control in the event of exposure to blood or bodily fluids.
(k) No licensee shall massage any person when the surface to be massaged or has open cuts, lesions or infection.

[OAR Docket #21-446; filed 6-15-21]

TITLE 210. STATE DEPARTMENT OF EDUCATION
CHAPTER 1. STATE BOARD OF EDUCATION

[RULEMAKING ACTION: PERMANENT final adoption]

RULES:
Subchapter 5. Due Process
210:1-5-6. Suspension and/or revocation of certificates [AMENDED]

AUTHORITY:
State Board of Education; 70 O.S. § 3-104; 70 O.S. § 6-101.21

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
December 11, 2020

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SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
This amendment to the administrative rule governing the suspension and revocation of teaching certificates explicitly recognizes violation of the Standards of Performance and Conduct for Teachers as grounds for the revocation of a certificate. While the rule has historically included "willful violation of a rule or regulation of the State Board of Education" as grounds for revocation, and that provision will remain, the explicit inclusion of violating the Standards of Performance and Conduct as grounds for certificate revocation is intended to call attention to the importance of the Standards for certified educators. Violations of the Standards of Performance and Conduct have been cited in many teaching certificate revocation actions in recent years, often in combination with other violations of law or regulations.

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.

SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 5. DUE PROCESS

210:1-5-6. Suspension and/or revocation of certificates
(a) Application. The rules and regulations of the State Board of Education governing the suspension and revocation of certificates apply to the following: superintendents of schools, principals, supervisors, librarians, school nurses, school bus drivers, visiting teachers, classroom teachers and other personnel performing instructional, administrative and supervisory services in the public schools. Except as otherwise specifically provided by law, the issuance or denial of a new certificate shall not be considered an individual proceeding subject to the process and procedures set forth in this Section.
(b) Grounds for revocation. A certificate shall be revoked only for:
(1) A willful violation of a rule or regulation of the State Board of Education, or the United States Department of Education; or
(2) A willful violation of any federal or state law, or
(3) A conviction for any of the offenses or bases for revocation set forth in 70 O.S. §§ 3-104 or 3-104.1; or
(4) For other proper cause, including but not limited to violation of the Standards of Performance and Conduct for Teachers at Chapter 20, Subchapter 29 of this Title.
(c) Duty to report and refrain from illegal activity. It shall be a violation of State Board of Education rules and regulations for any person holding a valid teaching certificate to be aware of and fail to report, or knowingly participate in any activity deemed illegal while participating in job-related activities of student organizations, athletic and scholastic competitions, fairs, stock shows, field trips, or any other activity related to the instructional program. Willful violation of (b)(1)-(b)(4) of this regulation or the failure to report or knowing participation in any activity deemed illegal may result in recommendation of revocation or suspension of the certificate, or such other penalty, as may be determined after due process by the State Board of Education.
(d) Right to hearing on revocation of an existing certificate. No certificate shall be revoked until the holder of the certificate has been provided with a copy of the application to revoke the certificate and opportunity for a hearing provided by the State Board of Education in accordance with the following procedures:
(1) Filing of application to revoke a certificate. An individual proceeding to revoke a certificate shall be initiated by filing an application to revoke a certificate. An application to revoke a certificate shall be filed with the Secretary of the State Board of Education by the State Department of Education. The application shall name the holder of the certificate to be revoked as the respondent in the action, and shall contain:
(A) A statement of the legal authority and jurisdiction under which the applicant seeks to initiate the proceeding and the hearing is to be held; 
(B) A reference to each particular statute and/or rule involved; 
(C) A short and plain statement of the allegations asserted; and 
(D) A statement of the facts alleged to give rise to the revocation. The application shall also state a proposed effective date for the relief requested (e.g., revocation), which shall be set no earlier than forty-five (45) calendar days from the date the complaint is filed.

(2) Informal disposition. Informal disposition of the application to revoke a certificate may be made by stipulation, agreed settlement, consent order, or default, unless otherwise precluded by law. Written notice signed by each party or counsel representatives shall be delivered to the Secretary of the State Board of Education prior to the time of the scheduled hearing.

(3) Notice to parties. Within three (3) business days of the date the application to revoke a certificate is filed with the Secretary of the State Board of Education, the Secretary shall send a copy of the application along with a notice of intent to revoke the certificate by certified or registered mail, restricted delivery with return receipt requested, to the holder of the certificate. It is the responsibility of every certificate holder to notify the State Department of Education upon a change of address, and the mailing address on file for each certificate holder shall be presumed to be a proper address for service of notice. Service of notice of intent to revoke a certificate shall be deemed complete upon certified or registered mailing of the notice to the certificate holder's last known address. In addition to the requirements of notice set forth at 75 O.S. § 309, the notice of intent to revoke the certificate shall include:

(A) A statement setting forth the proposed effective date of revocation of the certificate; and 
(B) A statement advising the holder that if the holder fails to appear for a hearing and contest the revocation, the allegations in the application for revocation will be deemed confessed and the Board may issue a final order to effect revocation of the certificate as of the effective date proposed in the notice.

(e) Emergency Action. Pursuant to 75 O.S. § 314, in the event the State Board of Education finds that public health, safety, or welfare imperatively requires emergency action, the State Board of Education may issue an emergency order summarily suspending a certificate pending an individual proceeding for revocation or other action. Such proceedings shall be promptly instituted and determined. Such an order shall include specific findings of fact specifying the grounds for the emergency action. Within three (3) business days of the issuance of the order by the Board, a copy of the order shall be sent to the holder of the certificate via certified or registered mail, delivery restricted to the certificate holder, with return receipt requested.

(f) Hearing procedures.
may order a stay or continuance of the proceedings for such time as may be necessary to secure a final ruling in the compliance proceedings.

(E) Costs of issuance and service of subpoe- nas. The costs covering the issuance and service of subpoenas and all witness fees incurred on behalf of a party to the proceedings, other than the Board, shall be borne by the party on whose behalf they are incurred.

(4) Right to representation. Any party to the individual proceeding shall at all times have the right to representation by counsel, provided that such counsel must be duly licensed to practice law by the Supreme Court of Oklahoma, and provided further that counsel shall have the right to appear and act for and on behalf of the party represented.

(5) Legal counsel to State Board of Education. The attorney for the State Board of Education shall present evidence to the Board, in furtherance of the application. If deemed necessary by the Chairperson of the Board, a request may be made of the Attorney General to provide counsel to the Board to rule on questions of admissibility of evidence, competency of witnesses, and any other questions of law. In the event that counsel is not requested from the Attorney General the Chairperson of the Board will rule on the evidence, competency of the witness and other questions of law.

(6) Disqualification of a Board member or hearing officer. A Board member or hearing officer shall withdraw from any individual proceeding in which he or she cannot accord a fair and impartial hearing or consideration. Any party may request the disqualification on the ground of his or her inability to give a fair and impartial hearing by filing an affidavit promptly upon discovery of the alleged disqualification, stating with particularity the grounds upon which it is claimed that a fair and impartial hearing cannot be accorded. The issue shall be determined promptly by the Board, or if it affects a member of the Board, by the remaining members thereof, if a quorum. Upon the entry of an order of disqualification affecting a hearing officer, the Board shall either assign a replacement hearing officer, or conduct the hearing itself. Upon the entry of an order of disqualification affecting a Board member, the Governor immediately shall appoint a member pro tempore to sit in place of the disqualified member in that proceeding.

(7) Notice of facts. The Board shall give notice to all parties, prior to, or at the hearing, of any facts of which it proposes to take official notice. Any party or his attorney may request that official notice be taken of any fact qualified for such notice by the statutes of this state. If such official notice is taken, it shall be stated in the record, and all parties shall have opportunity to contest and give evidence in rebuttal or derogation of the official notice.

(8) Presentation and consideration of evidence. The State Board of Education shall consider only evidence upon the specific cause contained in the notice, and evidence will be heard for such cause. Questions of the admissibility of evidence shall be governed by the provisions of 75 O.S. § 310.

(9) Order of procedure. The order of procedure at the hearing shall be as follows:

(A) Opening statements by legal counsel of both parties;
(B) Presentation of evidence by both parties followed by cross-examination of witnesses, and questions by State Board members or the hearing officer;
(C) Closing arguments by legal counsel of both parties; and
(D) Submission of case to the Board or the hearing officer for decision.

(10) Continuance of a hearing. The Board or hearing officer may continue or adjourn the hearing at any time for a specified time by notice or motion. The Board or hearing officer may grant a continuance upon motion of a party for good cause shown if written request is filed and served on all parties of record and filed with the Secretary of the Board at least five (5) days prior to the date set for hearing. A respondent may be granted only one (1) continuance.

(g) Deliberations and decisions. Deliberations by the Board or the hearing officer in an individual proceeding may be held in executive session pursuant to the provisions of the Open Meeting Act set forth at 25 O.S. § 307.

(1) Decision. Decisions shall be issued in accordance with the following procedures:

(A) After hearing all evidence, and all witnesses, the State Board of Education or, if applicable, the hearing officer, shall render its decision on whether the certificate shall be revoked.

(B) The decision of the State Board of Education or a hearing officer presiding at the hearing shall be announced at the conclusion of the hearing and notification of that decision shall be by certified or registered mail, restricted delivery with return receipt requested to the holder of the certificate.

(C) If the holder of the certificate fails to appear at the scheduled hearing without prior notification within the time frame to request a stay or continuance set forth in (f)(10) of this Section, demonstration of good cause, the Board or hearing officer shall hold the party in default and issue an order sustaining the allegations set forth in the application.

(D) If the applicant fails to appear at the scheduled hearing without prior notification within the time frame to request a stay or continuance set forth in subsection (f)(10) of this Section, demonstration of good cause, or fails to prove the allegations by clear and convincing evidence, the application shall be dismissed.

(2) Findings of fact and conclusions of law. After the decision is announced, but before issuance of the final order, if the Board has not heard the case or read the record of the individual proceeding, the hearing officer shall provide the parties with an opportunity to prepare and submit proposed findings of fact and conclusions of law in accordance with the provisions of 75 O.S. § 311.
After the parties have been given notice and an opportunity to file exceptions, present briefs and oral arguments to the proposed findings of fact and conclusions of law, the Board may take action to accept, reject, or modify the proposed Findings and Conclusions of the hearing officer. The Board shall render findings of fact and conclusions of law. All findings of fact made by the Board shall be based exclusively on the evidence presented during the course of the hearing or previously filed briefs, (made a part of the record), of the testimony of witnesses taken under oath.

(3) **Final order.** As the final determination of the matter, the final order shall constitute the final agency order and shall comply with the requirements set forth at 75 O.S. § 312. If no motion for rehearing, reopening or reconsideration of the order is filed in accordance with (h) of this Section, the final agency order shall represent exhaustion of all administrative remedies by the State Board of Education. All final orders in an individual proceeding shall be in writing and made a part of the record. Final orders are to be issued by the Chairperson of the Board or the presiding officer for transmission to the parties by the Secretary of the Board. Within five (5) business days of the date of issuance of the final order, parties shall be notified of a final order either personally or by certified mail, return receipt requested. Upon request, a copy of the order shall be delivered or mailed to each party and the party's attorney of record, if any.

(4) **Communication with parties.** Unless required for the disposition of ex parte matters authorized by law, the Chairperson and the members of the Board, the hearing officer, or the employees or the agents of the Board shall not communicate, directly or indirectly, in connection with any issue of fact, with any party or party, nor, in connection with any issue of law, with any party or his or her representative except upon notice and opportunity for all parties to participate. The Chairperson and members of the Board or their employees may communicate with one another and have the aid and advice of one or more personal assistants. Advice may also be secured from the Attorney General's office.

(h) **Record of hearing.**

(1) The record of a hearing shall be set forth in such form and detail as the Chairperson or the Board may direct. The hearing may also be fully transcribed, and shall be placed on file in the Secretary's office. Parties to the proceeding may have the proceedings transcribed by a court reporter at their own expense. In accordance with the requirements of 75 O.S. § 309, the record shall include:

(A) All pleadings, motions, and intermediate rulings;
(B) Evidence received or considered during the individual proceeding;
(C) A statement of matters officially noticed;
(D) Questions and offers of proof, objections, and rulings thereon;
(E) Proposed findings and exceptions;
(F) Any decision, opinion, or report by the Board or a hearing officer presiding at the hearing; and

(G) All other evidence or data submitted to the Board or hearing officer in connection with their consideration of the case.

(2) The State Board Secretary shall electronically record the proceedings, with the exception of the executive sessions The recording shall be made and maintained in accordance with the requirements of 75 O.S. § 309, and a copy shall be provided to any party to the proceeding upon request. If the requesting party should desire the tape(s) to be transcribed by a court reporter, the requesting party shall bear the expense.

(i) **Rights to a rehearing, reopening or reconsideration.**

(1) A petition for rehearing, reopening or reconsideration of a final order must be filed with the Secretary of the State Board within ten (10) days from the entry of the order. It must be signed by the party or his or her attorney, and must set forth with particularity the statutory grounds upon which it is based. However, a petition based upon fraud practiced by the prevailing party or upon procurement of the orders by perjured testimony or fictitious evidence may be filed at any time. All petitions for rehearing, reopening, or reconsideration will be considered and ruled upon as soon as the convenient conduct of the Board's business will permit.

(2) A petition for a rehearing, reopening, or reconsideration shall set forth the grounds for the request. The grounds for such a petition shall be either:

(A) Newly discovered or newly available evidence, relevant to the issues;
(B) Need for additional evidence adequately to develop the facts essential to proper decision;
(C) Probable error committed by the Agency in the proceeding or in its decision such as would be grounds for reversal on judicial review of the order;
(D) Need for further consideration of the issues and the evidence in the public interest; or
(E) A showing that issues not previously considered ought to be examined in order to properly dispose of the matter. The grounds which justify the rehearing shall be set forth by the State Board of Education which grants the order, or in the petition of the individual making the request for the hearing.

(3) It is the burden of the party requesting a rehearing to notify the opposing party of the appeal.

(4) Rehearing, reopening, or reconsideration of the matter may be heard by the State Board of Education or may be referred to a hearing officer. The hearing must be confined to those grounds on which the recourse was granted.

(j) **Judicial review.** Any person or party aggrieved or adversely affected by a final order in an individual proceeding is entitled to certain judicial review in accordance with the provisions of the Oklahoma Administrative Procedures Act, and the procedures set forth therein shall govern appeals.

(k) **Applications for reinstatement of a certificate.** After five (5) years of the effective date of revocation of a certificate, or after expungement of the offense(s) that formed the basis for the revocation by a court of competent jurisdiction, an
individual may apply for reinstatement of the certificate in accordance with the application procedures set forth by the State Department of Education.

(1) **Notifications of suspension or revocation.** Upon the suspension or revocation of an individual's certificate, the State Board of Education shall notify the superintendent of the district that most recently employed the certified individual based upon the individual's certification number and the personnel reports currently on file with the State Department of Education. In addition, the State Board shall to the extent possible notify the superintendents of all Oklahoma school districts. Notification shall also be provided to the extent possible to certification officers in each state or territory of the United States.

[OAR Docket #21-450; filed 6-15-21]

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

[OAR Docket #21-451]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:

Subchapter 13. Student Assessment and School Accountability
210:10-13-23. Emergency exemptions from assessments required by the Oklahoma School Testing Program [AMENDED]

AUTHORITY:
State Board of Education; 70 O.S. § 3-104, 70 O.S. § 1210.508-2

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
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SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:
Subchapter 13. Student Assessment and School Accountability
210:10-13-23 [AMENDED]

Gubernatorial approval:
April 2, 2020

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37 Ok Reg 741

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20-401

INCORPORATIONS BY REFERENCE:

n/a

GIST/ANALYSIS:
The rule that governs Oklahoma School Testing Program (OSTP) emergency medical exemptions for students has been amended to provide specific guidance for a large-scale public health emergency such as the COVID-19 outbreak. The added content provides:

"In the event of an emergency declared by a federal or state government entity that impacts the operation of public schools in Oklahoma, or upon an action taken by the State Board of Education declaring such an emergency, the State Department of Education shall be authorized to approve emergency medical exemptions from OSTP assessment requirements for all students whose ability to test is compromised by the emergency conditions. If a state of emergency suspends, interrupts, or otherwise substantially affects public school operations during the state testing window, the State Department of Education shall be authorized to approve general medical exemptions from OSTP assessments for all affected students."

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. SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 13. STUDENT ASSESSMENT AND SCHOOL ACCOUNTABILITY

210:10-13-23. Emergency exemptions from assessments required by the Oklahoma School Testing Program

(a) **Purpose.** Any public school district or public charter school may request an exemption from the administration of one or more statewide criterion-referenced tests and/or end-of-instruction exams administered pursuant to the provisions of the Oklahoma School Testing Program Act at 70 O.S. § 1210.508 et seq., for any of its enrolled students who are unable to participate in the assessment or a make-up assessment at any time during the testing window due to a documented significant medical emergency. The procedures set forth in (d) of this Section shall govern submission, processing, and evaluation of all requests for emergency exemptions submitted to the State Department of Education.

(b) **Application.** The provisions of this Section are not applicable to assessment determinations made by local school district staff, school administrators, or teachers pursuant to federal guidelines and state administrative rules. The requirements of this Section shall not interfere with the processes and procedures utilized by local school districts and charter schools to refrain from testing up to five percent (5%) of enrolled students. Such decisions shall continue to be made in accordance with local district policies and without review or approval of the State Department of Education.

(c) **Definitions.** The following words and terms, when used in this Section, shall have the following meanings:

(1) **"Immediate family member"** shall mean a parent, legal guardian, sibling, or child of the student for whom the exemption is requested.

(2) **"Significant medical emergency"** shall mean the debilitating onset of a severe or life-threatening physical or mental illness, infection, injury, disease and/or emotional trauma that meets all of the following criteria:
(A) The condition arises from an accident, disaster, crisis, or other exigent circumstances beyond the control of the student, the parents/legal guardians of the student, and the student's school or school district;

(B) The condition affects the student so severely as to incapacitate the student from participation in the assessment and corresponding make-up assessment at any time during the testing window;

(C) The condition affects the student so severely as to prevent the enrolled student from receiving instruction at school, at home, or through internet or online instruction;

(D) The student's incapacity to participate cannot be remedied with state-approved accommodations provided to the student by the school district as necessary to ensure equitable access to the assessment during the testing window; and

(E) The school or school district has been provided with written documentation of the condition that is verified in writing by a physician licensed to practice in the State of Oklahoma, or licensed in another jurisdiction and certified by an American Board of Medical Specialties (ABMS) Member Board or an American Board of Physician Specialties (ABPS) Member Board. A copy of the documentation verifying the student's condition shall be filed in the student's educational record.

(F) The term "significant medical emergency" shall not include:

(i) Short term, or minor illnesses or injuries;

(ii) Pregnancy (unless complications of a pregnancy otherwise meet the definition of a "significant medical emergency" herein);

(iii) Placement of the student in a juvenile detention or correctional facility; or

(iv) Refusal of a student or parent to participate in the assessment.

(v) The occurrence of one of the conditions listed in (F) shall not disqualify a student who is eligible for an emergency medical exemption on a different basis.

(G) Examples of situations that could be considered a "significant medical emergency" may include, but shall not be limited to conditions in which:

(i) The student is in the final stages of a terminal disease or degenerative illness, or the student has been placed in hospice care;

(ii) The student has been admitted to a hospital, infirmary, or other health care or treatment facility for the duration of the testing window that prohibits the student's secure access to the examination;

(iii) The student is comatose for the duration of the testing window;

(iv) The student has a serious chronic medical condition that will be worsened or intensified by external circumstances, and the student's physician determines that participation in the assessment could result in a significant medical emergency;

(v) The student has sustained serious mental or physical injury as a result of an accident, unintentional injury, or other catastrophic event such as:

(I) A transportation accident;

(II) A natural disaster or other event resulting in a declared state of emergency;

(III) An act of violence, including but not limited to: acts of physical assault, rape, kidnapping, homicide, torture, or terrorism;

(IV) Drowning;

(V) Poisoning, fall, or traumatic brain injury;

(VI) Fire or explosion in the student's home when the student was present;

(VII) Death or life-threatening injuries to, or significant medical emergency of, an immediate family member resulting from one of the examples in subparagraph (G).

(d) Procedure. Requests for emergency exemptions shall be submitted and evaluated in accordance with the following provisions:

(1) All requests for emergency exemptions shall be electronically submitted by the school district or charter school through the State Department of Education testing application no later than 5:00 p.m. of the last day of the testing window.

(2) The request for emergency exemption shall include all of the following information:

(A) A brief description of the significant medical emergency for which the exemption is requested;

(B) A brief explanation of why the emergency prevents the student's participation in the assessment;

(C) The date of the onset of the emergency;

(D) The expected or estimated duration/recovery period of the significant medical emergency;

(E) The number of days of instruction the student has missed as a result of the emergency and the number of any additional days of instruction the student is estimated or anticipated to miss after the date of submission of the exemption; and

(F) A copy of the written documentation provided by the student's physician pursuant to (c)(2)(E) of this Section.

(3) The request shall be supplemented by copies of any documentation subsequently requested by the State Department of Education necessary to document the information required by this paragraph and the definitions of "significant medical emergency" and "immediate family member" set forth in (c) of this Section.

(4) If a complete request for an emergency exemption is received during the applicable testing window, the State Department of Education will issue an approval or denial of the request and notify the school district or charter school of the determination within five (5) business days. The school district or charter school will receive notification through the Department's electronic testing
in accordance with the following procedures: 

(5) Requests for emergency exemptions submitted to the State Department of Education that fall outside of the provisions of 70 O.S. § 1210.508-2 and this Section may be referred to the appropriate agency and/or division within the Department and administratively closed. If the request for an emergency exemption is received during the applicable testing window, the Department will notify the school district or charter school through the electronic testing application system within five (5) business days that the request falls outside of the provisions of this Section.

(e) Exemptions for students with disabilities. All students receiving special education services and/or state-approved assessment accommodations must have a written IEP and/or Section 504 plan that documents how the student will participate in assessments administered pursuant to the OSTP. The existence of an IEP and/or a Section 504 plan, or the homebound status of the student, shall not be a basis for granting an exemption pursuant to this section. To qualify for an exemption, a homebound student or a student on an IEP or Section 504 plan must experience a significant medical emergency as defined in (c)(2)(A) through (c)(2)(E).

(f) Federal and state reporting. Any student who has received an exemption from one or more examinations in accordance with the provisions of this Section shall not be included in the calculation of the participation rate of the school and/or school district in the assessments mandated by federal and state law.

(g) Duration. Any request for an exemption from the administration of one or more statewide criterion-referenced tests and/or end-of-instruction tests granted pursuant to the procedures set forth in this Section shall be valid only for the current testing window in which the request was submitted.

(h) Appeal of a denial of a medical exemption. A request for a medical exemption that has been denied by the State Department of Education for failure to meet the criteria for "significant medical emergency" outlined in (c)(2) of this Section may be appealed to the State Board of Education in accordance with the following procedures:

(1) Petition for appeal. The school district or charter school in which the student is enrolled may appeal the Department's denial of a medical exemption to the State Board of Education. The parent or legal guardian of a student, an individual who has been issued letters of guardianship of the person of a student pursuant to the Oklahoma Guardianship and Conservatorship Act, or an adult who has assumed permanent care and custody of a student in accordance with local district policies and applicable state law must grant permission to the school district or charter school to file a petition for appeal to the State Board of Education. Parental consent shall be provided in writing and shall be documented by the requesting school district or charter school.

(2) Filing requirements. A petition for appeal must comply with the following requirements:

(A) Time of filing. The petition for appeal must be submitted in writing to the Secretary of the State Board of Education within ten (10) business days after the date the school district receives notice of the Department's denial of the medical exemption.

(B) Method of filing. Petitions for appeal may be submitted to the Secretary of the State Board of Education in person or by mail. A petition submitted by mail will be accepted as timely if the mailing envelope contains a postmark dated on or before the date of the filing deadline.

(C) Verification of a petition for appeal. The petition for appeal must be signed by the school Superintendent or the school Superintendent's designee, or charter school administrator or designee, for the purpose of verifying that, to the best of the individual's knowledge, the information submitted in the appeal is accurate and correct.

(D) Acceptance of a petition for filing. Upon receipt of the petition for appeal, the Secretary of the Board of Education shall file the petition and obtain copies of all records and information submitted by the school district or charter school to the State Department of Education pursuant to (c) of this Section. Copies of agency records and additional documentation submitted in the petition for appeal shall be provided to members of the State Board of Education for consideration. Only timely filed petitions for appeal shall be brought to the State Board of Education for consideration. The Board shall take action on the petition no later than twenty (20) calendar days after the date of the receipt of a timely filed petition.

(3) Review of petitions. Because the privacy of individual student data is protected by the Family Educational Rights and Privacy Act (FERPA) and Oklahoma's Student Data Accessibility, Transparency, and Accountability Act, the State Board of Education shall review petitions for appeal in executive session as authorized by 25 O.S. § 307 (A)(7). The State Board of Education shall evaluate each petition for appeal based on the following criteria to determine whether a "significant medical emergency" exists as contended by the appealing school district or charter school:

(A) The applicability of the criteria outlined in (c)(2) of this section related to the determination of a "significant medical emergency";

(B) The severity of the exigent circumstances giving rise to the student's condition;

(C) The extent of the student's incapacitation;

(D) The projected efficacy of allowable testing accommodations; or

(E) The existence of newly discovered documentation or newly available information that significantly and substantively reflects on the student's mental and/or physical state of being.
Permanent Final Adoptions

(4) **Actions on a petition for appeal.** After review of the petition for appeal in accordance with (h)(3) of this section, the State Board of Education shall take action on a petition for appeal based on the merits of the information provided in the written appeal.

(A) The Board shall consider each petition for appeal on an individual basis and shall issue an approval or denial of the request for an emergency exemption.

(B) The Secretary of the Board shall notify the school district or charter school and the State Department of Education in writing of the Board's determination.

(C) The State Department of Education shall document each determination in the testing application to maintain an accurate agency record of each request for an emergency exemption.

(D) Requests for student medical exemptions granted by the State Board of Education will be processed pursuant to (f) and (g) of this Section. Students denied medical exemptions by the State Board of Education will be included in the calculation of the participation rate of the school and/or school district in the assessments mandated by federal and state law.

(i) **Effect of public health emergencies or other declared emergencies.** In the event of an emergency declared by a federal or state government entity that impacts the operation of public schools in Oklahoma, or upon an action taken by the State Board of Education declaring such an emergency, the State Department of Education shall be authorized to approve emergency medical exemptions from OSTP assessment requirements for all students whose ability to test is compromised by the emergency conditions. If a state of emergency suspends, interrupts, or otherwise substantially affects public school operations during the state testing window, the State Department of Education shall be authorized to approve general medical exemptions from OSTP assessment requirements for all affected students.

[OAR Docket #21-451; filed 6-15-21]

**TITLE 210. STATE DEPARTMENT OF EDUCATION**

**CHAPTER 10. SCHOOL ADMINISTRATION AND INSTRUCTIONAL SERVICES**

[OAR Docket #21-452]

**RULEMAKING ACTION:** PERMANENT final adoption

**RULES:** Subchapter 13. Student Assessment and School Accountability 210:10-13-25. Determination of the chronic absenteeism indicator [NEW]

**AUTHORITY:** State Board of Education; 70 O.S. § 3-104; 70 O.S. § 1210.545

**SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:** November 1, 2020

**COMMENT PERIOD:** November 2, 2020 through December 4, 2020

**PUBLIC HEARING:** December 4, 2020

**ADOPTION:** December 17, 2020

**SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:** December 18, 2020

**LEGISLATIVE APPROVAL:** Approved June 11, 2021 by HJR 1046

**FINAL ADOPTION:** June 11, 2021

**EFFECTIVE:** August 26, 2021

**SUPERSEDED EMERGENCY ACTIONS:**

Superceded rules:

Subchapter 13. Student Assessment and School Accountability 210:10-13-25 [NEW]

Gubernatorial approval:

April 2, 2020

Register publication:

June 1, 2020

Docket number:

20-402

**INCORPORATIONS BY REFERENCE:** n/a

**GIST/ANALYSIS:**

The rule grants school districts the authority to establish local policies for determining whether certain student absences are eligible for medical exemptions from the chronic absenteeism indicator used in the school accountability system. There are also provisions specific to public health emergencies and similar large-scale emergencies, such as the COVID-19 pandemic. In the event of an emergency declared by the federal or state government or the State Board of Education, the Oklahoma school accountability system is directed to make any appropriate accommodations authorized under federal law to mitigate the effects of the emergency on school accountability determinations for the affected school year. During such a state of emergency, student absences related to the emergency shall not be included in the calculation of the chronic absenteeism indicator.

**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. SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:**

**SUBCHAPTER 13. STUDENT ASSESSMENT AND SCHOOL ACCOUNTABILITY**

210:10-13-25. **Determination of the chronic absenteeism indicator.**

(a) **Purpose of the chronic absenteeism indicator.** Because chronic absenteeism has been linked to lower academic performance, higher dropout rates, and diminished success after high school, Oklahoma has included chronic absenteeism as an indicator in the school accountability system adopted under the requirements of the Every Student Succeeds Act (ESSA). By highlighting the importance of regular school attendance to student success in school and beyond, the State of Oklahoma encourages schools to actively engage with students and their families in eliminating barriers to regular attendance, and to ensure students receive the supports needed to attend school every day.
(b) **Authorization of policy establishing a medical exemption from chronic absenteeism.** A public school district or charter school may establish a policy providing that student absences which are due to a significant medical condition (a severe, chronic, or life-threatening physical or mental illness, injury, or trauma) may be exempted from inclusion in the calculation of the chronic absenteeism indicator of the applicable student's school site upon determination of eligibility by a medical exemption review committee formed by the district or charter school. A chronic absenteeism medical exemption policy adopted by a public school district or charter school shall be developed in accordance with the guidelines in this Section.

(c) **Definitions.** The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates otherwise:

1. "**Chronic absenteeism**" means absence from school at least ten percent (10%) of the time that school is in session and the student is included in membership, eighteen (18) or more days on a 180 day school calendar or ten percent (10%) or more days on a 1,080 hours school calendar.

2. "**Significant medical condition**" means, for the purposes of this Section, a severe, chronic, or life-threatening physical or mental illness, infection, injury, disease, or emotional trauma.

(d) **Not all excused absences qualify for medical exemption.** Certain student absences are classified as "excused" under state law and/or school policies, meaning that a student is considered absent for a valid reason under law or policy and the absence may not be associated with any penalties to the student. Examples include medically documented absences, which are considered excused under 70 O.S. § 10-105(B), and absences related to the military deployment activities of a student's parent or guardian, which are excused under 70 O.S. § 510.1(V)(E). If a student is absent in relation to their own or their household's homeless status, such related absences should be excused pursuant to the federal McKinney-Vento Act so the related absences do not serve as a barrier to enrollment or retention. These and other types of absences considered under law or policy as a valid basis to be absent from school should be indicated as "excused" in a school's student information system. However, the classification of an absence as "excused" such that no penalties accrue to a student in relation to the absence does not automatically qualify the absence for a medical exemption for purposes of the chronic absenteeism indicator. In order to be eligible for consideration under a chronic absenteeism medical exemption policy, an absence must fall under the definition of "significant medical condition" given in this Section.

(e) **Absences from school that do not accrue toward chronic absentee status.** A student with disabilities who is on an Individualized Education Program (IEP), or a student with a physical or mental impairment who is on a Section 504 Plan, is considered in attendance and does not accrue absences while receiving offsite services outlined in the IEP or Section 504 plan. A student on an IEP or Section 504 Plan whose condition worsens or who requires more frequent treatments should have their IEP or Section 504 Plan updated accordingly. A student who is receiving homebound education services from their school district is considered in attendance and does not accrue absences while in homebound status.

(f) **Effect of exempt absence.** If a student has been determined to have a significant medical condition under the district or charter school's medical exemption policy, only absences that are related to the student's identified condition(s) or qualifying circumstances may be exempted from inclusion in the calculation of the chronic absenteeism indicator. Absences that are not related to the student's qualifying condition(s) or circumstances, such as routine illnesses or medical appointments, are not eligible for exemption under a school district's medical exemption policy. The exempt absence(s) of a student who has been granted an exemption of one or more absences from school in accordance with the provisions of this Section shall not be included in the calculation of the chronic absenteeism indicator on the school site report card.

(g) **Reporting absences determined medically exempt to the State Department of Education.** A school district or charter school that has adopted a chronic absenteeism medical exemption policy in accordance with this Section, and has determined under the policy that one or more student absences are medically exempt from inclusion in the chronic absenteeism indicator, shall report such absences determined medically exempt to the Oklahoma State Department of Education (OSDE) Office of Accountability. To ensure that an absence which has been determined eligible for a medical exemption by a school district's medical exemption review committee is identified as exempt in sufficient time for the absence to be excluded from the chronic absenteeism calculation, the Office of Accountability may set an annual deadline for the reporting of such medically exempt absences. The reporting of absences identified under a district's policy as medically exempt may require the submission of the district's chronic absenteeism medical exemption policy and documentation of the medical exemption review committee's approval of the exempted absences. All documentation considered during the medical exemption review committee's consideration of potentially eligible absences shall be maintained by the school district or charter school and shall be available to regional accreditation officers for auditing purposes.

(h) **Effect of public health emergencies or other declared emergencies.** In the event of an emergency declared by a federal or state government entity that impacts the operation of public schools in Oklahoma, or upon an action taken by the State Board of Education declaring such an emergency, the Oklahoma school accountability system shall make any appropriate accommodations authorized under federal law to mitigate the effects of the emergency on school accountability determinations for the affected school year(s). Student absences related to a state of emergency shall not be included in the calculation of the chronic absenteeism indicator. If there is any period of time during a state of emergency when public school operations are suspended, interrupted, or otherwise affected by
the emergency conditions, the affected dates shall be excluded from the calculation of the chronic absenteeism indicator.

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**TITLE 210. STATE DEPARTMENT OF EDUCATION**

**CHAPTER 10. SCHOOL ADMINISTRATION AND INSTRUCTIONAL SERVICES**

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**RULEMAKING ACTION:**
PERMANENT final adoption

**RULES:**
Subchapter 15. Textbooks
210:10-15-1. Purpose [AMENDED]

**AUTHORITY:**
State Board of Education; 70 O.S. § 3-104; 70 O.S. § 16-101 et seq.

**SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:**
November 1, 2020

**COMMENT PERIOD:**
January 15, 2021 through February 16, 2021

**PUBLIC HEARING:**
February 16, 2021

**ADOPTION:**
February 25, 2021

**SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:**
March 2, 2021

**LEGISLATIVE APPROVAL:**
Approved June 11, 2021 by HJR 1046

**FINAL ADOPTION:**
June 11, 2021

**EFFECTIVE:**
August 26, 2021

**SUPERSEDED EMERGENCY ACTIONS:**

n/a

**INCORPORATIONS BY REFERENCE:**

n/a

**GIST/ANALYSIS:**

The State Department of Education (OSDE) rules addressing alternate textbook selection are being amended to reflect legislative updates to the school textbook statutes made by House Bill 3466 (2020). Historically, the OSDE’s role in textbook selection applied only to the approval of alternate textbooks by school district petition after the State Textbook Committee had already selected the list of approved textbooks. Following legislative changes to 70 O.S. § 16-102, which added OSDE responsibilities to the initial textbook adoption process, the rule must be updated accordingly. The new content adds provisions addressing review teams of subject matter experts that the OSDE is responsible for assembling to assist the State Textbook Committee in its selections.

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**SUBCHAPTER 15. TEXTBOOKS**

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**210:10-15-1. Purpose**

Rules in this Subchapter establish a time frame and procedures by which five or more district boards of education may petition the State Board of Education to add a book or series of textbooks to the approved list selected by the State Textbook Committee ([70:16-102(D)]). They lay out provisions that apply to the selection of textbooks for Oklahoma public schools.

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(a) **Subject area textbook review teams.** Pursuant to 70 O.S. § 16-102, each year the State Department of Education (OSDE) shall assemble one or more teams of subject matter experts to assist the State Textbook Committee in reviewing textbooks and instructional materials for the subject areas under review. The subject area review team(s) assembled for each year will correspond with the subject area(s) under review that year in the state Textbook Adoption Cycle, with the number of review teams formed each year contingent on the number of subjects under review. Composition of the subject area review teams shall be consistent with the requirements of 70 O.S. § 16-102(E), and each team shall be selected according to the application process and criteria for the relevant subject area established by the OSDE in coordination with the State Textbook Committee. Subject to the availability of funds appropriated to the OSDE, members of subject area review teams shall be eligible for necessary travel expenses while in the performance of their duties, pursuant to the State Travel Reimbursement Act.

(b) **Rubric for the review of instructional materials.** In reviewing proposed textbooks and other instructional materials, subject area review teams shall apply the appropriate three-tiered rubric developed by the State Textbook Committee in consultation with the OSDE pursuant to 70 O.S. § 16-102(F).

(c) **Recommendations and records.** After completing its review of a textbook or other instructional material under the applicable rubric, and individually scoring each criterion including justification for the rating assigned, each subject area review team shall submit the team’s review documentation and recommended rating to the State Textbook Committee. The Committee shall consider, but is not required to accept, the recommended rating of the subject area review team, and may request that the review team provides additional information to support its recommendations. After the Committee has verified that the review process has been conducted in a fair and scrupulous manner, the Committee shall adopt a final rating for each textbook prior to including it on the list of approved textbooks. The completed rubric for each evaluated textbook, including the subject area review team’s recommendations, shall be publicly posted on the State Textbook Committee web page housed on the OSDE website.

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(2) **State Board of Education Textbook Petition alternate textbook petition.** Five or more district boards of education may petition the State Board of Education to add a book or series of textbooks to the approved list selected by the State Textbook Committee ([70:16-102(D)]). The State Board of...
PERMANENT final adoption

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

[OAR Docket #21-455]

Rulemaking Action:
PERMANENT final adoption

Rules:
Subchapter 3. Oklahoma Academic Standards
Part 21. Information Literacy
210:15-3-172. Overview [REVOKED]
210:15-3-172.1. Definitions [REVOKED]

Authority:
State Board of Education; 70 O.S. § 3-104(5)

Submission of Proposed Rules to Governor and Cabinet Secretary:
January 10, 2021

Comment Period:
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February 16, 2021

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June 11, 2021

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August 26, 2021

Superseded Emergency Actions:
n/a

Incorporations by Reference:
n/a

Gist/Analysis:
The Information Literacy standards were initially adopted in 2007, based on the 2007 American Association of School Librarians (AASL) standards. Because the AASL model standards addressing information literacy were updated in 2017, the OSDE proposed the associated administrative rules for amendment to incorporate the current guidelines. Through this amendment, the Information Literacy standards were also intended to be streamlined into one administrative rule, with revocations of the other rule sections currently in place in this Part. In House Joint Resolution 1046 (2020), the Oklahoma Legislature disapproved the administrative rule amendment updating the Information Literacy standards to align with the current AASL standards, but did not disapprove the proposed revocation of two of the original 2007 Information Literacy rules. The two rules that were proposed for revocation as part of the intended update are therefore revoked without replacement.

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Pursuant to the actions described herein, the following rules are considered finally adopted as set forth in 75 O.S. Sections 250.3(5) and 308(E), with an effective date of August 26, 2021:

Subchapter 3. Oklahoma Academic Standards

Part 21. Information Literacy
210:15-3-172. Overview [REVOKED]
(a) Information literacy is no longer a simple matter of being able to locate information in reference books. Digital information has increased the complexity of information literacy to include digital, visual, and technological literacy, in addition to textual literacy. These literacy skills are essential to success in the modern world.

(b) STANDARDS FOR THE 21ST CENTURY LEARNER, by the American Association of School Librarians (AASL) (2007), addresses the new complexity of information literacy. Because these standards outline the skills our students will need for future success, they have been adopted as the PRIORITY ACADEMIC STUDENT SKILLS for Information Literacy with the permission of AASL. These standards consist of skills, dispositions, responsibilities, and self-assessment strategies. Skills are the key abilities needed for understanding, learning, thinking, and mastering subjects (AASL). Dispositions are ongoing beliefs and attitudes that guide thinking and intellectual behavior that can be measured through actions taken (AASL). Responsibilities are common behaviors used by independent learners in researching, investigating, and problem solving (AASL). Self-assessment strategies are reflections of one's own learning to determine that the skills, dispositions, and responsibilities are effective (AASL). Taken together, these four strands, or components, outline the knowledge and skills a student must possess to become a responsible digital citizen.

e) Information literacy standards are to be taught as an integral part of curriculum content in science, social studies, language arts, reading, etc. To facilitate the identification of information literacy skills, a book icon follows each standard or objective within the curriculum document which has information literacy embedded within the curriculum. Students are best served when these are taught in collaboration and cooperation between the classroom teacher and the library media specialist. The classroom teacher and media specialist should provide opportunities for students to use information literacy skills in completion of class assignments.

(d) Specific benchmarks for each of the standards are provided in the Benchmark for Information Literacy document. This document is excerpted from STANDARDS FOR THE 21ST CENTURY LEARNER IN ACTION by the American Association of School Librarians (2009). This publication is considered an essential tool for library media specialists and should be part of the professional collection for all school libraries.

210:15-3-172.1. Definitions [REVOKED]
...
"Digital Citizenship" means the Mike Ribble and Gerald Bailey definition of digital citizenship as the norms of appropriate and responsible behavior with regard to technology use, indicated through nine elements. The nine elements are:

(A) Digital Etiquette. Electronic standards of conduct or procedure. Technology users often see this area as one of the most pressing problems when dealing with Digital Citizenship. We recognize inappropriate behavior when we see it, but before people use technology they do not learn digital etiquette (i.e., appropriate conduct). Many people feel uncomfortable talking to others about their digital etiquette. Often rules and regulations are created or the technology is simply banned to stop inappropriate use. It is not enough to create rules and policy; we must teach everyone to become responsible digital citizens in this new society.

(B) Digital Communication. Electronic exchange of information. One of the significant changes within the digital revolution is a person's ability to communicate with other people. In the 19th century, forms of communication were limited. In the 21st century, communication options have exploded to offer a wide variety of choices (e.g., e-mail, cellular phones, instant messaging). The expanding digital communication options have changed everything because people are able to keep in constant communication with anyone else. Now everyone has the opportunity to communicate and collaborate with anyone from anywhere and anytime. Unfortunately, many users have not been taught how to make appropriate decisions when faced with so many different digital communication options.

(C) Digital Literacy. Processes of teaching and learning about technology and the use of technology. While schools have made great progress in the area of technology infusion, much remains to be done. A renewed focus must be made on what technologies must be taught as well as how it should be used. New technologies are finding their way into the work place that are not being used in schools (e.g., videoconferencing, online sharing spaces such as wikis). In addition, workers in many different occupations need immediate information just in time information. This process requires sophisticated searching and processing skills (i.e., information literacy). Learners must be taught how to learn in a digital society. In other words, learners must be taught to learn anything, anytime, anywhere. Business, military, and medicine are excellent examples of how technology is being used differently in the 21st century. As new technologies emerge, learners need to learn how to use that technology quickly and appropriately. Digital Citizenship involves educating people in a new way; these individuals need a high degree of information literacy skills.

(D) Digital Access. Full electronic participation in society. Technology users need to be aware of and
support electronic access for all to create a foundation for Digital Citizenship. Digital exclusion of any kind does not enhance the growth of users in an electronic society. All people should have fair access to technology no matter who they are. Places or organizations with limited connectivity need to be addressed as well. To become productive citizens, we need to be committed to equal digital access.

(E) Digital Commerce. Electronic buying and selling of goods. Technology users need to understand that a large share of market economy is being done electronically. Legitimate and legal exchanges are occurring, but the buyer or seller need to be aware of the issues associated with it. The mainstream availability of Internet purchases of toys, clothing, cars, food, etc., has become commonplace to many users. At the same time, an equal amount of illegal/immoral goods and services are surfacing such as pornography and gambling. Users need to learn about how to be effective consumers in a new digital economy.

(F) Digital Law. Electronic responsibility for actions and deeds. Digital law deals with the ethics of technology within a society. Unethical use manifests itself in form of theft and/or crime. Ethical use manifests itself in the form of abiding by the laws of society. Users need to understand that stealing or causing damage to other people's work, identity, or property online is a crime. There are certain rules of society that users need to be aware in an ethical society. These laws apply to anyone who works or plays online. Hacking into others information, downloading illegal music, plagiarizing, creating destructive worms, viruses or creating Trojan Horses, sending spam, or stealing anyone's identify or property is unethical.

(G) Digital Rights & Responsibilities. These freedoms extended to everyone in a digital world. Just as in the American Constitution where there is a Bill of Rights, there is a basic set of rights extended to every digital citizen. Digital citizens have the right to privacy, free speech, etc. Basic digital rights must be addressed, discussed, and understood in the digital world. With these rights also come responsibilities as well. Users must help define how the technology is to be used in an appropriate manner. In a digital society these two areas must work together for everyone to be productive.

(H) Digital Health & Wellness. Physical and psychological well-being in a digital technology world. Eye safety, repetitive stress syndrome, and sound ergonomic practices are issues that need to be addressed in a new technological world. Beyond the physical issues are those of the psychological issues that are becoming more prevalent such as Internet addiction. Users need to be taught that there inherent dangers of technology. Digital Citizenship includes a culture where technology users are taught how to protect themselves through education and training.

(I) Digital Security (self-protection). Electronic precautions to guarantee safety. In any society, there are individuals who steal, deface, or disrupt other people. The same is true for the digital community. It is not enough to trust other members in the community for our own safety. In our own homes, we put locks on our doors and fire alarms in our houses to provide some level of protection. The same must be true for the digital security. We need to have virus protection, backups of data, and surge control of our equipment. As responsible citizens, we must protect our information from outside forces that might cause disruption or harm.

"Digital Imaging" means objects created from a camera, scanner, etc.

"Digital Media" means digitized content that can be transmitted over the Internet or computer networks, including text, graphics, audio, and video.

"Digital Storytelling" means some mix of computer-based images, text, audio, and/or video.

"Digital Tools" means any technological resource including, but not limited to, word processors, presentation tools, desktop publishers, geographical information systems, instant messaging or SMS, audio tools, video tools, mind mapping tools, graphic tools, modeling tools, time line tools, data processing, and spreadsheet tools.

"Editing" means content decisions including additions, deletions, and modifications of text, graphics, etc.

"Electronic Authoring Tools" means computer-based system that allows users to create content.

"File Types" mean

(A) .pdf—portable document file (Adobe Acrobat)
(B) .mp3—typical music file
(C) .xls—Microsoft Excel™ file
(D) .dat—database file
(E) .jpg/.jpeg—picture/clip art file
(F) .wmv—Windows movie file
(G) .jpeg—picture file (Most digital cameras take pictures in this format.)

"Graphical Organizers" means Visual representations of knowledge, concepts, or ideas.

"Hyperlink" means embedded text directing to a web page or remote site.

"Lifelong Learning" means the "lifelong, voluntary, and self-motivated" pursuit of knowledge for either personal or professional reasons. As such, it not only enhances social inclusion, active citizenship, and personal development, but also competitiveness and employability.

"Mapping Software" means software that chart data on a map.

"Media-Rich Presentation" means mixed media (audio, video, text, still images, animation, video interactivity).

"Online Learning Community" means common place on the Internet that addresses the learning needs of its members.
"Simulation" means acting out or mimicking an actual or probable real-life condition, event, or situation to solve or explore a problem, issue, or topic.

"Streaming Media" means media compressed to be viewed on a Web site.

"Technology" means the body of knowledge available that is of use in extracting, creating, distributing, manipulating or collecting data and/or information.

"(Technology) Applications" means the technology system designed to solve a specific problem.

"Technology Systems" means the interactive and interdependent components of technology (See technology) that combine to form a solution.

"Upload/Download" means download is moving a digital file (such as a media file or word processing file) from a server where it is stored to a local system for viewing or editing. Upload is moving a digital file from a local system to a server for storage or distribution.

"URL" means the address of a Web page.

210:15-3-184. Instructional Technology Standards

(a) **Creativity and Innovation.** Students demonstrate creative thinking, construct knowledge, and develop innovative products and processes using technology. Students will:

1. apply existing knowledge to generate new ideas, products, or processes.
2. create original works as a means of personal or group expression.
3. use models and simulations to explore complex systems and issues.
4. identify trends and forecast possibilities.

(b) **Communication and Collaboration.** Students use digital media and environments to communicate and work collaboratively, including at a distance, to support individual learning and contribute to the learning of others. Students will:

1. interact, collaborate, and publish with peers, experts, or others employing a variety of digital environments and media.
2. communicate information and ideas effectively to multiple audiences using a variety of media and formats.
3. develop cultural understanding and global awareness by engaging with learners from other cultures.
4. contribute to project teams to produce original works or solve problems.

(c) **Research and Information Fluency.** Students apply digital tools to gather, evaluate, and use information. Students will:

1. plan strategies to guide inquiry.
2. locate, organize, analyze, evaluate, synthesize, and ethically use information from a variety of sources and media.
3. evaluate and select information sources and digital tools based on the appropriateness to specific tasks.
4. process data and report results.

(d) **Critical Thinking, Problem-Solving, and Decision Making.** Students use critical thinking skills to plan and conduct research, manage projects, solve problems, and make informed decisions using appropriate digital tools and resources. Students will:

1. identify and define authentic problems and significant questions for investigation.
2. plan and manage activities to develop a solution or complete a project.
3. collect and analyze data to identify solutions and/or make informed decisions.
4. use multiple processes and diverse perspectives to explore alternative solutions.

(e) **Digital Citizenship.** Students understand human, cultural, and societal issues related to technology and practice legal and ethical behavior. Students will:

1. advocate and practice safe, legal, and responsible use of information and technology.
2. exhibit a positive attitude toward using technology that supports collaboration, learning, and productivity.
3. demonstrate personal responsibility for lifelong learning.
4. exhibit leadership for digital citizenship.

(f) **Technology Operations and Concepts.** Students demonstrate a broad understanding of technology concepts, systems, and operations. Students will:

1. understand and use technology systems.
2. select and use applications effectively and productively.
3. troubleshoot systems and applications.
4. transfer current knowledge to learning of new technologies.

(a) **Structure of the standards.** The Oklahoma Academic Standards for Instructional Technology incorporate the International Society for Technology in Education (ISTE) Standards for Students (2016). The standards are organized around seven (7) competency areas: Empowered Learner, Digital Citizen, Knowledge Constructor, Innovative Designer, Computational Thinker, Creative Communicator, and Global Collaborator. For each of the seven (7) competency areas, four (4) specific standards are included.

(b) **Empowered Learner.** Students leverage technology to take an active role in choosing, achieving, and demonstrating competency in their learning goals, informed by the learning sciences.

1. Students articulate and set personal learning goals, develop strategies leveraging technology to achieve them, and reflect on the learning process itself to improve learning outcomes.
2. Students build networks and customize their learning environments in ways that support the learning process.
3. Students use technology to seek feedback that informs and improves their practice and to demonstrate their learning in a variety of ways.
4. Students understand the fundamental concepts of technology operations; demonstrate the ability to choose, use, and troubleshoot current technologies; and are able to transfer their knowledge to explore emerging technologies.
Permanent Final Adoptions

(c) **Digital Citizen.** Students recognize the rights, responsibilities, and opportunities of living, learning, and working in an interconnected digital world. They act in ways that are safe, legal, and ethical.

1. Students cultivate and manage their digital identity and reputation, and are aware of the permanence of their actions in the digital world.
2. Students engage in positive, safe, legal, and ethical behavior when using technology, including social interactions online or when using networked devices.
3. Students demonstrate an understanding of and respect for the rights and obligations of using and sharing intellectual property.
4. Students manage their personal data to maintain digital privacy and security, and are aware of data-collection technology used to track their navigation online.

(d) **Knowledge Constructor.** Students critically curate a variety of resources using digital tools to construct knowledge, produce creative artifacts, and make meaningful learning experiences for themselves and others.

1. Students plan and employ effective research strategies to locate information and other resources for their intellectual or creative pursuits.
2. Students evaluate the accuracy, perspective, credibility, and relevance of information, media, data, or other resources.
3. Students curate information from digital resources using a variety of tools and methods to create collections of artifacts that demonstrate meaningful connections or conclusions.
4. Students build knowledge by actively exploring real-world issues and problems, developing ideas and theories, and pursuing answers and solutions.

(e) **Innovative Designer.** Students use a variety of technologies within a design process to identify and solve problems by creating new, useful, or imaginative solutions.

1. Students know and use a deliberate design process for generating ideas, testing theories, creating innovative artifacts, or solving authentic problems.
2. Students select and use digital tools to plan and manage a design process that considers design constraints and calculated risks.
3. Students develop, test, and refine prototypes as part of a cyclical design process.
4. Students exhibit a tolerance for ambiguity, perseverance, and the capacity to work with open-ended problems.

(f) **Computational Thinker.** Students develop and employ strategies for understanding and solving problems in ways that leverage the power of technological methods to develop and test solutions.

1. Students formulate problem definitions suited for technology-assisted methods such as data analysis, abstract models, and algorithmic thinking in exploring and finding solutions.
2. Students collect data or identify relevant data sets, use digital tools to analyze them, and represent data in various ways to facilitate problem-solving and decision-making.
3. Students break problems into component parts, extract key information, and develop descriptive models to understand complex systems or facilitate problem-solving.
4. Students understand how automation works, and use algorithmic thinking to develop a sequence of steps to create and test automated solutions.

(g) **Creative Communicator.** Students communicate clearly and express themselves creatively for a variety of purposes using the platforms, tools, styles, formats, and digital media appropriate to their goals.

1. Students choose the appropriate platforms and tools for meeting the desired objectives of their creation or communication.
2. Students create original works or responsibly repurpose or remix digital resources into new creations.
3. Students communicate complex ideas clearly and effectively by creating or using a variety of digital objects such as visualizations, models, or simulations.
4. Students publish or present content that customizes the message and medium for their intended audiences.

(h) **Global Collaborator.** Students use digital tools to broaden their perspectives and enrich their learning by collaborating with others and working effectively in teams locally and globally.

1. Students use digital tools to connect with learners from a variety of backgrounds and cultures, engaging with them in ways that broaden mutual understanding and learning.
2. Students use collaborative technologies to work with others—including peers, experts, or community members—to examine issues and problems from multiple viewpoints.
3. Students contribute constructively to project teams, assuming various roles and responsibilities to work effectively toward a common goal.
4. Students explore local and global issues and use collaborative technologies to work with others to investigate solutions.

210:15-3-185. Intermediate level prior to completion of grade 8 [REVOKED]

(a) **Standard.** The student will demonstrate knowledge of basic operations and concepts.

1. Apply strategies for identifying and solving routine hardware and software problems that occur during everyday use.
2. Demonstrate an understanding of concepts underlying hardware, software, and connectivity, and of practical applications to learning and problem solving.

(b) **Standard.** The student will demonstrate knowledge of social, ethical, and human issues.

1. Demonstrate knowledge of current changes in information technologies and the effect those changes have on the workplace and society.
(2) Exhibit legal and ethical behaviors when using information and technology, and discuss consequences of misuse.
(3) Research and evaluate the accuracy, relevance, appropriateness, comprehensiveness, and bias of electronic information sources concerning real-world problems.

c) Standard. The student will demonstrate knowledge of technology productivity tools.
(1) Use content-specific tools, software, and simulations (e.g., environmental probes, graphing calculators, exploratory environments, Web tools) to support learning and research.
(2) Apply productivity/multimedia tools and peripherals to support personal productivity, group collaboration, and learning throughout the curriculum.

d) Standard. The student will demonstrate knowledge of technology communication tools.
(1) Design, develop, publish, and present products (e.g., Web pages, videotapes) using technology resources that demonstrate and communicate curriculum concepts to audiences inside and outside the classroom.
(2) Collaborate with peers, experts, and others using telecommunications and collaborative tools to investigate curriculum-related problems, issues, and information, and to develop solutions or products for audiences inside and outside the classroom.

e) Standard. The student will demonstrate knowledge of technology research tools.
(1) Use content-specific tools, software, and simulations (e.g., environmental probes, graphing calculators, exploratory environments, Web tools) to support learning and research.
(2) Design, develop, publish, and present products (e.g., Web pages, videotapes) using technology resources that demonstrate and communicate curriculum concepts to audiences inside and outside the classroom.
(3) Collaborate with peers, experts, and others using telecommunications and collaborative tools to investigate curriculum-related problems, issues, and information, and to develop solutions or products for audiences inside and outside the classroom.
(4) Select and use appropriate tools and technology resources to accomplish a variety of tasks and solve problems.
(5) Research and evaluate the accuracy, relevance, appropriateness, comprehensiveness, and bias of electronic information sources concerning real-world problems.

f) Standard. The student will demonstrate knowledge of technology problem-solving and decision-making tools.
(1) Apply productivity/multimedia tools and peripherals to support personal productivity, group collaboration, and learning throughout the curriculum.
(2) Design, develop, publish, and present products (e.g., Web pages, videotapes) using technology resources that demonstrate and communicate curriculum concepts to audiences inside and outside the classroom.
(3) Select and use appropriate tools and technology resources to accomplish a variety of tasks and solve problems.
(4) Demonstrate an understanding of concepts underlying hardware, software, and connectivity, and of practical applications to learning and problem solving.
(5) Research and evaluate the accuracy, relevance, appropriateness, comprehensiveness, and bias of electronic information sources concerning real-world problems.

210:15-3-186. Advanced level prior to completion of grade 12 [REVOKED]
(a) Standard. The student will demonstrate knowledge of basic operations and concepts and make informed choices among technology systems, resources, and services.
(b) Standard. The student will demonstrate knowledge of social, ethical, and human issues.
(1) Identify capabilities and limitations of contemporary, emerging technology resources, and assess the potential of these systems and services to address personal, lifelong learning, and workplace needs.
(2) Make informed choices among technology systems, resources, and services.
(3) Analyze advantages and disadvantages of widespread use and reliance on technology in the workplace and in society as a whole.
(4) Demonstrate and advocate for legal and ethical behaviors among peers, family, and community regarding the use of technology and information.
(c) Standard. The student will demonstrate knowledge of technology productivity tool.
(1) Use technology tools and resources for managing and communicating personal/professional information (e.g., finances, schedules, addresses, purchases, correspondence).
(2) Investigate and apply expert systems, intelligent agents, and simulations in real-world situations.
(d) Standard. The student will demonstrate knowledge of technology communications tools.
(1) Use technology tools and resources for managing and communicating personal/professional information (e.g., finances, schedules, addresses, purchases, correspondence).
(2) Routinely and efficiently use online information resources to meet needs for collaboration, research, publications, communications, and productivity.
(3) Select and apply technology tools for research, information analysis, problem solving, and decision making in content learning.
(4) Collaborate with peers, experts, and others to contribute to a content-related knowledge base by using technology to compile, synthesize, produce, and disseminate information, models, and other creative works.
(e) Standard. The student will demonstrate knowledge of technology research tools.
(1) Evaluate technology-based options, including distance and distributed education, for lifelong learning.
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(2) Routinely and efficiently use online information resources to meet needs for collaboration, research, publications, communications, and productivity.
(3) Select and apply technology tools for research, information analysis, problem solving, and decision making in content learning.
(4) Investigate and apply expert systems, intelligent agents, and simulations in real-world situations.
(5) Collaborate with peers, experts, and others to contribute to a content-related knowledge base by using technology to compile, synthesize, produce, and disseminate information, models, and other creative works.

Standard. The student will demonstrate knowledge of technology problem solving and decision making tools:
(1) Routinely and efficiently use online information resources to meet needs for collaboration, research, publications, communications, and productivity.
(2) Investigate and apply expert systems, intelligent agents, and simulations in real-world situations.
(3) Collaborate with peers, experts, and others to contribute to a content-related knowledge base by using technology to compile, synthesize, produce, and disseminate information, models, and other creative works.

[OAR Docket #21-454; filed 6-15-21]

TITLE 210. STATE DEPARTMENT OF EDUCATION
CHAPTER 20. STAFF

[RULEMAKING ACTION: PERMANENT final adoption]

RULES:
Part 9. Teacher Certification
210:20-9-94. Period of validity of certificates [AMENDED]

AUTHORITY: State Board of Education; 70 O.S. § 3-104; 70 O.S. § 6-187

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
November 1, 2020

COMMENT PERIOD:
November 2, 2020 through December 4, 2020

PUBLIC HEARING:
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December 17, 2020

SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:
December 21, 2020

LEGISLATIVE APPROVAL:
Approved June 11, 2021 by HJR 1046

FINAL ADOPTION:
June 11, 2021

EFFECTIVE:
August 26, 2021

SUPERSEDED EMERGENCY ACTIONS:
Superseded rules:
Part 9. Teacher Certification
210:20-9-94 [AMENDED]

Gubernatorial approval:
April 2, 2020

Register publication:
June 1, 2020

Docket number:
20-403

INCORPORATIONS BY REFERENCE:

GIST/ANALYSIS:
This amendment adds new content to the rule that establishes the validity periods for different categories of teaching certificates. Historically, the rule placed a limit of two (2) total years on the authorization for an individual to be issued an emergency teaching certificate. Consistent with legislative amendments to 70 O.S. § 6-187, the rule content proposed for permanent adoption authorizes the State Board of Education to issue an emergency certificate to a qualifying applicant for a third or subsequent year. Emergency certified individuals and their employing school districts must meet the qualifications listed in the statute and rule to be eligible for an emergency certificate after they have already held emergency certification for two (2) or more years.

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. SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 9. PROFESSIONAL STANDARDS: TEACHER EDUCATION AND CERTIFICATION

PART 9. TEACHER CERTIFICATION

210:20-9-94. Period of validity of certificates
(a) Standard certificates normally have a validity period of five (5) years. The standard certificate will expire five (5) years from the nearest thirtieth day of June either preceding or following the effective date of the certificate.
(b) Provisional certificates, vocational and/or nonvocational, will have a validity period established by the State Department of Education.
(c) Emergency certificates normally have a validity period of one (1) school year. The certificate will expire the thirtieth day of June of the school year for which it was issued. The validity period for an emergency certificate may be extended for one (1) additional school year at the request of the superintendent of the employing district, subject to the approval of the State Board of Education. At the request of the superintendent of the employing district, an emergency certificate may be renewed by the State Board of Education for an additional year for an individual who has been employed by a school district for two (2) or more years, provided the following criteria are met:

1. The individual has been granted an emergency certificate for at least two (2) years;
2. The individual has a rating of “Effective” or higher on the qualitative portion of the last evaluation conducted pursuant to 70 O.S. § 6-101.16;
(3) The individual has not successfully completed the competency examinations required by applicable law;
(4) The individual, via the requesting school district, submits a portfolio of their work to the State Board of Education, which shall include evidence of progress toward standard certification;
(5) The employing school district board of education agrees to renew the individual’s contract for the ensuing fiscal year; and
(6) The superintendent of the employing school district submits to the State Board of Education the reason the emergency certificate should be renewed, and provides evidence of the district’s attempts to, and inability to, hire a teacher who holds a standard teaching certificate. The maximum validity period for an emergency certificate extended by State Board approval will be two (2) years.

d) Individuals employed by a school district under an emergency or provisional certificate shall not be considered career teachers and therefore not entitled to the protections of the Teacher Due Process Act of 1990.

[OAR Docket #21-456; filed 6-15-21]

TITLE 210. STATE DEPARTMENT OF EDUCATION
CHAPTER 20. STAFF

[OAR Docket #21-457]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Part 9. Teacher Certification
210:20-9-110. Alternative placement teaching certificates [AMENDED]

AUTHORITY:
State Board of Education; 70 O.S. § 3-104; 70 O.S. § 6-122.3

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
February 8, 2021

COMMENT PERIOD:
February 16, 2021 through March 18, 2021

PUBLIC HEARING:
March 18, 2021

ADOPTION:
March 25, 2021

SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:
March 26, 2021

LEGISLATIVE APPROVAL:
Approved June 11, 2021 by HJR 1046

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June 11, 2021

EFFECTIVE:
August 26, 2021

SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
Senate Bill 1115 (2020) amended 70 O.S. § 6-122.3 to provide that in consultation with the Commission for Educational Quality and Accountability (OEEA), the State Board of Education is authorized to “grant an exception to the requirement to complete a subject area examination for initial certification in a field which does not require an advanced degree pursuant to [statute.] if the candidate has an advanced degree in a subject that is substantially comparable to the content assessed on a subject area examination.” The rule amendment provides that an applicant for alternative certification who holds an advanced degree is exempt from completing the Oklahoma Subject Area Test (OSAT) for certification in the subject area of their advanced degree. (This OSAT exemption is not available in a certification area that requires an advanced degree for eligibility: school principal or superintendent, school counselor, library media specialist, or reading specialist.)

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. SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 9. PROFESSIONAL STANDARDS: TEACHER EDUCATION AND CERTIFICATION

PART 9. TEACHER CERTIFICATION

210:20-9-110. Alternative placement teaching certificates
(a) Issuance of provisional alternative teaching certificates. The State Department of Education shall issue a three (3) year, nonrenewable provisional alternative placement teaching certificate to an individual who completes the application for an alternative placement teaching certificate and submits all documentation necessary to verify that the applicant meets all of the following criteria:

(1) Post-secondary education. The applicant for alternative placement certification holds:
(A) At least a baccalaureate degree from an institution whose accreditation is recognized by the Oklahoma State Regents for Higher Education and has attained a retention grade point average of not less than 2.50 on a 4.0 scale; or
(B) A terminal degree in any field from an institution accredited by a national or regional accrediting agency recognized by the United States Department of Education, verified as a terminal degree by the Oklahoma State Regents for Higher Education; or
(C) At least a baccalaureate degree from an institution whose accreditation is recognized by the Oklahoma State Regents for Higher Education, and has completed at least two (2) years of qualified work experience. For purposes of this section, qualified work experience must be documentable through standard employment verification procedures, and relevant to a certification area or area of specialization as determined by the State Board of Education, the Office of Educational Quality and Accountability, the Department of Career and Technology Education, and/or the State Regents for Higher Education.
Competency in a certification area. In addition to having completed qualifying post-secondary education, the applicant demonstrates competency in an area of specialization for an elementary-secondary certificate, a secondary certificate, or a vocational-technical certificate. Competency in a certification area may be demonstrated through the following:

(A) Completion of an academic major, or at least thirty (30) credit hours of post-secondary coursework, in a field that corresponds to a certification area.

(B) Completion of an academic minor, or at least fifteen (15) credit hours of post-secondary coursework, in a field that corresponds to a certification area, plus at least one (1) year of qualified work experience or relevant volunteer experience in the same field. Volunteer experience must be verified through documentation and/or references.

(C) At least three (3) years of qualified work experience or relevant volunteer experience in a field that corresponds to an area of certification, or a combination of relevant work and volunteer experience totaling at least three (3) years, plus a written recommendation from an employer or volunteer coordinator.

(D) Successful completion of a relevant professional exam (e.g., accountancy, nursing).

(E) Publication of a relevant article in a peer-reviewed academic journal or trade journal.

(F) Other documentable means of demonstrating competency, subject to the approval of the State Department of Education.

(3) Intent to earn standard certification. The applicant declares their intention to earn standard certification by means of an alternative placement program that meets the requirements of 70 O.S. § 6-122.3 in not more than three (3) years. An applicant shall be deemed to have declared their intention to earn standard certification through submitting a completed application for alternative certification.

(4) Teacher competency examinations. The applicant has passed all of the following teacher competency examinations:

(A) The Oklahoma General Education Test (OGET); and

(B) The Oklahoma Subject Area Test (OSAT) in each area of specialization for which certification is sought, unless the applicant is eligible for an exception to the OSAT requirement under 70 O.S. § 6-122.3(e). Pursuant to statute, in consultation with the Commission for Educational Quality and Accountability, the State Board of Education may grant an exception to the requirement to complete the OSAT exam for initial certification in a subject area for which the applicant holds a substantially related advanced degree from an accredited institution. This exception is not available for subject areas which require an advanced degree for certification, such as school administrator, school counselor, library media specialist, and reading specialist certificates.

(5) Intent to serve as a public school teacher. The applicant declares their intention to serve as a teacher at an Oklahoma public school. An applicant shall be deemed to have declared their intention to seek employment at an accredited Oklahoma public school district through submitting a completed application for alternative certification.

(b) Requirements for enrollment in an alternative certification program. As a prerequisite to enrollment in an alternative placement program set forth in 70 O.S. § 6-122.3, applicants shall meet all of the following requirements:

(1) The applicant has never been denied admittance to a teacher education program approved by the Oklahoma State Regents for Higher Education, the North Central Association of Colleges and Schools and by the Oklahoma Commission for Educational Quality and Accountability to offer teacher education programs; and has never been enrolled in and subsequently failed courses necessary to successfully meet the minimum requirements of the program;

(2) The applicant has on file with the director of teacher education at an Oklahoma institution of higher education a plan for meeting standard certification requirements within three (3) years; and

(3) The applicant is participating in the teacher residency program set forth in 70 O.S. § 6-195;

(c) Requirements for professional education instruction. Participants in alternative placement programs as addressed in subsection (b) must complete between six (6) and eighteen (18) credit hours of professional education instruction, or between ninety (90) and two hundred seventy (270) clock hours of school district-approved professional development, with the minimum hours of instruction required dependent on the applicant's prior level of education and/or experience. Professional education requirements must be completed within three (3) years after entering the Alternative Placement program. For all participants, professional education instruction must include at least one college credit course addressing pedagogical principles and at least one college credit course addressing classroom management. For each year of documented experience in the relevant certification area, a participant's total required professional education may be reduced by three (3) credit hours or forty-five (45) clock hours, provided all participants must complete at least six (6) credit hours or ninety (90) clock hours of professional education instruction. Minimum required instructional hours shall be determined as follows:

(1) For alternative placement program participants who hold a terminal degree, six (6) credit hours or ninety (90) clock hours of professional education instruction are required.

(2) For alternative placement program participants who hold a non-terminal degree beyond a baccalaureate degree, twelve (12) credit hours or one hundred eighty (180) clock hours of professional education instruction are required.

(3) For alternative placement program participants who hold a baccalaureate degree, eighteen (18) credit hours or two hundred seventy (270) clock hours of professional education instruction are required.
(d) **Issuance of standard teaching certificates.** The State Department of Education shall issue a standard teaching certificate to an individual who successfully completes all of the requirements set forth in (a), (b), and (c) of this Section within three (3) years of the date of issuance of the applicant's provisional alternative teaching certificate and meets all of the following requirements:

1. The applicant has passed the Oklahoma Professional Teaching Exam (OPTE) for either elementary/middle level or secondary level; and
2. The applicant has completed all professional education requirements of the alternative placement program set forth in 70 O.S. § 6-122.3 and the administrative rules and/or adopted policies of the State Board of Education.

(e) **No student teaching experience required.** Student teaching and/or pre-student teaching field experience shall not be required of alternative program applicants as a condition of receiving a provisional or standard certificate pursuant to the provisions of this Section.

(f) **Criminal history record check.** Prior to employing an alternatively certified teacher, the district board of education shall request a criminal history record check of the individual under the provisions of 70 O.S. § 5-142.

(g) **State Board of Education exceptions.** In accordance with the requirements of 70 O.S. § 6-122.3, the State Board of Education may grant a waiver or exception to any of the requirements of this Section and may grant a certificate upon demonstration of specific competency in the subject area of specialization by the applicant. An applicant for alternative certification who does not have at least two (2) years of relevant work experience, but demonstrates competency in the subject area in which certification is sought, may request an exception to the work experience requirement of 70 O.S. § 6-122.3.

[OAR Docket #21-457; filed 6-15-21]

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**TITLE 210. STATE DEPARTMENT OF EDUCATION**

**CHAPTER 25. FINANCE**

[OAR Docket #21-458]

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**RULEMAKING ACTION:**
PERMANENT final adoption

**RULES:**
Subchapter 5. Budgeting and Business Management
Part 1. Implementation
210:25-5-4. Accounting [AMENDED]

**AUTHORITY:**
State Board of Education; 70 O.S. § 3-104; 70 O.S. § 5-135.2; 70 O.S. § 22-11

**SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:**
December 11, 2020

**COMMENT PERIOD:**
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**PUBLIC HEARING:**
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January 28, 2021

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**SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:**
January 28, 2021

**LEGISLATIVE APPROVAL:**
Approved June 11, 2021 by HJR 1046

**FINAL ADOPTION:**
June 11, 2021

**EFFECTIVE:**
August 26, 2021

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**SUPERSEDED EMERGENCY ACTIONS:**

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**INCORPORATIONS BY REFERENCE:**

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**GIST/ANALYSIS:**

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**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:**

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**PART 1. IMPLEMENTATION**

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**210:25-5-4. Accounting**

(a) The financial structure of an Oklahoma public school district consists of various classifications as referenced in Oklahoma Administrative Code (OAC) 210:25-7-1, 4Oklahoma Cost Accounting System (OCAS). School District accounting systems shall be organized and operated on a basis that assures legal compliance by the recording and summarizing of financial transactions within funds, each of which is completely independent of any other. Each fund shall account for and continually maintain the identity of its revenues and expenditures. Financial transactions for purposes of this regulation and as referenced in 70 O.S. 2001—§ 5-135.2 shall be
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defined as a detailed reporting of revenue within the Source of Revenue dimension. Revenue shall be reported to the bold codes within each of the following broad categories: District Source of Revenue, Intermediate Source of Revenue, State Source of Revenue, and Federal Source of Revenue. Expenditures shall be reported by the bold codes within the Function dimension as follows: Instruction, Support Services-Students, Support Services-Instructional Staff, Support Services-General Administration, Support Services-School Administration, Support Services-Central, Operation and Maintenance of Plant Services, Student Transportation Services, Child Nutrition Programs Operations, Community Services Operations and Facilities Acquisition and Construction Services. Additional dimensions for Revenue and Expenditures are coded to provide classification by Fiscal Year, Fund, Project Reporting, Object, Program, Subject, Job Classification, and Operational Unit, where applicable.

(b) Beginning July 1 but no later than September 1 of each year, every school district and charter school board of education shall prepare and submit to the State Department of Education, through the Oklahoma Cost Accounting System (OCAS), a statement of actual income and expenditures of the district or charter school for the fiscal year that ended the preceding June 30. The year-end financial report recording and summarizing all revenue and expenditure financial transactions will be completed and certified locked on the due date or before September 1 of the applicable year. For purposes of the OCAS system, “locked” means that the data submitted has passed the system’s initial edit checks and the district has finalized the submission. To assure the validity and accuracy of financial reporting and accounting, between September 1 and September 30 of each year, school districts and charter schools shall have the opportunity to review and make corrections to the data submitted. By September 30, the data submission shall be certified by the district superintendent or head of charter school. If the school district or charter school does not report any inaccuracies by September 30, the State Department of Education will rely on the data submitted and certified by the school district or charter school to be complete and closed. Upon good cause demonstrated, between October 1 and December 1, a school district or charter school may appeal, in writing, to the State Department of Education for additional changes to the data. For purposes of this Subsection, “good cause” means that a miscalculation was made or that relevant data was omitted from the previously certified submission. The State Department of Education will review the appeal and, if it is determined good cause has been demonstrated as defined in this Subsection, the identified changes to the previously certified data will be authorized. Nothing in this Section shall preclude the State Department of Education or the State Board of Education from conducting regular or periodic reviews of school district or charter school financial records as authorized by law and ensuring a public school operates pursuant to the OCAS system.

(c) The school district must inform the Financial Accounting Section of the State Department of Education of any changes made at the district level to any of the financial transactions already submitted to the State Department of Education. Further, none of the data submitted by law can be changed or altered by either the school district or the Financial Accounting Section after December 15 of each year.

(d) As referenced in 70 O.S. 2001, § 5-135.2 (B), the State Department of Education shall reduce the monthly payment of a district's State Aid funds if the district is not operating pursuant to the OCAS system. Upon final determination, including but not limited to the process set forth in Subsection (b), the reduction of monthly payments shall begin with the first day that the school district or charter school was determined to not be operating in compliance with the OCAS system. The reduction may be waived by the State Board of Education if the school district or charter school can demonstrate that failure to operate pursuant to the OCAS system was due to circumstances beyond the control of the district or charter school, and that every effort is being made to operate in compliance with the OCAS system. Not operating pursuant to said system shall be defined as a district not:

1. accurately recording and reporting all revenue and expenditures by applicable OCAS bold code dimensions;
2. submitting OCAS financial records on time and as required, including as provided in Subsection (b), via the Web-based system of all recorded and reported revenue and expenditures by applicable OCAS bold code dimensions to the State Department of Education;
3. ascertaining that current and accurate applicable OCAS codes are being utilized as updated and maintained by the State Department of Education;
4. complying with regulations as outlined in OAC 210:25-3-7 (Financial information processing), OAC 210:25-5-10 (The encumbrance clerk), OAC 210:25-5-11 (The school district treasurer), or OAC 210:25-5-13 (School activity fund);
5. reconciling all recorded and reported revenue and expenditures by applicable OCAS bold code dimensions by balancing data with bank receipts and statements, purchase orders, warrant registers, investment ledgers, and all balance sheet accounts; and

(e) For appropriated funds, all indebtedness should be encumbered (have a purchase order issued and be recorded) on the day the obligation is incurred, rather than when it becomes due, and supporting documentation should be provided for all indebtedness.

(f) Upon the approval of the State Board of Education, school districts may make capital expenditures up to a maximum amount of $50,000 (fifty thousand dollars) during the current fiscal year within the General Fund pursuant to 70 O.S. 2001, § 1-117, if the school district meets the established criteria as outlined in the Statutes. School districts shall be voting the maximum five (5) building fund mills. General Fund monies authorized by the State Board of Education for expenditures must be expended within the current fiscal year. Any such funds encumbered as of June 30th of the current fiscal year, but not expended by November 15th of the subsequent fiscal year, shall lapse and return to the original purpose of such funds.

(g) A school district shall be authorized to utilize general fund monies for capital expenditures, in addition to the amount
specified in subsection (e), pursuant to the provisions of 70 O.S. 2001, § 1-117.

(7g) Inventory cards or data processing records shall be kept on all equipment and removable fixtures, showing purchase order number when known, date of purchase (when known, if not known an estimated date shall be used), amount of purchase (if known, if not known present value must be estimated) a description of the item, the serial number (when applicable) and the location of the item. New purchases shall be included in the records on the same day in which they are physically received by the district. Disposed equipment must be removed from the records on the disposal date and a detailed description of the circumstances which results in the disposal recorded. Disposed equipment should not be included in the records of future years.

[OAR Docket #21-458; filed 6-15-21]

TITLE 210. STATE DEPARTMENT OF EDUCATION
CHAPTER 35. STANDARDS FOR ACCREDITATION OF ELEMENTARY, MIDDLE LEVEL, SECONDARY, AND CAREER AND TECHNOLOGY SCHOOLS

[OAR Docket #21-459]

GIST/ANALYSIS:
This amendment updates the administrative rule addressing alternative instructional delivery systems, including virtual instruction provided by means of the internet. In addition to updating definitions and other provisions to reflect changes in technology since the rule's adoption, the added content requires public schools to adopt policies for "distance learning plans", providing for how instruction will be offered to students outside a traditional classroom setting in the event of an emergency that closes or significantly impacts school campuses. Under the rule, public school distance learning plans must ensure equitable access to instruction for all students regardless of their resources, and distance learning policies must address issues such as attendance and course completion.

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. SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 21. ALTERNATIVE INSTRUCTIONAL DELIVERY SYSTEMS

210:35-21-2. Alternative instructional delivery systems
(a) Definitions. The following words and terms, when used in this section, shall have the following meaning unless the context clearly indicates otherwise:

(1) "Synchronous instruction" means the instructor and student's primary interactions are in real time. Regular classroom instruction is synchronous instruction, as well as two-way interactive video. Web-based instruction that requires real-time interaction between student(s) and instructor as the primary format of instruction is also synchronous instruction.

(2) "Asynchronous instruction" means instructor and student interaction is not dependent on real time. Asynchronous instruction allows the student to engage in learning activities anywhere at any time. For instruction to be considered asynchronous, the primary format of instruction does not depend on real-time interaction of the participants.

(3) "Web-based instruction" means the use of the World Wide Web as the primary medium of instruction, with a computer serving as the primary tool of instruction. Web-based instruction may be synchronous or asynchronous.

(2) "Distance learning plan" means a plan implemented under a public school district or charter school's distance learning policy as authorized by subsection (c), describing any means by which instruction will be delivered to students outside a traditional school setting. A distance learning plan must meet the requirements listed in subsection (c) of this Section.

(3) "Synchronous instruction" means the instructor and student's primary interactions are in real time. Regular classroom instruction is synchronous instruction, as well as two way interactive video. Virtual instruction that
requires real time interaction between student(s) and instructor as the primary format of instruction is also synchronous instruction.

(4) "Two-way interactive video instruction" means real-time (synchronous) interaction between student(s) and instructor by means of an electronic medium that provides for both audio (sound) and video (sight) signal. Students and instructors participating in two-way interactive video instruction may both see and hear each other in an approximation of real-time.

(5) "Virtual instruction" means the use of the internet or other such digital information transmission systems as the primary medium of instruction. Virtual instruction may be synchronous or asynchronous, or may combine synchronous and asynchronous instruction.

(b) Alternative Instructional Delivery System. Internet-based Virtual instructional programs offered for instructional purposes and/or high school credit shall be approved by and under the supervision of the local board of education of the school district where the course is offered. The State Board of Education reserves the right to request information and materials sufficient to evaluate the proposed course(s) for the purposes of course code alignment and other authorized purposes.

(c) Local board policy. All local school district boards of education in the state of Oklahoma shall adopt policies regarding Internet-based virtual instructional courses which shall comply with the following guidelines.

(1) Web-based Virtual and two-way interactive video instruction shall be viewed as methods by which the public schools within the state can expand their course offerings and access to instructional resources. These new technologies should not be viewed solely as substitutes for direct, face-to-face student and teacher interactions, but as a means of expanding the ability of the local district to bring the world of knowledge to their students. With the exception of a charter school authorized by its sponsor to provide virtual instruction only, or during emergency circumstances as addressed below, a public school shall offer in-person classroom instructional opportunities in addition to any virtual instructional opportunities offered to students.

(A) Virtual instruction in distance learning plans. As authorized in the event of an emergency declared by a federal or state government entity that impacts the operation of public schools in Oklahoma, or upon an action taken by the State Board of Education declaring such an emergency that leads to the temporary emergency closure of school campuses or otherwise significantly impacts the operation of public schools in Oklahoma as determined by the State Board of Education, public schools may implement distance learning plans which provide for distance learning that is accessible to all students. Further, a public school district or charter school may adopt a policy providing for the short-term implementation of a distance learning plan due to a localized emergency, such as a weather-related school closure or a localized public health emergency. A school's approved academic calendar may build in one or more emergency closure "makeup days" to be delivered through the distance learning plan, in the same manner as a school district's calendar may build in additional standard school days to be held as makeup days in case of emergency weather closures.

(B) Virtual instruction in home-based education. A public school district or charter school may adopt a distance learning plan policy that provides for virtual or partially virtual instruction to deliver home-based education to a student who cannot attend school in person for a period of time due to extended medical or other issues, pursuant to Oklahoma Administrative Code 210:10-1-5. If a school district or charter school delivers its home-based education program solely through virtual instruction, any participating student who does not already have access to the necessary connectivity and/or device(s) shall be provided the connectivity and device(s) necessary to access the instruction free of charge.

(C) Distance learning plan requirements. A school district or charter school shall submit a copy of its distance learning plan to the Oklahoma State Department of Education (OSDE) Office of Accreditation within ten (10) business days of adoption by the school district board of education or charter school governing board. If an update or revision of the policy is adopted, such amended policy shall also be submitted to the OSDE Office of Accreditation within ten (10) business days of adoption. A public school policy authorizing the implementation of a local distance learning plan must include the following considerations:

(i) Equitable access. Participation in the distance learning plan must be accessible to every student regardless of household resources. This means that if a public school requires students to engage with instruction or content using the internet or other means of remote connectivity, the district must ensure the student has access to the connectivity and any device(s) necessary, and if not, the district must provide them for student use free of charge. If a school district or charter school cannot provide connectivity and device access for the use of all students due to limitations such as budget and/or geography, but plans to use virtual instruction as part of its distance learning plan as authorized in subsection (c)(1)(A), the distance learning plan must provide for alternate methods to deliver equitably equivalent instruction to all students. Such alternate means could include approaches such as paper packets of instructional materials supplemented by periodic direct contact with teachers, in person or by telephone or other method of communication. A school district must ensure that the student has access to all materials necessary for participating in a public school’s
distance learning plan, and if the student does not already have the necessary materials, must ensure access free of charge, e.g., by providing packets of paper instructional materials, blank paper for assignment completion, and writing instruments or other supplies as appropriate for the grade level or subject area (e.g., geometric compass, protractor, crayons/colored pencils if required for assignment completion). If a public school's policy for distance learning allows for different instructional delivery methods due to the inability to provide connectivity and device(s) to all students, the policy must address the school's method(s) for making individualized determinations of which students would be able to access virtual instruction and which would not, including equitable plans for serving students who would not have access to virtual instruction.

(ii) **Alignment with standards.** A local distance learning plan must provide that instruction and content provided through virtual education or other distance learning delivery methods is consistent with the Oklahoma Academic Standards for the subject area and/or grade level in which credit is awarded. Instruction and content provided through distance learning delivery methods other than virtual instruction must be equivalently equivalent to the instruction and content provided through virtual instruction.

(iii) **Policies.** As a condition of adopting an authorized local distance learning plan, a school district or charter school shall establish clear written policies for students receiving instructional services in the plan, which must include measurements of attendance for students and staff, awarding of credits for course completion, and participation in extracurricular activities. Separate attendance policies may be appropriate for full-time virtual education and part-time virtual education. Attendance policies for distance learning provided by means other than virtual education may consider factors such as assignment completion and engagement with instructional supports, provided no student shall have a grade lowered or be otherwise penalized for failure to engage with instructional supports the student does not have the resources to access (e.g., telephone service, internet access, transportation). Records of student enrollment and attendance in virtual instruction programs shall be maintained through the school district or charter school's authorized student information system, consistent with all requirements of Oklahoma Administrative Code 210:10-1-5. Virtual attendance policies for Oklahoma school districts and charter schools shall include the following provisions:

(I) The first date of attendance for a student participating in a virtual instruction program shall be the date on which the student first completes an instructional activity as defined in 70 O.S. § 3-145.8; and

(II) The defined time period, assignment completion status, or other means used to determine student attendance in the virtual program shall meet or exceed the minimum measures of virtual attendance listed at 70 O.S. § 3-145.8(B).

(2) To ensure equitable access to instruction, in the development of a policy authorizing a distance learning plan as addressed in (c)(1), it is strongly recommended that a school district or charter school consult a working group of community stakeholders. Diligent efforts shall be made to include persons of different backgrounds and experiences to provide for the development of a distance learning plan that is accessible to the entire school community. Such a working group should include: school leaders and teachers; parents/guardians and other community members representing different socioeconomic statuses, racial and ethnic identities, and cultural perspectives; representatives of any Native American tribal nation(s) with territory or members served by the district; and other persons or groups identified by the district whose perspectives are appropriate to consider in the development of a distance learning plan.

(3) The local school board or charter school shall be the entity granting student credit for completion of courses offered by means of Internet-based virtual instruction, including instruction provided by means of an authorized contract with an instructional services provider. The local district school board or charter school governing board will assume all the same responsibility for such course work courses offered by such means as for all other courses offered by the district.

(4) Only students who are regularly enrolled in the school district, either as resident students or transfer students, shall be allowed to enroll in alternative instructional delivery systems courses offered for credit through the local school district.

(5) A district board of education may authorize enrollment on a part-time basis utilizing Internet-based courses for students who have dropped out of school or have been suspended from school provided such student was enrolled at any time in a public school in this state during the previous three (3) school years previously been denied a diploma, pursuant to 70 O.S. § 11-103.6(Q).

(6) Students enrolled on a full-time basis shall be authorized to enroll in Internet-based virtual courses.

(7) The principal or designee of the local school shall evaluate and approve or disapprove all students' requests to participate in courses delivered by means of Internet-based virtual instruction provided that all requests eligible pursuant to Oklahoma Administrative Code 210:15-34 are approved as provided therein. Only
Permalink Final Adoptions

those enrollments approved by such a process shall be eligible for credit granted by the local school district.

(28) A certified staff member shall be identified by the local school principal to serve as the building level contact person to assist students enrolling in online courses and serve as a liaison to the online teachers and provider(s).

(9) Students earning credit by means of Internet-based instruction shall participate in all assessments required by the Oklahoma School Testing Program. No student shall be allowed to participate in any assessments at a place other than the school site at which the student is enrolled.

(910) Courses offered for credit by means of Internet-based instruction shall be aligned with the Priority Academic Student Skills (PASS) Oklahoma Academic Standards. Districts may also establish additional criteria as a basis for course selection, provided any additional criteria are consistent with 70 O.S. § 1-111 Oklahoma Administrative Code 210:15-34.

(411) Oklahoma statutory or legal provisions limiting the number of students public school teachers may supervise in each period of instruction and the total number of students allowed daily shall apply to synchronous Internet-based virtual and two-way interactive video courses, provided any associated moratorium or exemption that applies to traditional classroom instruction shall also apply to synchronous instruction. The number of students each instructor may be required to supervise in asynchronous Internet-based virtual courses shall be established by means of local school board policy.

(112) Each teacher of two-way interactive video and or Internet-based virtual courses shall be provided inservice training pertaining to the methodology of instructional delivery and the technical aspects of distance learning.

(123) The issues regarding the monitoring of student progress, graded assignments, and testing in Internet-based virtual instruction courses shall be addressed by the local school board policy.

(134) The security of student data and records shall be addressed by the local school board policy. No individual student data obtained through participation in Internet-based virtual instruction courses shall be used for any purpose other than those that support the instruction of the individual student. Under all circumstances, the provisions of the Family Educational Rights and Privacy Act (FERPA) apply to student data held or accessed by any public school or its contractors or agents, including any contracted provider of virtual instruction or other distance learning media.

(14) District level aggregated data obtained through participation in Internet-based instruction courses shall be addressed by the local school board policy.

(15) All federal and state statutes and regulations pertaining to student privacy, the transmission or posting of images or other content on the Internet or "World Wide Web", copyright of materials, Federal Communications Commission (FCC) rules pertaining to the public broadcasting of audio and video, and other such issues shall apply to virtual instruction platforms, media, and any associated content be addressed by the local school board policy.

(16) Prior to the beginning of instruction, cooperating school districts sharing courses by means of two-way interactive video technology shall, by means of contractual agreement, address such issues as the instruction costs, bell schedule, school calendars, student behavior, teacher evaluation, textbooks or other course materials, class periods and other such interactive video sessions, student grades and grading policies, teacher load, and instructor employment.

(17) With the exception of distance learning plans implemented in emergency circumstances as authorized in (c)(1)(A), Contractual agreements shall be established between the school district and parent(s) or legal guardian, of students participating in alternative instructional delivery system courses prior to the beginning of instruction. These contracts may address such issues as grading criteria, time allotted for course completion, student attendance, and the responsibility for course costs and equipment necessary to access the course content.

(18) Instructors of Internet-based virtual courses shall be:

(A) certified in Oklahoma or another state to teach in the content area of the course offered, or;

(B) a faculty member at an accredited institution of higher education, possessing the specific content expertise necessary to teach the course.

(19) Districts shall establish criteria for determining the appropriateness of particular Internet-based virtual courses for individual students prior to student enrollment in such courses, which shall be consistent with the provisions of 70 O.S. § 1-111 and Oklahoma Administrative Code 210:15-34.

[OAR Docket #21-459; filed 6-15-21]

TITLE 210. STATE DEPARTMENT OF EDUCATION

CHAPTER 40. GRANTS AND PROGRAMS-IN-AID

[OAR Docket #21-460]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 87. Charter Schools
210.40-87-3. Distribution and reporting of state appropriated funds to charter school sponsors and charter schools [AMENDED]
210.40-87-10. Charter School Closure Fund [NEW]

AUTHORITY:
State Board of Education; 70 O.S. § 3-104; 70 O.S. § 3-142

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
January 10, 2021
Permanent Final Adoptions

COMMENT PERIOD: January 15, 2021 through February 16, 2021
PUBLIC HEARING: February 16, 2021
ADOPTION: February 25, 2021
SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE: March 2, 2021
LEGISLATIVE APPROVAL: Approved June 11, 2021 by HJR 1046
FINAL ADOPTION: June 11, 2021
EFFECTIVE: August 26, 2021
SUPERSEDED EMERGENCY ACTIONS: n/a
INCORPORATIONS BY REFERENCE: n/a
GIST/ANALYSIS:
The administrative rules for charter schools are being updated to reflect new legislative provisions. House Bill 3369 (2020) amended 70 O.S. § 3-142 to place limits on a charter school sponsor’s retention of state funds allocated to the school, and to establish a charter school closure fund intended to reimburse sponsors for eligible costs associated with the closure of a charter school. HB 3369 amended the maximum fee that a charter school sponsor is authorized to charge a sponsored school for administrative services, from five percent (5%) to three percent (3%) of the school’s State Aid allocation, and Oklahoma Administrative Code 210:40-87-3 is being updated to reflect the new 3% statutory cap for administrative fees.

OAC 210:40-87-10 is the proposed new rule for the charter school closure fund created by HB 3369. This rule provides that in order to be eligible for reimbursement of costs associated with the closure of a charter school, the school's sponsor must demonstrate that it has fulfilled all the obligations of a sponsoring entity under the Oklahoma Charter Schools Act and associated rules.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 87. CHARTER SCHOOLS

210:40-87-3. Distribution and reporting of state appropriated funds to charter school sponsors and charter schools
(a) Distribution and disbursement. Distribution and disbursement of all State Aid allocations and any other state appropriated revenue to a charter school and its sponsor in accordance with the requirements of 70 O.S. § 3-142 shall be conducted in accordance with the following provisions:
(1) Requirements for distribution of funds; sponsor administrative costs. The State Department of Education (OSDE) shall not distribute state appropriated funds to a charter school sponsor for disbursement to its charter school until all of the following requirements have been met:
(A) The charter school sponsor must provide the State Department of Education with financial records documenting any state funds retained by the sponsor for administrative services rendered during the previous fiscal year. Fees for administrative services shall comply with the provisions of 70 O.S. § 3-142, not to exceed three percent (3%) of the charter school's State Aid allocation. A sponsor of a charter school shall not retain any additional State Aid allocation or charge the charter school any additional fee above the amounts allowed under 70 O.S. § 3-142(A), unless the additional fees are for services rendered, as evidenced by itemized records detailing the additional services provided and the actual costs of providing the services.
(B) Financial transactions for all state appropriated funds for the previous fiscal year have been reported to the State Department of Education by the charter school sponsor and/or the charter school in accordance with the requirements of 70 O.S. § 5-135.2, with all reports submitted on time and as required by subsection (b) of this Section.
(C) In addition to the above requirements, prior to the charter school's initial year of operation, the charter school sponsor shall ensure that the charter school has met all of the following requirements no later than June 30 prior to the charter school's initial year of operation:
(i) The charter school shall submit a copy of the approved and executed charter school charter and a copy of the approved and executed contract with the sponsor to the State Department of Education;
(ii) The charter school shall provide the State Department of Education with documentation that it has established and will maintain a student information system that meets the requirements of 70 O.S. § 18-200.1;
(iii) The charter school shall provide the State Department of Education with documentation that it has established an approved financial accounting system that meets the requirements of the Oklahoma Cost Accounting System (OCAS); and
(iv) The charter school shall have been issued a county and district identification number from the Accreditation Division of the State Department of Education.
(2) Distribution to charter school. A charter school sponsor shall distribute state flow-through funding to the charter school within ten (10) business days from the date of receipt of funds by electronic transfer from the State Department of Education.
(3) Effect of disbursement. Disbursement of funds to a charter school from the charter school's sponsor shall result in the charter school having fiscal control over the funds received.
(b) Reporting requirements. In addition to any other requirements imposed by statute or rule, including but not limited to 70 O.S. § 5-200, Charter school sponsors and charter schools shall meet the following reporting requirements:

Oklahoma Register (Volume 38, Number 23)
(1) Annual statement of income and expenditures. Every sponsor of a charter school and every charter school shall annually prepare and submit a statement of actual income and expenditures as follows, in accordance with Oklahoma Administrative Code 210:25-5-4:

(A) Charter school sponsors. No later than September 1 of each year, every sponsor of a charter school shall prepare a statement of actual income and expenditures of the sponsor for the fiscal year that ended on the preceding June 30 and transmit the income and expenditure data to the State Department of Education in accordance with the requirements of 70 O.S. § 5-135.2. At the time of submitting the statement of actual income and expenditures, and upon request at any time by the OSDE or the State Board of Education, the charter school sponsor shall submit financial records documenting any state funds retained by the sponsor for administrative services rendered for the previous year. A sponsor of a charter school shall not retain any additional State Aid allocation or charge the charter school any additional fee above the percentage provided for in the charter sponsorship contract, not to exceed three percent (3%) of the charter school’s State Aid appropriation, unless the additional fees are for services rendered. Documentation for any additional fees above three percent (3%) charged to a charter school by its sponsor shall include the parties’ written agreement, itemized records detailing the additional services provided, and the actual costs of providing the services. The State Department of Education (OSDE) shall post the income and expenditure data and the administrative services data on the Department’s website in a form that is accessible to the public.

(B) Charter schools. No later than September 1 of each year, every charter school shall prepare a statement of actual income and expenditures for the fiscal year that ended on the preceding June 30 and transmit the income and expenditure data to the State Department of Education OSDE in accordance with the requirements of 70 O.S. § 5-135.2 and 70 O.S. §§-135.2, and Oklahoma Administrative Code 210:25-5-4. The Department of Education OSDE shall post the income and expenditure data and the administrative services data on the Department’s website in a form that is accessible to the public. In all financial operations and reporting, each charter school shall be separate and distinct from every other charter school, including those charter schools sponsored by the same entity.

(2) Financial statement and estimate of needs. No later than October 1 of each year, every charter school shall prepare and submit the following to its sponsor and the State Department of Education:

(A) A sworn financial statement showing the true fiscal condition of the charter school as of the close of the previous fiscal year ended June 30 that meets the requirements of 68 O.S. § 3002; and

(B) A written itemized statement of estimated needs and probable income from all sources for the current fiscal year that meets the requirements of 68 O.S. § 3002.

(3) Amendments to charter school charter or sponsorship contract affecting state funding. Within thirty (30) calendar days of the date of execution of any amendment of a charter school’s charter and/or contract for sponsorship, the charter school shall notify the State Department of Education in writing of any modifications to terms of the charter/contract that could affect or potentially affect calculation and/or distribution of state funding. Examples of modifications include, but shall not be limited to amendments to the following terms:

(A) Requirements and procedures for program and financial audits;
(B) Grade levels served by the charter school;
(C) School day of early childhood and kindergarten programs (e.g., half-day or full-day);
(D) Minimum or maximum numbers of pupils served;
(E) Participation in state employee benefit programs (e.g., OTRS); and
(F) Provisions specifying disposition of property acquired by the charter school upon expiration or termination of a contract for sponsorship.

(4) Required reports upon closure of a charter school. Upon expiration or termination of contract for charter school sponsorship, or upon failure of the charter school to continue operations, the charter school sponsor shall be responsible for ensuring that the State Department of Education is provided with a final audit that complies with the annual audit requirements of the Oklahoma Public School Audit Law and accompanying regulations, and an itemized statement detailing the disposition of all charter school real and personal property. All statements required pursuant to the provisions of this paragraph shall be provided to the State Department of Education no later than ninety (90) days from the date of termination or expiration of the contract for sponsorship or the last date classes are held by the charter school, whichever occurs first. Eligibility for Charter School Closure Fund reimbursement to a sponsor for costs incurred due to the closure of a charter school shall be governed by 70 O.S. § 3-134 and Oklahoma Administrative Code 210:40-87-10.

210:40-87-10. Charter School Closure Fund

(a) Purpose. This Section lays out contribution requirements, and sponsor reimbursement eligibility provisions, for the Charter School Closure Fund established pursuant to 70 O.S. § 3-142.

(b) Contributions by charter schools. As required under the Oklahoma Charter Schools Act, every school year each charter school shall pay to the Charter School Closure Fund five dollars ($5) per student, based on Average Daily Membership (ADM) as defined by 70 O.S. § 18-107. This payment must be submitted within thirty (30) days of the end of the
first nine (9) weeks of the applicable school year. If the Charter School Closure Fund has a balance of one million dollars ($1,000,000) or more on July 1, no payments to the fund will be required for the upcoming school year.

(c) **Eligibility for reimbursement to a sponsor from the Charter School Closure Fund.** Prior to filing claims with the Office of Management and Enterprise Services (OMES) for reimbursement of costs incurred due to the closure of a charter school under its sponsorship, a charter school sponsor must document that it has fulfilled all duties of a sponsor under the Oklahoma Charter Schools Act and associated rules. Evidence of proper execution of the duties of charter school sponsorship shall be submitted to the State Department of Education (OSDE) for verification and must include all of the following:

(1) A copy of the charter school sponsor's procedure for accepting, approving, and disapproving charter school applications in accordance with 70 O.S. § 3-134(E).

(2) As required by 70 O.S. § 3-134(K), a copy of the charter school sponsor's policies and practices consistent with recognized principles and standards for quality charter authorizing, including:

- **A.** Organizational capacity and infrastructure;
- **B.** Soliciting and evaluating charter applications;
- **C.** Performance contracting;
- **D.** Ongoing charter school oversight and evaluation; and
- **E.** Charter renewal decision-making.

(3) Beginning with school year 2020-2021, financial records documenting any state funds retained by the sponsor for administrative services rendered to the charter school. If the state funds retained by the sponsor exceed three percent (3%) of the charter school's State Aid for any school year after 2020-2021, this documentation must include itemized records detailing what additional services were provided by the sponsor and the actual costs of providing the additional services to the charter school.

[OAR Docket #21-460; filed 6-15-21]

**TITLE 260. OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES**

**CHAPTER 25. MERIT SYSTEM OF PERSONNEL ADMINISTRATION RULES**

[OAR Docket #21-421]

**RULEMAKING ACTION:** PERMANENT final adoption

**RULES:**

- Subchapter 11. Employee Actions
  - Part 13. Resignations
    - 260:25-11-134. Resignation or leave without pay to accept an unclassified position [AMENDED]
  - Subchapter 15. Time and Leave
    - Part 5. Miscellaneous Types of Leave
    - Part 7. Leave When Offices Are Closed Or Services Reduced
      - 260:25-15-71. Leave when an office state office building is temporarily closed due to unsafe working conditions or hazardous weather; or when services are temporarily reduced due to hazardous weather (paid administrative leave) [AMENDED]

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

**SUBCHAPTER 11. EMPLOYEE ACTIONS**

**PART 13. RESIGNATIONS**
260:25-11-134. Resignation or leave without pay to accept an unclassified position
(a) No classified employee may be assigned to an unclassified or exempt position unless the employee so desires and such acceptance shall be transmitted in writing to the Administrator.
(b) Any classified employee shall be deemed to have resigned the classified position on the date of accepting an appointment to a position in the exempt or unclassified service of the state; except that, a person appointed to a temporary or acting position in the exempt or unclassified service, including appointment as an acting incumbent as provided in Section 840-5.5(A)(50)(49) of Title 74 of the Oklahoma Statutes, may alternatively request leave without pay status in the classified position while assigned to the unclassified or exempt position. Such leave without pay shall not exceed 2 years from the date of the appointment to the unclassified service.

SUBCHAPTER 15. TIME AND LEAVE

PART 5. MISCELLANEOUS TYPES OF LEAVE

(a) The Appointing Authority may grant a probationary or permanent employee time off from regular duties, with compensation for absence necessary when some member of his or her immediate family or household requires the employee's care because of illness or injury, when an employee's son or daughter requires care and supervision due to unavailability of the dependent's routine caregiver or caregiving facility, or in the case of death in the immediate family or household or in the case of personal disaster. Enforced leave shall be charged against the employee's sick leave and may not be granted in excess of accumulated sick leave. The number of days granted will be governed by the circumstance of the case, but in no event shall they exceed 10 working days in any calendar year.
(b) Immediate Family is defined as spouse, children, parents, brothers, sisters, including step, grand, half, foster, or in-law relationships.
(c) Household is defined as those persons who reside in the same home, who have reciprocal duties and provide financial support for one another. This term shall include foster children and legal wards even if they do not live in the household. The term does not include persons sharing the same general house or when the living style is primarily that of a dormitory or commune.
(d) Personal Disaster is defined as an unforeseeable, catastrophic event such as the destruction of the employee's residence.
(e) Son or daughter is defined as 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 18 years of age or is 18 years of age or older and incapable of self-care because of a mental or physical disability.

PART 7. LEAVE WHEN OFFICES ARE CLOSED OR SERVICES REDUCED

260:25-15-71. Leave when an office or state office building is temporarily closed due to unsafe working conditions or hazardous weather; or when services are temporarily reduced due to hazardous weather (paid administrative leave)
(a) If agency office building are closed because of an imminent peril threatening the public health, safety, or welfare of state employees or the public, or when state office buildings are temporarily closed or reduced due to hazardous weather conditions, the Appointing Authority shall place employees who are scheduled to work in the affected work areas on paid administrative leave or, if applicable, shall assign them to work in another location, including, but not limited to, a telework location. During their normal duty hours, employees on paid administrative leave due to unsafe working conditions are on stand-by or on-call status. Appointing Authorities may call employees to return to their normal duties or respond to the demands of the situation as necessary. [74:840-2.20A(A)]
(b) As used in this Section, paid administrative leave means leave granted to affected employees if offices of agencies are closed because of an imminent peril threatening the public health, safety, or welfare of state employees or the public, or when state offices are temporarily closed or reduced due to hazardous weather. Examples of reasons for temporarily closing an office due to unsafe working conditions are: leaks of toxic fumes in buildings; life threatening damage to building structures; or emergency operations which would be disrupted by the presence of the usual work force; or any other condition which poses a significant threat to the safety of the work force.
(c) Paid administrative leave shall be accorded to all affected employees only when a state office building is temporarily closed or services are temporarily reduced due to hazardous weather in accordance with 260:25-15-70 and this Section. Upon its reopening, normal Merit Rules governing leave and agency procedures shall apply. The granting of administrative leave applies only to employees scheduled to work onsite in a state office building during the time period of the closure or reduced services. Administrative leave shall not be granted to employees that telework or have the ability to telework unless otherwise approved by the Appointing Authority or on a case-by-case basis. Administrative leave does not apply to employees who are absent during the closure or reduction on any previously approved leave. Employees who are not eligible to accrue leave, such as temporary employees, shall not be granted administrative leave under this section when state services are temporarily closed or temporarily reduced due to hazardous weather conditions.
(d) When the Governor or a designee of the Governor authorizes agencies or parts of agencies to maintain basic minimum services because hazardous weather conditions impede or delay the movement of employees to and from work, employees responsible for providing such basic minimum services shall report to work. Appointing Authorities of agencies shall be responsible for determining essential agency functions [basic minimum services] and ensuring that employees who staff such functions are so informed. [74:840-2.20A(B)] Employees who are considered responsible for basic minimum services and
who are required to work when state services are temporarily reduced due to hazardous weather conditions shall be entitled to accrue administrative leave on a straight-time basis up to eight hours per day for hours worked in their regularly scheduled work periods during such reduction. Administrative leave accrued under this provision must be taken within 180 days of its accrual or the employee shall be paid for the leave. An extension of the time period for taking the leave may be approved for up to an additional 180 days, providing the Appointing Authority submits a written request with sufficient justification to the Human Capital Management Division. Accrued administrative leave must be used before granting of any annual leave except when the employee may lose accrued leave under 260260:25-15-10 and 260:25-15-11(b) (5).

(e) Employees who are responsible for basic minimum services who do not report to work have the following options to account for leave:

1. Charge the absence to accumulated compensatory time;
2. Charge the absence to accumulated annual leave;
3. Make up lost time in a manner consistent with the FLSA, if the Appointing Authority determines that office hours and schedules permit.

(f) An employee who leaves earlier than a designated early dismissal time, or who arrives later than a designated late arrival time, shall be charged leave for the excess time.

(g) An employee who is not responsible for basic minimum services shall not be allowed to accrue administrative leave in accordance with (d) of this Section for time worked.

(h) Employees who are placed on paid administrative leave shall receive up to eight hours per day of paid administrative leave.

SUBCHAPTER 17. PERFORMANCE EVALUATION AND CAREER ENHANCEMENT PROGRAMS

PART 3. EMPLOYEE PERFORMANCE MANAGEMENT SYSTEM

260:25-17-31. Employee performance management system

(a) The Office of Management and Enterprise Services shall make available one standard performance management system that shall be used by all agencies for completing employee performance evaluations. The purpose of this employee performance management system is to evaluate the performance of each employee in the executive branch of state government except those in the exempt unclassified service as specified in paragraphs 1 and 2 of subsection A of Section 840-5.5 and those employees employed by the institutions under the administrative authority of The Oklahoma State System of Higher Education.

(b) The employee performance management system shall provide for the following:

1. An objective evaluation by the immediate supervisor of the performance of the employee within the assigned duties of the job. The evaluation shall contain the agency number, date of review, and employee identification number;
2. The identification by the immediate supervisor of accountabilities and behaviors upon which the employee will be evaluated;
3. A mid-term interview with the immediate supervisor for the purpose of discussing the progress of the employee in meeting the accountabilities and behaviors upon which the employee will be evaluated;
4. Identification of performance strengths and performance areas for development;
5. A final interview with the employee by the immediate supervisor who shall provide the employee with a copy of the performance evaluation; and
6. The opportunity for the employee to submit written comments regarding the performance evaluation.

(c) Each classified employee in probationary status shall be rated at least thirty days prior to the end of the probationary period. All unclassified and permanent classified employees not otherwise exempt from this requirement shall have an evaluation period of no more than twelve months. Supervisors may perform as many additional evaluations as they deem necessary in order to effectively manage the performance of a subordinate.

(d) The immediate supervisor shall hold a meeting in person with the employee at least three times during a 12-month evaluation period.

1. One meeting shall take place at the beginning of the evaluation period in order to communicate the accountabilities and behaviors upon which the employee will be evaluated. A copy shall be provided to the employee.
2. One meeting shall take place during the rating period for the purpose of discussing the progress of the employee in meeting the accountabilities upon which the employee will be evaluated.
3. One meeting shall take place at the end of the review period to provide the final evaluation. A copy of the evaluation shall be provided to the employee, and the employee shall have the opportunity to provide written comments.

(e) The agency shall use the performance evaluations of current or former state employees in decisions regarding promotions, appointments, demotions, performance pay increases, and discharges. Reductions-in-force shall not be considered discharges. With or without the performance evaluations the Appointing Authority can make decisions regarding demotions and discharges on current state employees if determined necessary.

(f) The agency shall retain a copy of the performance evaluation for each employee of the agency. A copy of the performance evaluation shall be retained in the employee's personnel file.

(g) The basic document to be used in conducting performance evaluations is the Performance Management Process form, a form prescribed by the Administrator. The form
PART 9. MANDATORY SUPERVISORY TRAINING

260:25-17-93. Supervisory training requirements
(a) Beginning November 1, 1999, all supervisors shall complete 12 hours of supervisory training according to this Part each calendar year [74:840-3.1].
(b) Persons appointed to supervisory positions after November 1, 1999, shall complete 24 hours of supervisory training according to this Part within 12 months before or after assuming a supervisory position [74:840-3.1]. Supervisors shall complete training courses in the State of Oklahoma Performance Management Process and progressive discipline within the first 12 months of being appointed to a supervisory position.
(c) The appointing authority of each agency shall make sure each supervisory employee is notified and scheduled to attend required supervisory training and shall make time available for each supervisory employee to complete the training [74:840-3.1].
(d) Training courses conducted by employing agencies, public and private schools, and colleges and universities may count toward supervisory training requirements if the coursework meets the definition for supervisory training in 260:25-17-91.
(e) HCM does not accept facsimiles or "FAXes" instead of original official documents except for the following documents:
   (1) Agency Payroll Initialization (HCM-38);
   (2) Agency Transfer (HCM-30);
   (3) Carl Albert Public Internship Program application materials, and completed and signed agreement forms;
   (4) Certified Public Manager nomination;
   (5) Classification Grievance Audit Request (HCM-70);
   (6) Dependent birthday change (EBC-20);
   (7) Delegated authority application;
   (8) Documents and related correspondence on legislation, rules, and Employment Relations Services (except for Employee Assistance Program participant documents and alleged discrimination complaint documents);
   (9) HRDS Course Nomination;
   (10) Interagency employee transfer correspondence;
   (11) Mandatory Supervisory Training Report;
   (12) Model Project application;
   (13) Notice to Announce (HCM-29);
   (14) PEP Nomination (HCM-102);
   (15) Personnel Transaction Freeze Exception Request;
   (16) Position Description Questionnaires;
   (17) Quality Oklahoma Project Report;
   (18) Reallocation Forms;
   (19) Request for personnel action;
   (20) State Mentor Program nomination forms, application materials, and Appointing Authority endorsement forms;
   (21) State Personnel Interchange Program completed and signed agreement and contract forms;
   (22) Test Use and Security Agreement; and
   (23) Voluntary Payroll Deduction Application (VPD-1) and related correspondence.
(f) Unless a document clearly states otherwise, the signature of a person on a document filed with HCM shall mean the person has read it and has personal knowledge of the information it contains, that every statement is true, that no statements are misleading; and that filing the document is not a delay tactic. If any document is not signed or is signed with intent to defeat the purposes of the rules in this Title, the Administrator may ignore it and continue as though it had not been filed.

OAR Docket #21-421; filed 6-14-21
TITLE 260. OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES
CHAPTER 45. EMPLOYEES GROUP INSURANCE DIVISION - ADMINISTRATIVE AND GENERAL PROVISIONS

[OAR Docket #21-422]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 5. Grievance Panel Procedures
260:45-5-1. Request for hearing [AMENDED]
260:45-5-8. Scheduling of hearings [AMENDED]

AUTHORITY:
The Director of the Office of Management and Enterprise Services; 62 O.S. §34.3.1, 62 O.S. §34.6(8)

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
November 25, 2020

COMMENT PERIOD:
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ADOPTION:
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LEGISLATIVE APPROVAL:
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SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
Clarify language, eliminate obsolete language, correct omissions and streamline to promote and enhance operations, through removal of inaccurate or redundant verbiage, and to simplify language.

The rules and regulations are necessary to promote and enhance effective operation of the Employees Group Insurance Division. It is proposed that the rules and regulations be amended. The effect of the amended rules is to provide for the continued efficiency, responsiveness, the correction of citations and scrivener's errors, and changes to improve the clarity of the rules.

CONTACT PERSON:
Byron Knox, Deputy General Counsel, (405) 717-8744

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 5. GRIEVANCE PANEL PROCEDURES

260:45-5-1. Request for hearing

(a) Grievances. EGID has established procedures by which:
(1) Independent Review Organizations shall act as an appeals body for complaints by insured members regarding adverse benefit determinations based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit,

(2) A three [3] member Grievance Panel shall act as an appeals body for complaints by insured members regarding all other issues.

(b) Court Administrator Appointees. The Court Administrator shall designate Grievance Panel members as shall be necessary. The members of the Grievance Panel shall consist of two [2] Attorneys licensed to practice law in this state and one [1] state licensed health care professional or health care administrator who has at least three [3] years practical experience, has had or has admitting privileges to a State of Oklahoma hospital, has a working knowledge of prescription medication, or has worked in an administrative capacity at some point in their career.

(c) Governor Appointees. The state health care professional shall be appointed by the Governor. At the Governor's discretion, one or more qualified individuals may also be appointed as an alternate to serve on the Grievance Panel in the event the Governor's primary appointee becomes unable to serve.

(d) Right to a Hearing. Any covered member who has exhausted EGID's internal review procedures and has timely requested in writing a hearing before the Grievance Panel pursuant to 260:45-5-1(a)(2) shall receive a hearing in person or through licensed counsel before the panel.

(e) Remedy. Grievance procedures conducted by the three [3] member Grievance Panel shall be subject to the Oklahoma Administrative Procedures Act, including provisions thereof for review of agency decisions by the district court.

(f) Failure to timely submit hearing request. All Grievance Panel requests must be filed within sixty [60] days from the date the member is notified that the member's claim, benefit, coverage, or other matter has been denied and that EGID's internal review procedures have been exhausted. After more than sixty [60] days from the date the member was first notified that the member's claim, benefit, coverage, or other matter has been denied and that EGID's internal review procedures have been exhausted, the matter shall be deemed finally resolved.

(g) Aggrieved member covered by an HMO. Any member covered by an HMO is entitled to a hearing before the Panel in the same manner as all other covered members for those matters not covered by an Independent Review Organization. The member must exhaust the HMO's internal grievance procedure, except for an emergency or if the HMO fails to timely respond, before requesting a Grievance Panel hearing. The member must file, along with his request for hearing, a written certification from the HMO that the member has exhausted said procedure, or a detailed explanation of the emergency or of the HMO's failure to respond.

(h) Submission of Grievance request. Any Grievance request shall be in writing on a form provided by EGID for such purpose or in writing by the employee if in substantial compliance with the form and shall contain the following information:
(1) Name of employee, Social Security Number and address;
260:45-5-8. Scheduling of hearings  
All requests for hearings assigned to the three [3] member Grievance Panel shall be presented to, and heard by the Grievance Panel in open court within sixty [60] days of receipt of a properly submitted written request. The Request for Grievance Panel Hearing form unless the matter is: settled by agreement of the parties; or the Panel orders a continuance for good cause shown.

[OAR Docket #21-422; filed 6-14-21]  

TITLE 260. OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES  
CHAPTER 50. EMPLOYEES GROUP INSURANCE DIVISION - HEALTH, DENTAL, VISION AND LIFE PLANS  

[OAR Docket #21-423]

RULEMAKING ACTION:  
PERMANENT final adoption  

RULES:  
Subchapter 1. Purpose and Definitions  
260:50-1-2. Definitions [AMENDED]  
Subchapter 3. Administration of Plans  
260:50-3-2. Approval of exceptional claims and eligibility matters [AMENDED]  
260:50-3-18. Eligibility criteria for disabled dependent over the age of twenty-six [26] [AMENDED]  
260:50-3-19. Termination of dependent coverage [AMENDED]  
Subchapter 5. Coverage and Limitations  
Part 3. HealthChoice Plans  
260:50-5-2. Schedule of benefits and benefit administration procedures or guidelines as adopted by EGID [AMENDED]  

AUTHORITY:  
The Director of the Office of Management and Enterprise Services; 62 O.S. §34.3.1; 62 O.S. §34.68.  

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:  
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SUPERSEDED EMERGENCY ACTIONS:  
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Subchapter 1. Purpose and Definitions  
260:50-1-2. Definitions [AMENDED]  

Gubernatorial approval:  
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38 Ok Reg 549  

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21-35  

INCORPORATIONS BY REFERENCE:  
n/a  

GIST/ANALYSIS:  
260:50-1-2. This rule is necessary to avoid serious prejudice to the public interest and to avoid violation of federal law or regulation or other state law. It will ensure that rural hospitals within the State that are CMS approved, but not accredited by a nationally recognized accrediting organization, continue to be reimbursed as a HealthChoice provider as required by the federal Affordable Care Act. It will also ensure that acute care facilities that are not CMS approved, but are accredited by a nationally recognized accrediting organization, will be reimbursed as a HealthChoice provider as required by the federal Affordable Care Act. Current rules require that eligible HealthChoice providers be both CMS approved and accredited by a nationally recognized accrediting organization. 

Clarify language, eliminate obsolete language, correct omissions and streamline to promote and enhance operations, through removal of inaccurate or redundant verbiage, and to simplify language. The rules and regulations are necessary to promote and enhance effective operation of the Employees Group Insurance Division. It is proposed that the rules and regulations be amended. The effect of the amended rules is to provide for the continued efficiency, responsiveness, the correction of citations and scrivener's errors, and changes to improve the clarity of the rules. 

CONTACT PERSON:  
Byron Knox, Deputy General Counsel, (405) 717-8744  

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:  

SUBCHAPTER 1. PURPOSE AND DEFINITIONS  

260:50-1-2. Definitions  
The following words and terms as defined by EGID, when used in this chapter, shall have the following meaning, unless the content clearly indicates otherwise:  

"Administrative error" occurs when the coverage elections the member makes are not the same as those entered into payroll for deduction from the member's paycheck. This does not include untimely member coverage elections or member misrepresentation. When such an administrative error results in underpaid premiums, full payment to EGID shall be required.
before coverage elected by the member can be made effective. If overpayment occurs, EGID shall refund overpaid funds to the appropriate party.

"Administrator" means the Administrator of the Employees Group Insurance Division or a designee.

"Allowable fee" means the maximum allowed amount based on the HealthChoice Network Provider Contracts payable to a provider by EGID and the member for covered services.

"Attorney representing EGID" means any attorney designated by the Administrator to appear on behalf of EGID.

"The Board" means the seven [7] Oklahoma Employees Insurance and Benefits Board members designated by statute [74 O.S. §1303(1)].

"Business Associate" shall have the meaning given to "Business Associate" under the Health Insurance Portability and Accountability Act of 1996, Privacy Rule, including, but not limited to, 45 CFR §160.103.

"Carrier" means the State of Oklahoma.

"Comprehensive benefits" means benefits which reimburse the expense of facility room and board, other hospital services, certain out-patient expenses, maternity benefits, surgical expense, including obstetrical care, in-hospital medical care expense, diagnostic radiological and laboratory benefits, providers' services provided by house and office calls, treatments administered in providers' office, prescription drugs, psychiatric services, Christian Science practitioners' services, Christian Science nurses' services, optometric medical services for injury or illness of the eye, home health care, home nursing service, hospice care such other benefits as may be determined by EGID. Such benefits shall be provided on a copayment or coinsurance basis, the insured to pay a proportion that applies to all or part of the benefits as determined by EGID. [74 O.S. §1303 (14)]

"Cosmetic procedure" means a procedure that primarily serves to improve appearance.

"Current employee" means an employee in the service of a participating entity who receives compensation for services actually rendered and is listed on the payrolls and personnel records of said employer, as a current and present employee, including employees who are otherwise eligible who are on approved leave without pay, not to exceed twenty-four [24] months. An education employee absent from employment, not to exceed eight [8] years, because of election or appointment as local, state, or national education association officer who is otherwise eligible prior to taking approved leave without pay will be considered an eligible, current employee. A person elected by popular vote will be considered an eligible employee during his tenure of office. Eligible employees are defined by statute. [74 O.S. §1303 and §1315]

"Custodial care" means treatment or services regardless of who recommends them or where they are provided, that could be given safely and reasonably by a person not medically skilled. These services are designed mainly to help the patient with daily living activities. These activities include but are not limited to: personal care as in walking, getting in and out of bed, bathing, eating by spoon, tube or gastrostomy, exercising, dressing, using toilet, preparing meals or special diets, moving the patient, acting as companion or sitter, and supervising medication which can usually be self-administered.

"Dependent" means the primary member's spouse (if not legally separated by court order), including common-law. Dependents also include a member's daughter, son, stepdaughter, stepson, eligible foster child, adopted child, child for whom the primary member has been granted legal guardianship or child legally placed with the primary member for adoption up to the child's twenty-sixth [26th] birthday. In addition other unmarried children up to age twenty-six [26] may be considered dependents if the child lives with the member and the member is primarily responsible for the child's support. A child that meets the definition of a disabled dependent in this section and also all requirements in 260:50-3-18, may also be covered regardless of age if the child is incapable of self-support because of mental or physical incapacity that existed prior to reaching age twenty-six [26]. Coverage is not automatic and must be approved with a review of medical information. A dependent deemed disabled by Social Security does not automatically mean that this disabled dependent will meet the Plan requirements. [74 O.S. §1303(14)]. See additional eligibility criteria for disabled dependents over the age of twenty-six [26] at 260:50-3-18. Participating employer groups may have a more restrictive definition of Dependent.

"Durable medical equipment" means medically necessary equipment, prescribed by a provider, which serves a therapeutic purpose in the treatment of an illness or an injury. Durable medical equipment is for the exclusive use of the afflicted member and is designed for prolonged use. Specific criteria and limitations apply.

"Eligible Provider" means a practitioner who or a facility that is recognized by EGID as eligible for reimbursement. EGID reserves the right to determine provider eligibility for network and non-Network reimbursement.

"Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd e(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

"Enrollment period" means the time period in which an individual may make an election of coverage or changes to coverage in effect.

"Excepted Benefits" means the four categories of benefits as established in section 2791 of the PHS Act, section 733 of ERISA and section 9832 of the Internal Revenue Code, as summarized in IRS Bulletin 2015-14 and subsequent regulatory guidance. These Excepted Benefits include but are not limited to vision coverage, dental coverage, long-term care insurance, Medicare supplement coverage, automobile
liability insurance, workers compensation, accidental death and dismemberment insurance and specific disease coverage (such as cancer).

"Facility" means any organization as defined by EGID which is duly licensed under the laws of the state of operation, and also either Medicare certified as applicable, or accredited by a CMS approved Medicare accreditation organization.

"Fee schedule" means a listing of one or more allowable fees.

"Former participating employees and dependents" means eligible former employees who have elected benefits within thirty [30] days of termination of service and includes those who have retired, or vested through an eligible State of Oklahoma retirement system, or who have completed the statutory required years of service, or who have other coverage rights through Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Oklahoma Personnel Act. An eligible dependent is covered through the participating former employee or the dependent is eligible as a survivor or has coverage rights through COBRA.

"Health information" means any information, whether oral or recorded in any form or medium: (1) that relates to the past, present or future physical or mental condition of a member; the provision of health care to a member; or the past, present or future payment for the provision of health care to a member; and (2) that identifies the member or with respect to which there is a reasonable basis to believe the information can be used to identify the member.

"Home health care" means a plan of continued care of an insured person who is under the care of a provider who certifies that without the Home health care, confinement in a hospital or skilled nursing facility would be required. Specific criteria and limitations apply.

"Hospice care" means a concept of supportive care for terminally ill patients. Treatment focuses on the relief of pain and suffering associated with a terminal illness. Specific criteria and limitations apply.

"Inaccurate or erroneous information" means materially erroneous, false, inaccurate, or misleading information that was intentionally submitted in order to obtain a specific coverage.

"Initial enrollment period" means the first thirty [30] days following the employee's entry-on-duty date. A group initial enrollment period is defined as the thirty [30] days following the enrollment date of the participating entity.


"Maintenance care" means there is no measurable progress of goals achieved, no skilled care required, no measurable improvement in daily function or self-care, or no change in basic treatment or outcome.

"Medically necessary" means services or supplies which are provided for the diagnosis and treatment of the medical and/or mental health/substance abuse condition and complies with criteria adopted by EGID. Direct care and treatment are within standards of good medical practice within the community, and are appropriate and necessary for the symptoms, diagnosis or treatment of the condition. The services or supplies must be the most appropriate supply or level of service, which can safely be provided. For hospital stays, this means that inpatient acute care is necessary due to the intensity of services the member is receiving or the severity of the member's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The services or supplies cannot be primarily for the convenience of the member, caregiver, or provider. The fact that services or supplies are medically necessary does not, in itself, assure that the services or supplies are covered by the Plan.

"Members" means all persons covered by one or more of the group insurance plans offered by EGID including eligible current and qualified former employees of participating entities and their eligible covered dependents.

"Mental health and substance abuse" means conditions including a mental or emotional disorder of any kind, organic or inorganic, and/or alcoholism and drug dependency.

"Network provider" means a practitioner who or facility that is duly licensed or operates under the laws of the state in which the "Network provider" operates, satisfies credentialing criteria as established by EGID, and has entered into a contract with EGID to accept scheduled reimbursement for covered health care services and supplies provided to members.

"Non-Network out-of-pocket" means the member's expenses include the total of the member's deductibles and co-insurance costs plus all amounts that continue to be charged by the non-Network provider after the HealthChoice allowable fees have been paid.

"OEIBB" means Oklahoma Employees Insurance and Benefits Board.

"Open enrollment period" means a limited period of time as approved by either EGID or the Legislature in which a specified group of individuals are permitted to enroll.

"Option period" means the time set aside at least annually by EGID in which enrolled plan members may make changes to their enrollments. Eligible but not enrolled employees may also make application for enrollment during this time. Enrollment is subject to approval by EGID.

"Orthodontic limitation" means an individual who enrolls in the Dental Plan will not be eligible for any orthodontic benefits for services occurring within the first twelve [12] months after the effective date of coverage. Continuing orthodontic services for newly hired employees who had previous group dental coverage will be paid by prorating or according to plan benefits.

"Other hospital services and supplies" means services and supplies rendered by the hospital that are required for treatment, but not including room and board nor the professional services of any provider, nor any private duty, special or intensive nursing services, by whatever name called, regardless of whatever such services are rendered under the direction of the hospital or otherwise.

"Participating entity" means any employer or organization whose employees or members are eligible to be participants in any plan authorized by or through the Oklahoma Employees Insurance and Benefits' Act.
"The Plan or Plans" means the self-insured Plans by the State of Oklahoma for the purpose of providing health benefits to eligible members and may include such other benefits as may be determined by EGID. Such benefits shall be provided on a coinsurance basis and the insured pays a proportion of the cost of such benefits.

"Primary insured" means the member who first became eligible for the insurance coverage creating eligibility rights for dependents.

"Prosthetic appliance" means an artificial appliance that replaces body parts that may be missing or defective as a result of surgical intervention, trauma, disease, or developmental anomaly. Said appliance must be medically necessary.

"Provider" means a physician or other practitioner who or facility that who is duly licensed or certified operates under the laws of the state in which the Provider practices and is recognized by this Plan, to render health and dental care services and/or supplies.

"Qualifying Event" means an event that changes a member's family or health insurance situation and qualifies the member and/or dependent for a special enrollment period. The most common qualifying life events are the loss of health care coverage, a change in household (such as marriage or birth of a child), or a change of residence or other federally required mandates. A complete summary of qualifying events are set out in Title 26, Treasury Regulations, Section 125.

"Schedule of benefits" means the EGID plan description of one or more covered services.

"Skilled care" means treatment or services provided by licensed medical personnel as prescribed by a provider. Treatment or services that could not be given safely or reasonably by a person who is not medically skilled and would need continuous supervision of the effectiveness of the treatment and progress of the condition. Specific criteria and limitations are applied.

SUBCHAPTER 3. ADMINISTRATION OF PLANS

260:50-3-2. Approval of exceptional claims and eligibility matters

The Administrator shall have the authority to approve individual exceptional claims or eligibility matters when circumstances require. The Administrator shall provide a regular report on exceptional claims approved to the Board or a committee designated by the Board.

260:50-3-18. Eligibility criteria for disabled dependent over the age of twenty-six [26]

Eligibility criteria for covering a disabled dependent beyond the age of twenty-six [26] pursuant to 74 O. S. §1303(14) are as follows, provided all other eligibility requirements are also satisfied:

(1) It is intended that the following dependents beyond the age of twenty-six [26] are eligible for coverage under this provision:

(A) An individual who has been medically determined to be incapable of self-support because of mental or physical incapacity that currently exists and has continuously existed since before reaching the age of twenty-six [26] years; and

(B) The individual resides in the primary member's home at least six [6] months of the year, and is the primary member's natural child, foster child, adopted child, or a child of the primary member's spouse when the spouse has been ordered by a Court to provide health insurance for the child; and

(C) If the requirements of subsection (A) and (B) are met, eligibility through court appointed guardianship will be accepted for disabled children, foster children and grandchildren, but only when guardianship existed prior to the dependent reaching age nineteen [19]. The assessment/application for coverage must be submitted within thirty [30] days of obtaining legal guardianship. Power of attorney, including durable power of attorney, does not qualify as guardianship. Coverage ceases at the end of the month in which the primary member's appointment as guardian is terminated.

(D) An approved disabled dependent who has been medically determined to be incapable of self-support because of mental or physical incapacity that currently exists and has continuously existed since before reaching the age of twenty-six [26] years can only be added to coverage within thirty [30] days of a qualifying event. While changes to coverage (benefits or plan options) may be made during the annual Option Period, enrollment of a disabled dependent will not be considered without a qualifying event.

(2) Other criteria required for disabled dependent status are:

(A) For a primary member who is a new hire or a re-hire, assessment/application for disabled dependent status must be completed and submitted to EGID within thirty [30] days of primary member's initial enrollment. As stated above, the disabled dependent must have been medically determined to be incapable of self-support because of mental or physical incapacity that currently exists and has continuously existed since before reaching the age of twenty-six [26] years.

(B) Primary members must submit a copy of their federal and/or state income tax returns for the prior year reflecting their support of the dependent.

(C) Dependents are eligible only for the coverage in which the primary insured is enrolled. Only dependent life insurance can be carried by both parents if each is a primary member under the plan; and

(D) Primary members must apply for disabled dependent status for an eligible individual who has been medically determined to be incapable of self-support because of mental or physical incapacity that currently exists and has continuously existed since before reaching the age of twenty-six [26] years at least
Permanent Final Adoptions


(3) Disabled dependent status must be continued for a minimum of one [1] year. If the dependent having the disabled status is dropped from coverage, the primary member may not reapply for disabled dependent status for the dependent for a period of twelve [12] months. The twelve [12] month requirement does not apply when the dependent has lost other group coverage.

260:50-3-19. Termination of dependent coverage

(a) Waiting period of twelve [12] months. If coverage is discontinued for dependents, the employee cannot reapply for the discontinued coverage for any dependents again for at least twelve [12] months. Reinstated coverage shall be subject to penalty for orthodontic limitations.

(b) Loss of other group health, dental, vision or life insurance coverage. The twelve [12] month requirement does not apply when the dependent has lost other group health, dental, vision and/or group life insurance coverage and is seeking reinstatement pursuant to Rule 260:50-3-17(8). Excepted Benefits do not qualify as other health coverage for purposes of this rule.

(c) Dependent reaches age twenty-six [26]. Coverage will be terminated for dependents reaching age twenty-six [26] on the first [1st] day of the month following their twenty-sixth [26th] birthday, except disabled dependents who are incapable of self-support and who have been deemed eligible for coverage by EGID.

SUBCHAPTER 5. COVERAGE AND LIMITATIONS

PART 3. HEALTHCHOICE PLANS

260:50-5-2. Schedule of benefits and benefit administration procedures or guidelines as adopted by EGID

All benefits for HealthChoice plans offered through EGID as described in the rules in this title shall be paid according to the handbooks, schedule of benefits and benefit administration procedures or guidelines as adopted by EGID. The schedule of benefits and benefit administration procedures or guidelines as adopted by EGID shall be available for inspection by the public during regular office hours at 3545 N. W. 58, Suite 600, Oklahoma City, Oklahoma 73112-OMES EGID, 2401 N. Lincoln Boulevard, Suite 300, Oklahoma City, OK 73105.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

[OAR Docket #21-378]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

317:2-1-2 [AMENDED]
317:2-1-2.5 [AMENDED]
317:2-1-13 [AMENDED]
317:2-1-14 [AMENDED]

(Reference APA WF # 20-19A)

AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:

December 22, 2020

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Superseded rules:

317:2-1-2 [AMENDED]
317:2-1-2.5 [AMENDED]
317:2-1-13 [AMENDED]
317:2-1-14 [AMENDED]

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38 Ok Reg 401

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20-1090

(Reference APA WF # 20-19A)

INCORPORATIONS BY REFERENCE:

n/a

GIST/ANALYSIS:
The proposed revisions replace incorrect rule section references with the appropriate references. Additionally, revisions will remove appeals language for programs that no longer exist and will identify the appropriate appeal form to fill out when filing an appeal. Finally, revisions will include minor cleanup to fix grammatical and formatting errors.

CONTACT PERSON:
Sandra Puebla, Director of Federal and State Authorities, 405-522-7270, Sandra.Puebla@okhca.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(S) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

317:2-1-2. Appeals
(a) Request for appeals.
(1) For the purpose of calculating the timeframe for requesting an administrative appeal of an agency action, the date on the written notice shall not be included. The last day of the timeframe shall be included, unless it is a legal holiday as defined by Title 25 of the Oklahoma Statutes (O.S.) Section (§) 82.1, or any other day the Oklahoma Health Care Authority (OHCA) is closed or closes early, in which case, the timeframe runs until the close of the next full business day.
(2) An appeals request that an aggrieved member or provider sends via mail is deemed filed on the date that the agency receives it.

(b) Member process overview.
(1) The appeals process allows a member to appeal a decision relating to program benefits. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.
(2) In order to initiate an appeal, the member must file a LD-1 (Member Complaint/Grievance Form) within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with Oklahoma Administrative Code (OAC) 317:2-1-2(a), above, or, in matters in which a formal notice is not sent by the agency, within thirty (30) days of the date on which the member knew or should have known the facts or circumstances serving as the basis for appeal.
(3) If the LD-1 form is not received timely, the administrative law judge (ALJ) will cause to be issued a letter stating the appeal will not be heard. In the case of tax warrant intercept appeals, if the LD-1 form is not received by OHCA within the timeframe pursuant to 68 O.S. § 205.2, OHCA similarly will cause to be issued a letter stating the appeal will not be heard because it is untimely.
(4) If the LD-1 form is not completely filled out or if necessary documentation is not included, then the appeal will not be heard.
(5) OHCA will advise members that if assistance is needed in reading or completing the grievance form, arrangements will be made to provide such assistance.
(6) Upon receipt of the member's appeal, a fair hearing before the ALJ will be scheduled. The member will be notified in writing of the date and time of the hearing. The member must appear at the hearing, either in person or telephonically. Requests for a telephone hearing must be received in writing on OHCA's LD-4 (Request for Telephonic Hearing) form no later than ten (10) calendar days prior to the scheduled hearing date. Telephonic hearing requests will only be granted by the OHCA's chief executive officer (CEO) or his/her designee, at his/her sole discretion, for good cause shown, including, for example, the member's physical condition, travel distances, or other limitations that either preclude an in-person appearance or would impose a substantial hardship on the member.
(7) The hearing shall be conducted according to OAC 317:2-1.5. The ALJ's decision may be appealed to the CEO of the OHCA, which is a record review at which the parties do not appear (OAC 317:2-1-13).

(8) Member appeals are ordinarily decided within ninety (90) days from the date on which the member's timely request for a fair hearing is received, unless:
(A) The appellant was granted an expedited appeal pursuant to OAC 317:2-1-2.5;
(B) The OHCA cannot reach a decision because the appellant requests a delay or fails to take a required action, as reflected in the record;
(C) There is an administrative or other emergency beyond OHCA's control, as reflected in the record; or
(D) The appellant filed a request for an appeal of a denied step therapy exception request, pursuant to OAC 317:2-1-18.

(9) Tax warrant intercept appeals will be heard directly by the ALJ. A decision is normally rendered by the ALJ within twenty (20) days of the hearing before the ALJ.

(c) Provider process overview.
(1) The proceedings as described in this subsection contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(d)(2).
(2) All provider appeals are initially heard by the OHCA ALJ under OAC 317:2-1-2(d)(2).

(A) In order to initiate an appeal, a provider must file the appropriate LD form within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with OAC 317:2-1-2(a), above. LD-2 forms should be used for Program Integrity audit appeals; LD-3 forms are used for all other provider appeals.
(B) Except for OHCA Program Integrity audit appeals, if the appropriate LD form is not received timely, the ALJ will cause a letter to be issued stating that the appeal will not be heard.
(C) A decision ordinarily will be issued by the ALJ within forty-five (45) days of the close of all evidence in the appeal.
(D) Unless otherwise limited by OAC 317:2-1-7 or 317:2-1-13, the ALJ's decision is appealable to OHCA's CEO.

(d) ALJ Jurisdiction. The ALJ has jurisdiction of the following matters:
(1) Member appeals.
(A) Discrimination complaints regarding the SoonerCare program;
(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;
(C) Fee-for-service appeals regarding the furnishing of services, including prior authorizations;
(D) Appeals which relate to the tax warrant intercept system through the OHCA. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the ALJ within twenty (20) days of the hearing;
(E) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative
sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within twenty (20) days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;

(F) Appeals which relate to eligibility determinations made by OHCA;

(G) Appeals of insureds participating in Sure Oklahoma which are authorized by OAC 317:45-9-8; and

(H) Appeals which relate to a requested step therapy protocol exception as provided by 63 O.S. § 7310.

(2) Provider appeals.

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to disenroll member from provider's Soonercare Choice panel;

(C) Appeals by long-term care facilities for administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5)(B) and (d)(8);

(D) Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to Title 74 O.S. § 85.1 et seq.;

(E) Drug rebate appeals;

(F) Provider appeals of OHCA Program Integrity audit findings pursuant to OAC 317:2-1-17. This is the final and only appeals process for appeals of OHCA Program Integrity audit findings;

(G) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives;

(H) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, supplemental payment, fees or penalties as specifically provided in OAC 317:2-1-15; and

(I) The Nursing Facility Supplemental Payment Program (NFSPP) and its issues consisting of the amount of each component of the intergovernmental transfer, the Upper Payment Limit payment, the Upper Payment Limit Gap, and the penalties specifically provided in OAC 317:30-5-136. This is the final and only process for appeals regarding NFSPP; and

(J) Appeals from any adjustment made to a long-term care facility's cost report pursuant to OAC 317:30-5-132, including any appeal following a request for reconsideration made pursuant to OAC 317:30-5-132.1.

317:2-1-2.5. Expedited appeals

(a) An Appellant may request an expedited hearing, if the time otherwise permitted for a hearing as described in Oklahoma Administrative Code (OAC) 317:2-1-2(ab)(8) could jeopardize the Appellant's life or health or ability to attain, maintain, or regain maximum function. Any request for expedited consideration should be made to the Administrative Law Judge (ALJ), with a copy to the Oklahoma Health Care Authority (OHCA) Legal division and shall be ruled upon within three (3) working days of the date of the request. The request shall specify the reason for the appeal and the specific basis for the Appellant's assertion that a delay will jeopardize the Appellant's life or health.

(b) If the ALJ determines that an expedited hearing is warranted, he or she shall:

1. Schedule the matter for hearing pursuant to OAC 317:2-1-5. Telephonic hearings may be scheduled as appropriate under the particular facts of the case; and

2. Issue a preliminary or final decision as expeditiously as possible, but no later than three (3) working days the close of the expedited hearing.

(c) If the ALJ determines that the request does not meet the criteria for expedited consideration, he or she shall:

1. Schedule the appeal for hearing within the ordinary timeframe, in accordance with OAC 317:2-1-2(ab)(8); and

2. Notify the Appellant of the denial orally or through a written notice as described in OAC 317:35-5-66. If oral notification is provided, the ALJ shall issue a written notification within three (3) calendar days of the denial.

317:2-1-13. Appeal to the chief executive officer

(a) The Oklahoma Health Care Authority offers approximately forty (40) different types of administrative appeals. Some of the appeals are appealable to the chief executive officer (CEO) and some are not. The following appeals may be heard by the CEO following the decision of an administrative law judge:

1. Appeals under Oklahoma Administrative Code (OAC) 317:2-1-2(d)(1)A to (d)(1)H, with the exception of subsection (d)(1)E; and

2. Appeals under OAC 317:2-1-2(d)(2)A to (d)(2)L, with the exceptions of subsections (d)(2)F and (G) (d)(2)(A), (E), (F), (G), and (I); and

3. Appeals under 317:2-1-10.

(b) Appeals to the CEO must be filed with the OHCA within thirty (30) days of the date of the Order, or decision by OHCA.

(c) No new evidence may be presented to the CEO.

(d) Appeals to the CEO under (a) of this Section may be filed by the provider, member, or agency. The CEO will ordinarily render decisions within sixty (60) days of the receipt of the appeal.

317:2-1-14. Contract award protest process

Suppliers who respond to a solicitation issued and awarded by the Authority pursuant to 74 Oklahoma Statutes (O.S.) § 85.5 (TN) may protest the award of a contract under such solicitation.

1. A supplier shall submit written notice to the OHCA Legal Division of a protest of an award of a contract by OHCA within ten (10) business days of contract award. The protest shall state supplier facts and reasons for protest.

Oklahoma Register (Volume 38, Number 23) 960 August 16, 2021
(2) The OHCA Legal Division shall review the supplier's protest and contract award documents. Written notice of the decision to sustain or deny the supplier's protest will be sent to the supplier within ten (10) business days of receipt of supplier's written notice.

(3) If the OHCA Legal Division denies the supplier's protest, the supplier may request a hearing to administratively resolve the matter within thirty (30) calendar days of receipt of the written denial by filing a form LD-2LD-3 with the Docket Clerk.

(4) The process afforded the supplier will be the process found at Oklahoma Administrative Code 317:2-1-2(c).

(5) The Administrative Law Judge's decision will constitute the final administrative decision of the Oklahoma Health Care Authority.

[OAR Docket #21-378; filed 6-14-21]

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**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**

**CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS**

[OAR Docket #21-377]

**RULEMAKING ACTION:**

PERMANENT final adoption

**RULES:**

317:2-1-2.6 [NEW]

(Reference APA WF # 20-05)

**AUTHORITY:**

The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board; 42 C.F.R. Section 431.230

**SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:**

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Superseded rules:

317:2-1-2.6 [NEW]

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20-571

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**INCORPORATIONS BY REFERENCE:**

n/a

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**GIST/ANALYSIS:**

The proposed revisions will bring the agency into compliance with Section 431.230 of Title 42 of the Code of Federal Regulations by describing the conditions in which Medicaid benefits will continue or be reinstated pending an appeal. Additionally, the proposed new rule will describe the application, obligations, and implications for the appellant when Medicaid benefits are continued or reinstated pending an appeal.

**CONTACT PERSON:**

Sandra Puebla, Director of Federal and State Authorities, 405-522-7270, Sandra.Puebla@okhca.org.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:**

317:2-1-2.6. **Continuation of benefits or services pending appeal**

(a) In accordance with Section 431.230 of Title 42 of the Code of Federal Regulations, if an Appellant submits a written request for a hearing within ten (10) days of the notice of the adverse agency action, the Appellant may also request that existing benefits or services (hereinafter, collectively referred to as "services") be continued or reinstated until the earlier of dismissal of the appeal, Appellant's withdrawal of the appeal, or an initial hearing decision adverse to the Appellant.

(b) If the Appellant fails to indicate a preference as to continuation or reinstatement of services in a written request for hearing made within ten (10) days of the notice of the adverse agency action, services shall be continued or reinstated. Provided, however, that a SoonerCare member shall not be entitled to continuation or reinstatement of services pending an appeal related to the following:

(1) When a service is denied because the member has exceeded the limit applicable to that service;

(2) When a request for a prior authorization is denied for a prescription drug. However:

(A) The Oklahoma Health Care Authority (OHCA) may authorize a single seventy-two (72) hour emergency supply of the drug, in accordance with Oklahoma Administrative Code (OAC) 317:30-5-77.2;

(B) A SoonerCare provider may initiate a step therapy exception request on behalf of a member, in accordance with OAC 317:30-5-77.4;

(3) When coverage of a prescription drug or service is denied because the requested drug or service is not a category or class of drugs or services covered by OHCA;

(4) When coverage for a prescription drug is denied because the enrollee has been locked into one (1) pharmacy and the member seeks to fill a prescription at another pharmacy; or

(5) When a physician or other licensed health care practitioner has failed to prescribe or order the service or level of service for which continuation or reinstatement is requested;

(c) If services are continued or reinstated during the appeals process and the hearing is not decided in the Appellant's favor.
Permanent Final Adoptions

OHCA may seek to recover reimbursement of all services received pending the hearing decision.

[OAR Docket #21-377; filed 6-14-21]

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

[OAR Docket #21-379]

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PERMANENT final adoption

RULES:
Subchapter 7. Soonercare
Part 3. Enrollment Criteria
317:25-7-13 [AMENDED]
(Reference APA WF # 20-15A)

AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board; 42 CFR 440.130(d); Section 1115 of the Social Security Act; Oklahoma State Question 802 of 2019.

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38 Ok Reg 403

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20-1085

(Reference APA WF # 20-15A)

INCORPORATIONS BY REFERENCE:

n/a

GIST/ANALYSIS:
The proposed revisions support other agency rules, which propose to establish coverage of residential substance use disorder (SUD) treatment for Medicaid-eligible individuals and removes the eligibility exclusion of members in an institution for mental disease (IMD) under the Soonercare Choice program.

CONTACT PERSON:
Sandra Puebla, Director of Federal and State Authorities, 405-522-7270, Sandra.Puebla@okhca.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 7. SOONERCARE

PART 3. ENROLLMENT CRITERIA

317:25-7-13. Enrollment ineligibility
Members in certain categories are excluded from participation in the Soonercare Choice program. All other members may be enrolled in the Soonercare Choice program and subject to the provisions of this Subchapter. Members excluded from participation in Soonercare Choice include:
1. Individuals receiving services in a long-term care facility, in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or through a Home and Community Based Waiver;
2. Individuals in the former foster care children's group [see Oklahoma Administrative Code (OAC) 317:35-5-2];
3. Individuals in benefit programs with limited scope, such as Tuberculosis, Family Planning, or pregnancy only;
4. Non-qualified or ineligible aliens;
5. Children in subsidized adoptions;
6. Individuals who are dually-eligible for Soonercare and Medicare; and/or
7. Individuals who are in an Institution for Mental Disease (IMD); and/or
8. Individuals who have other creditable coverage.

[OAR Docket #21-379; filed 6-14-21]

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

[OAR Docket #21-392]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-5 [AMENDED]
(Reference APA WF # 20-29)

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n/a
GIST/ANALYSIS:
The proposed revisions put in policy the provider's requirement to refund any amount the provider collected from the member for copayment in error and/or collected after the family had reached its aggregate cost sharing maximum.
CONTACT PERSON:
Sandra Puebla, Director of Federal and State Authorities, 405-522-7270, Sandra.Puebla@okhca.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

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 Oklahoma Administrative Code (OAC) 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority (OHCA) 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 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 SoonerCare Choice contracts in the SoonerCare program.
(b) Assignment in fee-for-service. Oklahoma'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 co-payment required by the State Plan to be paid by the member and make no additional charges to the 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 member must not be billed and the member is not responsible for any balance except the amount indicated by OHCA. The only amount a member may be responsible for is a co-payment, or the member may be responsible for services not covered under the medical programs. In any event, the 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, Provider Services.
(3) When potential assignment violations are detected, the 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 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 SoonerCare Choice program must adhere to the rules of this subsection regarding assignment.
(1) If the service provided to the member is outside of the scope of the services outlined in the SoonerCare contract, then the provider may bill or seek collection from the member.
(2) If the service is in or out of the scope of the contracts referenced in (1) of this subsection, the OHCA shall be the final authority for this decision.
(3) Violation of this provision shall be grounds for a contract termination in the fee-for-service and SoonerCare programs.
(d) Cost sharing/co-payment. Section 1902(a)(14) of the Social Security Act permits states to require certain members to share some of the costs of SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. OHCA requires a co-payment of some SoonerCare members for certain medical services provided through the fee-for-service program. A co-payment is a charge which must be paid by the member to the service provider when the service is covered by SoonerCare. Section 1916(e) of the Act requires that a provider participating in the SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the co-payment. A person's assertion of their inability to pay the co-payment establishes this inability. This rule does not change the fact that a member is liable for these charges, and it does not preclude the provider from attempting to collect the co-payment.
(1) Co-payment is not required of the following members:
(A) Individuals under age twenty-one (21). Each member's date of birth is available on the REVS system or through a commercial swipe card system.
Permanent Final Adoptions

(B) Members in nursing facilities (NF) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

(C) Home and Community-Based Services (HCBS) waiver members except for prescription drugs.

(D) American Indian and Alaska Native members, per Section 5006 of the American Recovery and Reinvestment Act of 2009 and as established in the federally-approved Oklahoma Medicaid State Plan.

(E) Individuals who are categorically eligible for SoonerCare through the Breast and Cervical Cancer Treatment program.

(F) Individuals receiving hospice care, as defined in section 1905(o) of the Social Security Act.

(2) Co-payment is not required for the following services:

(A) Family planning services. This includes all contraceptives and services rendered.

(B) Emergency services provided in a hospital, clinic, office, or other facility.

(C) Services furnished to pregnant women, if those services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, including prenatal vitamins.

(D) Smoking and tobacco cessation counseling and products.

(E) Blood glucose testing supplies and insulin syringes.

(F) Medication-assisted treatment (MAT) drugs.

(3) Co-payments are required in an amount not to exceed the federal allowable for the following:

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

(C) Ambulatory surgery visits including free-standing ambulatory surgery centers.

(D) Encounters with the following rendering providers:

(i) Physicians;

(ii) Advanced practice registered nurses;

(iii) Physician assistants;

(iv) Optometrists;

(v) Home health agencies;

(vi) Certified registered nurse anesthetists;

(vii) Anesthesiologist assistants;

(viii) Durable medical equipment providers; and

(ix) Outpatient behavioral health providers.

(E) Prescription drugs.

(F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.

(4) Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of five percent (5%) of the family's income applied on a monthly basis, as specified by the agency.

(5) Providers will be required to refund any co-payment amounts the provider collected from the member in error and/or above the family's aggregate cost sharing maximum.

[OAR Docket #21-392; filed 6-14-21]

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

[OAR Docket #21-382]

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Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-25 [AMENDED]
(Reference APA WF # 20-11)

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n/a

GIST/ANALYSIS:
The proposed revisions comply will standardize the language in policy regarding the payment of Medicare deductibles, coinsurance, and copays between Medicare Part A, Part B, and Part C.

CONTACT PERSON:
Sandra Puebla, Director of Federal and State Authorities, 405-522-7270, Sandra.Puebla@okhca.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED
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**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 1. GENERAL SCOPE AND ADMINISTRATION**

317:30-3-25. **Crossovers (coinsurance and deductible)(deductibles, coinsurance, and copays)**

(a) **Medicare Part BA.** Payment is made for Medicare deductible and coinsurance, deductibles, coinsurance, and copays on behalf of eligible individuals according to the methodology outlined in the Oklahoma Medicaid State Plan.

(b) **Medicare Part AB.** Payment is made for Medicare deductible and coinsurance, deductibles, coinsurance, and copays on behalf of eligible individuals according to the methodology outlined in the Oklahoma Medicaid State Plan.

(c) **Medicare Advantage Plans.** Payment is made for Medicare HMO co-payments. For services offered by Medicare Advantage Plans that revert to traditional Medicare type benefits, payment is made for coinsurance and deductibles according to subsection (a) and (b) in this section.

(c) **Medicare Part C (Medicare Advantage Plans).** Payment is made for Medicare deductibles, coinsurance, and copays on behalf of eligible individuals according to the methodology outlined in the Oklahoma Medicaid State Plan.

[OAR Docket #21-382; filed 6-14-21]

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**

**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

[OAR Docket #21-380]

**RULEMAKING ACTION:**

PERMANENT final adoption

**RULES:**

Subchapter 3. General Provider Policies

Part 1. General Scope and Administration

317:30-3-31 [AMENDED]

Subchapter 5. Individual Providers and Specialties

Part 3. Hospitals

317:30-5-42.20 [NEW]

317:30-5-47 [AMENDED]

317:30-5-47.6 [NEW]

(Reference APA WF # 20-01)

**AUTHORITY:**

The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board

**SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:**

November 24, 2020

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 1. GENERAL SCOPE AND ADMINISTRATION**

317:30-3-31. **Prior authorization for health care-related goods and services**

(a) Under the Oklahoma SoonerCare program, there are health care-related goods and services that require prior authorization (PA) by the Oklahoma Health Care Authority (OHCA). PA is a process to determine if a prescribed good or service is medically necessary; it is not, however, a guarantee
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of member eligibility or of SoonerCare payment. All goods or services requiring PA will be authorized on the basis of information submitted to OHCA, including:

1. The relevant code, as is appropriate for the good or service requested (for example, Current Procedural Terminology (CPT) codes for services; Healthcare Common Procedure Coding System (HCPCS) codes, for durable medical equipment; or National Drug Codes (NDC), for drugs); and/or
2. Any other information required by OHCA, in the format as prescribed. The OHCA authorization file will reflect the codes that have been authorized.

(b) The OHCA staff will issue a determination for each requested good or service requiring a PA. The provider will be advised of that determination, either through the provider portal, or for requests made for out-of-state services, meals, mileage, transportation and lodging, by letter or other written communication. The member will be advised by letter. Policy regarding member appeal of a denied PA is available at Oklahoma Administrative Code (OAC) 317:2-1-2.

(c) The following is an inexhaustive list of the goods and services that may require a PA, for at least some SoonerCare member populations, under some circumstances. This list is subject to change, with OHCA expressly reserving the right to add a PA requirement to a covered good or service or to remove a PA requirement from a covered good or service.

1. Physical therapy for children;
2. Speech therapy for children;
3. Occupational therapy for children;
4. High Tech Imaging (for ex. CT, MRA, MRI, PET);
5. Some dental procedures, including, but not limited to orthodontics (orthodontics are covered for children only);
6. Inpatient psychiatric services;
7. Some prescription drugs and/or physician administered, and/or high-investment drugs;
8. Ventilators;
9. Hearing aids (covered for children only);
10. Prosthetics;
11. High risk OB (obstetrical) services;
12. Drug testing;
13. Enteral therapy (covered for children only);
14. Hyperalimentation;
15. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, supplies, or equipment that are determined to be medically necessary for a child or adolescent, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, regardless of whether such services, supplies, or equipment are listed as covered in Oklahoma's the Oklahoma Medicaid State Plan;
16. Adaptive equipment for persons residing in private Intermediate Care Facilities for Individuals with Intellectual Disabilities; intermediate care facilities for individuals with intellectual disabilities (ICF/IID);
17. Some ancillary services provided in a long term care hospital or in a long term care facility;
18. Rental of hospital beds, support surfaces, oxygen and oxygen related products, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts;
19. Allergy testing and immunotherapy;
20. Bariatric surgery;
21. Genetic testing;
22. Out-of-state services; and
23. Meals, travel, and lodging.

(d) Providers should refer to the relevant Part of OAC 317:30-5 for additional provider specific guidance on PA requirements. Providers may also refer to the OHCA Provider Billing and Procedure Manual, available on OHCA’s website, and the SoonerCare Medical Necessity Criteria for Inpatient Behavioral Health Services Manual to see how and where to submit PA requests, as well as to find information about documentation. Providers should refer to the provider-specific Part for PA requirements. For additional PA information and submission requests, providers may refer to the OHCA Provider Billing and Procedure Manual and the SoonerCare Medical Necessity Criteria for Inpatient Behavioral Health Services Manual available at https://okhca.org.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

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 the Oklahoma Health Care Authority (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 [refer to Oklahoma Administrative Code (OAC) 317:30-5-41].
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) In the event a member is admitted as an inpatient, but is determined to not qualify for an inpatient payment based on OHCA criteria, the hospital may bill on an outpatient claim for the ancillary services provided during that time.

(e) 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.
(f) Physical, occupational, and speech therapy services are covered when performed in an outpatient hospital-based setting. Coverage is limited to one (1) evaluation/re-evaluation visit (unit) per discipline per calendar year and fifteen (15) visits (units) per discipline per date of service per calendar year. Claims for these services must include the appropriate revenue code(s).

(g) Diabetes self-management training (DSMT), education and support (DSMES) services are provided to members diagnosed with diabetes. DSMT/DSMES services are comprised of one (1) hour of individual instruction (face-to-face encounters between the certified diabetes educator and the member) and nine (9) hours of group instruction on diabetes self-management. Members shall receive up to ten (10) hours of services during the first twelve (12) month period beginning with the initial training date. After the first twelve (12) month period has ended, members shall only be eligible for two (2) hours of individual instruction on DSMT/DSMES per calendar year. Refer to OAC 317:30-5-1080 through 317:30-5-1084 for specific provider and program requirements, and reimbursement methodology.

(h) For high-investment drugs, refer to OAC 317:30-5-4220.

317:30-5-4220. High-investment drugs - outpatient hospitals

(a) The Oklahoma Health Care Authority (OHCA) designates certain high-investment drugs to be reimbursed separately pursuant to the Oklahoma Medicaid State Plan for members receiving services at an outpatient hospital.

(b) The list of OHCA-designated high-investment drugs is set forth on the Pharmacy page of the OHCA website, which is available at https://okhca.org. This list may be updated as deemed necessary.

(c) All high-investment drugs require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31], and the outpatient hospital stay continues to be subject to applicable medical necessity criteria requirements [refer to OAC 317:30-3-1(ef)].

(d) OHCA-designated high-investment drugs provided to eligible members, when treated in out-of-state outpatient hospitals, may be reimbursed in the same manner as in-state hospitals. Out-of-state outpatient hospitals must meet applicable out-of-state conditions of payment set forth in OAC 317:30-3-89 through 317:30-3-92, and in the Oklahoma Medicaid State Plan.

317:30-5-47. Reimbursement for inpatient hospital services

Reimbursement will be made for inpatient hospital services in the following manner:

(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed the lesser of the billed charges or the Diagnosis Related Group (DRG) amount. In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if either the amount billed by the hospital or DRG payment, whichever applies, is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualifies for a cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met.

(2) The lesser of the billed charges or DRG amount and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:

(A) laboratory services;
(B) prosthesis and orthotic devices, including pacemakers, lenses, artificial joints, cochlear implants, implantable pumps;
(C) technical component on radiology services;
(D) transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;
(E) pre-admission diagnostic testing performed within seventy-two (72) hours of admission; and
(F) organ transplants.

(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(4) Covered inpatient services provided to eligible members of the Oklahoma—SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals. Refer to OAC 317:30-3-90 and 317:30-3-91.

(5) Cases which indicate transfer from one (1) acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.

(6) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer.

(7) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

(8) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed one hundred percent (100%) of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.

(9) New providers entering the SoonerCare program may be assigned a peer group and will be reimbursed at the peer group rate for the DRG payment methodology or the statewide median rate for per diem methods.
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(10) All inpatient services are reimbursed per the methodology described in this section and/or as approved under the Oklahoma Medicaid State Plan.

(11) For high-investment drugs, refer to OAC 317:30-5-47.6.

317:30-5-47.6. High-investment drugs - inpatient hospitals

(a) The Oklahoma Health Care Authority (OHCA) designates certain high-investment drugs to be reimbursed separately pursuant to the Oklahoma Medicaid State Plan for members receiving services at an inpatient hospital.

(b) The list of OHCA-designated high-investment drugs is set forth on the Pharmacy page of the OHCA website, which is available at https://okhca.org. This list may be updated as deemed necessary.

(c) All high-investment drugs require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31], and the inpatient hospital stay continues to be subject to applicable medical necessity criteria requirements [refer to OAC 317:30-3-1(f)].

(d) OHCA-designated high-investment drugs provided to eligible members, when treated in out-of-state inpatient hospitals, may be reimbursed in the same manner as in-state hospitals. Out-of-state inpatient hospitals must meet applicable out-of-state conditions of payment set forth in OAC 317:30-3-89 through 317:30-3-92, and in the Oklahoma Medicaid State Plan.

[OAR Docket #21-380; filed 6-14-21]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #21-381]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-34 [NEW]
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The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board; 21st Century Cures Act, codified at 42 U.S.C. Section 1396b(1)

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na

GIST/ANALYSIS:
The proposed revisions will comply with the 21st Century Cures Act which requires providers of personal care services to utilize an electronic visit verification (EVV) system where visit details are documented in real time. The revisions will require that certain details of the visit including the type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends are entered into the EVV system. Further revisions outline personal care provider requirements and claims reimbursement as it applies to EVV use.

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., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-34. Electronic visit verification (EVV) system

An EVV system is a telephone-based, computer-based, or other electronic-based system that verifies and documents the time and location of services requiring an in-home visit, including, but not limited to, self-directed services, in accordance with an approved prior authorization or individual plan of care, and pursuant to Title 42 of the United States Code, Section (§) 1396b(1).

(1) Verification requirements. An EVV system must verify the following for in-home or community services:
(A) Type of service performed (service code and any applicable modifier);
(B) Date of service;
(C) SoonerCare member identification number of the individual receiving the service;
(D) Unique vendor identification number for the individual providing the service (service provider);
(E) Location where service starts and ends; and
(F) Time the service starts and ends.

(2) **Services requiring EVV system use.** An EVV system must be used for personal care services, as defined by Oklahoma Administrative Code (OAC) 317:35-15-2.

(3) **Services not requiring EVV system use.** When services are provided through home and community-based waivers, EVV is not required if those services are provided in:

(A) Combination with community residential supports, per Oklahoma Administrative Code (OAC) 340:100-5-22.1;
(B) Combination with group home services, per OAC 340:100-6;
(C) Congregate settings where twenty-four (24) hour service is available; or
(D) Settings where the member and service provider live-in the same residence.

(4) **Provider requirements.** Providers are required to use an OHCA authorized and approved EVV system or aggregator. Providers may use the designated statewide EVV system, or their own EVV compliant system. A provider of personal care services using an EVV system must:

(A) Comply with all applicable federal and state laws and regulations, including, but not limited to, HIPAA privacy and security law, as defined in Section 3009 of the Public Health Service Act; required reporting of abused and/or neglected children, adolescents, and vulnerable adults [Section (§) 1-2-101 of Title 10A of the Oklahoma Statutes (O.S.) and 43A O.S. § 10-104]; and OAC 317:30-3-4.1, Uniform Electronic Transaction Act;
(B) Adopt internal policies and procedures regarding the EVV system;
(C) Ensure that employees are adequately trained on the EVV system's proper use, and make available to them real-time technical resources and support, such as a help desk or call center information;
(D) Ensure employees are adequately trained to properly engage the personal care agency's backup system when the EVV system is not available; and
(E) Ensure that the system:
   (i) Accommodates members and service providers with hearing, physical, or visual impairments;
   (ii) Accommodates multiple members and/or service providers in the same home or at the same phone number, as well as multiple work shifts per member per day;
   (iii) Supports the addition or deletion of members, service providers, and health care services, at any time during the month, as authorized by the OHCA and/or the Oklahoma Department of Human Services (OKDHS);
   (iv) Notifies supervisory staff at the personal care agency of any untimely or missed shifts, or any other deviation in scheduled care;
   (v) Documents the existence of and justification for all manual modifications, adjustments, or exceptions after the service provider has entered or failed to enter the information in paragraph (1), above; and
   (vi) Has the ability to respond to requests for records or documentation in the timeframe and format requested by OHCA;

(F) Be capable of retrieving current and archived data to produce summary reports of the information verified in Paragraph (1), above, as well as the information documented in (3)(E)(vi), above;

(G) Maintain reliable backup and recovery processes that ensure all data is preserved in the event of a system malfunction or disaster situation;

(H) Retain all data regarding the delivery of health care services for a minimum of six (6) years; and

(I) Establish a process to deactivate an employee's access to the EVV or designated system records upon termination of the designated employee's employment.

(5) **Claims reimbursement.** SoonerCare will not pay a claim for reimbursement unless the data is from an OHCA authorized and approved EVV system or aggregator; and includes all of the EVV verification requirements [refer to (1)(A through F) of this section]:

(A) Corresponds with the health care services for which reimbursement is claimed; and

(B) Is consistent with any approved prior authorization or individual plan of care.

(6) **Program integrity.** Paid claims may be subject to retrospective review and recoupment, as appropriate, in accordance with OAC 317:30-3-2.1.

(7) **Procedures for EVV system failure or EVV system unavailability.** The EVV system provides alternate backup solutions if the automated system is unavailable; however, in the event of the EVV system failure, the provider documents the specified data in paragraph (1), above, in accordance with internal backup policies and procedures. This documentation is sufficient to account for in-home services. The personal care agency's backup procedures are only permitted when the EVV system is unavailable. For complete EVV system outages, providers would need to enter the specified data in paragraph (1), above, via web claim once the system is back online.

[OAR Docket #21-381; filed 6-14-21]
Permanent Final Adoptions

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

[OAR Docket #21-397]

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RULES:
Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-57.1 [NEW]
317:30-3-60 [AMENDED]
Part 4. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program/Child-Health Services
317:30-3-65.5 [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-2 [AMENDED]
317:30-5-14.1 [AMENDED]
317:30-5-20 [AMENDED]
Part 3. Hospitals
317:30-5-41.2 [AMENDED]
317:30-5-42.18 [AMENDED]
Part 5. Pharmacies
317:30-5-72.1 [AMENDED]
Part 7. Certified Laboratories
317:30-5-105 [AMENDED]
Part 31. Room and Board Providers
317:30-5-321 [AMENDED]
Part 32. SoonerRide Non-Emergency Transportation (NEMT)
317:30-5-327.4 [AMENDED]
Part 33. Transportation by Ambulance
317:30-5-337 [AMENDED]
Part 63. Ambulatory Surgical Centers (ASC)
317:30-5-567 [AMENDED]
(Reference APA WF # 20-38)

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n/a

GIST/ANALYSIS:
The proposed revisions add guidelines for coverage of clinical trials, medical necessity criteria for coverage of routine care services during a clinical trial, and clarifying that experimental and investigational treatment is not covered. This rule change is necessary as OHCA receives requests to pay for services that are related to experimental treatment.

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., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-57.1. Clinical trials
(a) Definition. A clinical trial is a federally funded study that is either being conducted under an Investigational New Drug (IND) application or is exempt from having an IND application and helps to prevent, detect, or treat cancer or a life-threatening illness, injury, or disease.
(b) Medical necessity. Clinical trials must be determined to be medically necessary for the individual affected member. Documentation in the member's plan of care should support the medical necessity of the clinical trial for the affected individual member and that the clinical trial is for the medical purposes only. Requests for clinical trials in aid of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-3-1(f) for policy on medical necessity.
(c) Documentation/requirements. All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). An OHCA approved clinical trial must include the following:

(1) The clinical trial does one (1) of the following for the treatment of cancer or a life-threatening illness, injury, or disease:
   (A) Tests how to administer a health care service;
   (B) Tests responses to a health care service;
   (C) Compares effectiveness of a health care service;
   or
   (D) Studies new uses of a health care service.

(2) The clinical trial is approved and funded by one (1) of the following:
   (A) Research facilities that have an established peer review program that has been approved by the National Institutes of Health Center (NIH);
   (B) The Centers for Disease Control and Prevention;
   (C) The Agency for Health Care Research and Quality (AHRO);
   (D) The Centers for Medicare and Medicaid Services (CMS);
   (E) The United State Department of Veterans Affairs (VA);
(F) The United States Department of Defense (DOD);
(G) The Food and Drug Administration;
(H) The United States Department of Energy; or
(I) Research entities that meet the eligibility criteria for a support grant from a NIH center.

(3) Is conducted in a facility where the personnel have training and expertise needed to provide the type of care required and there is written protocol for the approved clinical trial;
(4) Complies with appropriate federal regulations regarding the protection of human subjects; and
(5) For full guidelines, please refer to www.okhca.org/mau.

d) Routine care costs.

(1) The following are included in routine care costs for approved clinical trials and by a SoonerCare contracted provider:
(A) Costs that are required for the administration of the investigational item or service and are not a covered benefit of the clinical trial;
(B) Costs regarding the appropriate monitoring of the effects from the item or service; and
(C) Costs that are necessary for the prevention, diagnosis or treatment of medical complications for a non-covered item or service that was provided in the clinical trial.

(2) The following are excluded from routine care costs in approved clinical trials:
(A) The investigational item or service;
(B) Items or services that the study gives for free;
(C) Items or services that are only utilized when determining if the individual is eligible for the clinical trial;
(D) Items or services that are used only for data collection or analysis;
(E) Evaluations that are designed to only test toxicity or disease pathology;
(F) Experimental, investigational, and unproven treatments or procedures and all related services provided outside of an approved clinical trial; and
(G) Any non-FDA approved drugs that were provided or made available to the member during the approved clinical trial will not be covered after the trial ends.

(3) Applicable plan limitations for coverage for out-of-network and out-of-state providers will apply to routine care costs in an approved clinical trial.
(4) Applicable utilization management guidelines will apply to routine care costs in an approval clinical trial.

e) Experimental and investigational. SoonerCare does not cover for medical, surgical, or other health care procedures, which are considered experimental or investigational in nature.

317:30-3-60. General program exclusions - children

(a) The following are excluded from 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.
(3) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.
(4) 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 members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(6) 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 experimental or investigational. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.
(9) Services of a Certified Surgical Assistant.
(10) Services of a Chiropractor.
(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 OKHCA Oklahoma Health Care Authority (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)-(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.

PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM/CHILD-HEALTH SERVICES

317:30-3-65.5. Diagnosis and treatment

When a screening indicates the need for further evaluation of an individual’s health, a referral for appropriate diagnostic studies or treatment services must be provided without delay. Diagnostic services are defined as those services necessary to fully evaluate defects, physical or behavioral health illnesses or conditions discovered by the screening.

(1) Health care, treatment, or other measures to correct or ameliorate defects, physical or mental illnesses or conditions must also be provided and will be covered by the EPSDT/OHCA Child Health Program as medically necessary. The defects, illnesses and conditions must have been discovered during the screening or shown to have increased in severity.

(2) Services, deemed medically necessary and allowable under federal Medicaid regulations, may be covered by the EPSDT/OHCA Child Health program even though those services may not be part of the Oklahoma Health Care Authority Medicaid program. However, such services must be prior authorized and must be allowable under federal Medicaid regulations.

(3) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3.57.1.

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) 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, but is not limited to, 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 (1) inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies.

(G) Physician services on an outpatient basis include:

(i) A maximum of four (4) visits per member per month, including primary care or specialty, with the exception of SoonerCare Choice members.

(ii) Additional visits are allowed per month for treatment related to emergency medical conditions and family planning services.

(H) Direct physician services in a nursing facility.

(i) A maximum of two (2) nursing facility visits per month are allowed; and if the visit(s) is for psychiatric services, it must be provided by a psychiatrist or a physician with appropriate behavioral health training.

(ii) To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the explanation of Medicare benefits (EOMB) showing denial and mark "carrier denied coverage."

(I) Diagnostic x-ray and laboratory services.

(J) Mammography screening and additional follow-up mammograms as per current guidelines.

(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, Oklahoma Department of Human Services (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 twenty-one (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 the insertion and/or
The appropriate contract on file.

The payment to a physician for medically necessary organ and tissue transplants are reviewed and authorized 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.

Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure. Donor expenses that occur after the ninety (90) day global reimbursement period must be submitted to the OHCA for review.

Total parenteral nutritional (TPN) therapy for identified diagnoses and when prior authorized.

Ventilator equipment.

Home dialysis equipment and supplies.

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.

Smoking and tobacco use cessation counseling for treatment of members 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 (8) sessions are covered per year per individual.

(iii) Smoking and tobacco use cessation counseling is a covered service when performed by physicians, physician assistants (PA), advanced registered nurse practitioners (ARNP), certified nurse midwives (CNM), dentists, Oklahoma State Health Department (OSDH) and Federally Qualified Health Center (FQHC) nursing staff, and maternal/child health licensed clinical social worker trained as a certified tobacco treatment specialist (CTTS). It is reimbursed in addition to any other appropriate global payments for obstetrical care,

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.

(Q) Laboratory testing.

(R) Payment for ultrasounds for pregnant women as specified in Oklahoma Administrative Code (OAC) 317:30-5-22.

(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.

(T) 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 signs off on the billed encounter;
(ii) Attending physician is present in the clinic/hospital setting and available for consultation; and
(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(U) Payment for services rendered by medical residents in an outpatient academic setting when the following conditions are met:

(i) The resident has obtained a medical license or a special license for training from the appropriate regulatory state medical board; and
(ii) Has the appropriate contract on file with the OHCA to render services within the scope of their licensure.

(V) The payment to a physician for medically directing the services of a certified registered nurse anesthetist (CRNA) or for the direct supervision of the services of an anesthesiologist assistant (AA) is limited. 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.

(W) Screening and follow up pap smears as per current guidelines.

(X) Medically necessary organ and tissue transplantation services for children and adults are covered services based upon the conditions listed in (i)-(v) of this subparagraph:

(i) All transplantation services, except kidney and cornea, must be prior authorized;
(ii) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;
(iii) All organ transplants must be performed at a Medicare-approved transplantation center;
(iv) Procedures considered experimental or investigational are not covered— and more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1; and
(v) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

(Y) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure. Donor expenses that occur after the ninety (90) day global reimbursement period must be submitted to the OHCA for review.

(Z) Total parenteral nutritional (TPN) therapy for identified diagnoses and when prior authorized.

(AA) Ventilator equipment.

(BB) Home dialysis equipment and supplies.

(CC) 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.

(DD) Smoking and tobacco use cessation counseling for treatment of members using tobacco.
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primary care provider (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 that addresses the 5A's and office note signature along with the member specific information addressed in the five (5) steps and the time spent by the practitioner performing the counseling. Anything under three (3) minutes is considered part of a routine visit and not separately billable.

(EE) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(FF) Genetic testing and other molecular pathology services are covered when medically necessary. Genetic testing may be considered medically necessary when the following conditions are met:

(i) The member displays clinical features of a suspected genetic condition, is at direct risk of inheriting the genetic condition in question (e.g., a causative familial variant has been identified) or has been diagnosed with a condition where identification of specific genetic changes will impact treatment or management; and

(ii) Clinical studies published in peer-reviewed literature have established strong evidence that the result of the test will positively impact the clinical decision-making or clinical outcome for the member; and

(iii) The testing method is proven to be scientifically valid for the identification of a specific genetically-linked inheritable disease or clinically important molecular marker; and

(iv) A medical geneticist, physician, or licensed genetic counselor provides documentation that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.

(2) General coverage exclusions include, but is not limited to, 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 (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Routine eye examinations for the sole purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of lenses, frames or visual aids.

(E) Pre-operative care within twenty-four (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 twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomies.

(I) Medical services considered experimental or investigational. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

(J) Payment for more than four (4) outpatient visits per member (home or office) per month, except visits in connection with family planning, services related to emergency medical conditions, or primary care services provided to SoonerCare Choice members.

(K) Payment for more than two (2) nursing facility visits per month.

(L) More than one (1) inpatient visit per day per physician.

(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.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(P) 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).

(Q) Speech and hearing services.

(R) Mileage.

(S) A routine hospital visit on the date of discharge unless the member expired.

(T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(U) Inpatient chemical dependency treatment.

(V) Fertility treatment.

(W) Payment for removal of benign skin lesions.

(X) Sleep studies.

(b) Children. Payment is made to physicians for medical and surgical services for members under the age of twenty-one (21) within the scope of the 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. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. 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 twenty-one (21) years of age must be prior authorized by an agency designated by the OHCA. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.
   (a) All inpatient 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) For out of state placements, refer to OAC 317:30-3-89 through 317:30-3-92.

2. **General Acute inpatient service limitations.** All general Acute inpatient hospital services for members under the age of twenty-one (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 twenty-one (21) years of age apply to all hospitals and residential psychiatric treatment facilities.

5. **Early and periodic screening diagnosis and treatment (EPSDT) program.** Payment is made to eligible providers for EPDST of members under age twenty-one (21). These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.12 for specific guidelines.

6. **Reporting suspected abuse and/or neglect.** Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, Section 1-2-101 of Title 10A of the Oklahoma Statutes and 43A O.S. § 10-104. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (OKDHS) hotline, at 1-800-522-3511; any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local OKDHS county office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the OKDHS hotline. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. § 58.

7. **General exclusions.** The following are excluded from coverage for members under the age of twenty-one (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 (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.
   (d) Pre-operative care within twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by CPT and CMS.
   (e) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
   (f) Sterilization of members who are under twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
   (g) Non-therapeutic hysterectomies.
   (h) Medical services considered experimental or investigational. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.
   (i) More than one (1) 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 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.
   (l) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
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(M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(O) Mileage.
(P) A routine hospital visit on date of discharge unless the member expired.

(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 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 ninety (90) days of the date of Medicare payment and within one (1) 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 ninety (90) days of the Medicare payment and within one (1) 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 EOMB showing the reason for the denial.

317:30-5-14.1. Allergy services

(a) Allergy testing. Allergy testing is the process of identifying allergen(s) that may cause an allergic or anaphylactic reaction and the degree of the reaction. By identifying the allergen(s), the member can avoid exposures and the allergic reaction can be managed appropriately. Treatment options for allergies are avoidance of the allergen(s), pharmacological therapy, and/or immunotherapy. OHCA Oklahoma Health Care Authority (OHCA) may consider allergy testing medically necessary when a complete medical, immunological history, and physical examination is performed and indicates symptoms are suggestive of a chronic allergy. Allergy testing may also be determined medically necessary if diagnosis indicates an allergy and simple medical treatment and avoidance of the allergen(s) were tried and showed inadequate response.

(1) Coverage. OHCA will provide reimbursement for allergy testing when the following conditions are met:

(A) Testing is done in a hospital or providers office under direct supervision of an eligible provider;
(B) The diagnostic testing is based on the member's immunologic history and physical examination, which document that the antigen(s) being used for testing have a reasonable probability of exposure in the member's environment;
(C) The member has significant life-threatening symptomatology or a chronic allergic state (e.g., asthma) which has not responded to conservative measures;
(D) The member's records document the need for allergy testing and the justification for the number of tests performed;
(E) The complete report of the test results, as well as controls, will be kept as part of the medical record; and
(F) The member is observed for a minimum of twenty (20) minutes following allergy testing to monitor for signs of allergic or anaphylactic reactions.

(2) Provider requirements. Only contracted providers (a physician (MD or DO), physician's assistant, or advanced practice nurse) who are board certified or board eligible in allergy and immunology or have received training in allergy and immunology in an accredited academic institution for a minimum of one (1) month clinical rotation (authenticated by supporting letter from institution or mentor).

(A) Follow-up administration of medically indicated allergy immunotherapy can be done by a practitioner other than an allergist.
(B) Allergy testing and/or immunotherapy for SoonerCare members younger than five (5) years of age preferably should be performed by an allergy specialist.

(3) Description of services. There are a variety of tests to identify the allergen(s) that may be responsible for the member's allergic response. OHCA covers the following allergy test(s) for SoonerCare members:

(A) Direct skin tests:

(i) Percutaneous (i.e., scratch, prick, or puncture) tests are performed for inhalant allergies, suspected food allergies, hymenoptera allergies, or specific drug allergies.
(ii) Intracutaneous (i.e., intradermal) tests are performed commonly when a significant allergic history is obtained and results of the percutaneous test are negative or equivocal.

(B) Patch or application tests;
(C) Photo or photo patch skin tests;
(D) Inhaled bronchial challenge testing (not including necessary pulmonary function tests);
(E) Ingestion challenge tests (this test is used to confirm an allergy to a food or food additives); and
(F) Double-blind food challenge testing.

(G) Ophthalmic mucous membrane or direct nasal membrane tests, serum allergy tests, serial dilution endpoint tests, or any unlisted allergy procedure not stated above will require prior authorization.

(4) Reimbursement. Reimbursement for allergy testing is limited to a total of 60 tests every three years. Repeat allergy testing for the same allergen(s) within three years will require prior authorization. Any service related to allergy testing beyond predetermined limits must be submitted with the appropriate documentation to OHCA for prior authorization consideration.

(5) Non-covered services. OHCA does not cover allergy testing determined to be investigational or experimental in nature. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.
(b) **Allergy immunotherapy.** Allergy immunotherapy involves administration of allergenic extracts at periodic intervals, with the goal of reducing symptoms, including titrating to a dosage that is maintained as maintenance therapy. Allergy immunotherapy is initiated once the offending allergen(s) has been identified through exposure and/or allergy testing. The documented allergy should correspond to the allergen planned for immunotherapy. OHCA may consider allergy immunotherapy medically necessary for members who have significant life-threatening symptomology or a chronic allergic state that cannot be managed by medication, avoidance, or environmental control measures. Before beginning allergy immunotherapy, consideration must be given to other common medical conditions that could make allergy immunotherapy more risky.

1. **Coverage requirements.** Allergy immunotherapy is covered when the following criteria are met and documented in the medical record:
   - (A) The member has allergic asthma, or
   - (B) Allergic rhinitis and/or conjunctivitis, or
   - (C) Life-threatening allergy to hymenoptera (stinging insect allergy), or
   - (D) There is clinical evidence of an inhalant allergen(s) sensitivity; and
   - (E) Documentation supports that the member’s symptoms are not controlled with medications and avoidance of the allergen(s) are impractical.


3. **Administering sites.** Allergy immunotherapy should be administered in a medical facility with trained staff and proper medical equipment available in the case of significant reaction. Should home administration be necessary, the following requirements must be met:
   - (A) Adequate documentation must be present in the member's record indicating why home administration is medically necessary;
   - (B) Documentation must indicate the member and/or family member have been properly trained in recognizing and treating anaphylactic and/or allergic reactions to allergy immunotherapy administration;
   - (C) Epinephrine kits must be available to the member and the family and the member and/or family have been instructed in its use;
   - (D) Documentation of member and/or family member having been properly trained in antigen(s) dosing plan, withdrawing of correct amount of antigen(s) from the vial and administration of allergy immunotherapy;
   - (E) The signed consent by the member or family member to administer allergy immunotherapy at home;
   - (F) The provider initiated allergy immunotherapy in their office and is planning to continue therapy at the member's home; and

4. **Payment.** Payment is made for the administration of allergy injections, the administration fee is compensable.

5. **Limitations.** The following limitations and restrictions apply to immunotherapy:
   - (A) When a contracted provider actually administers or supervises administration of the allergy injections, the administration fee is compensable;
   - (B) Reimbursement for the administration only codes is limited to one per member, per day;
   - (C) No reimbursement is made for administration of allergy injections when the allergy injection is self-administered by the member; and
   - (D) For antigens purchased by the provider for supervision, preparation and provision for allergy immunotherapy, an invoice reflecting the purchase should be made available upon request for post-payment review.

6. **Limitations.** The following limitations and restrictions apply to immunotherapy:
   - (A) A presumption of failure can be assumed if, after twelve (12) months of allergy immunotherapy, the member does not experience any signs of improvement, and all other reasonable factors have been ruled out.
   - (B) Documented success of allergy immunotherapy treatment is evidenced by:
     - (i) A noticeable decrease of hypersensitivity symptoms, or
     - (ii) An increase in tolerance to the offending allergen(s), or
     - (iii) A reduction in medication usage.
   - (C) Very low dose immunotherapy or continued submaximal dose has not been shown to be effective and will be denied as not medically necessary.
   - (D) Liquid antigen(s) prepared for sublingual administration are not covered as they have not been proven to be safe and effective.
   - (E) Food and Drug Administration (FDA) approved oral desensitization therapies may be covered as part of the member's pharmacy benefits and requires prior authorization.
   - (F) If a provider is preparing single dose vials of antigens to be administered by a different provider, member or family member, only thirty (30) units per treatment period of ninety (90) days with a limit of one hundred and twenty (120) units per year is allowed. Additional units above the stated limits will require prior authorization.
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) Compensable services. Providers may be reimbursed for compensable 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) 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 Centers for Medicare and Medicaid Services and have a current contract on file with the Oklahoma Health Care Authority (OHCA). Providers performing laboratory services must have the appropriate CLIA certification specific to the level of testing performed.

(B) Only medically necessary laboratory services are compensable.

(i) Testing must be medically indicated as evidenced by patient-specific indications in the medical record.

(ii) Testing is only compensable if the results will affect patient care and are performed to diagnose conditions and illnesses with specific symptoms.

(iii) Testing is only compensable if the services are performed in furtherance of the diagnosis and/or treatment of conditions that are covered under SoonerCare.

(C) Laboratory testing must be ordered by the physician or non-physician provider, and must be individualized to the patient and the patient's medical history or assessment indicators as evidenced in the medical documentation.

(D) Laboratory testing for routine diagnostic or screening tests following clinical guidelines such as those found in the American Academy of Pediatrics (AAP) Bright Futures' periodicity schedule, the United States Preventive Services Task Force (USPSTF) A and B recommendations, the American Academy of Family Practitioners (AAFP), or other nationally recognized medical professional academy or society standards of care, is compensable. Additionally, such sources as named in this subdivision should meet medical necessity criteria as outlined in Oklahoma Administrative Code (OAC) 317:30-3-1(f).

(2) Non-compensable laboratory services.

(A) Laboratory testing for routine diagnostic or screening tests not supported by the clinical guidelines of a nationally recognized medical professional academy or society standard of care, and/or testing that is performed without apparent relationship to treatment or diagnosis of a specific illness, symptom, complaint or injury is not covered.

(B) Non-specific, blanket panel or standing orders for laboratory testing, custom panels particular to the ordering provider, or lab panels which have no impact on the patient's plan of care are not covered.

(C) Split billing, or dividing the billed services for the same patient for the same date of service by the same rendering laboratory into two (2) or more claims is not allowed.

(D) 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.

(E) Claims for inpatient full service laboratory procedures are not covered since this is considered a part of the hospital rate.

(F) Billing multiple units of nucleic acid detection for individual infectious organisms when testing for more than one (1) infectious organism in a specimen is not permissible. Instead, OHCA considers it appropriate to bill a single unit of a procedure code indicated for multiple organism testing.

(G) Billing multiple Current Procedural Terminology (CPT) codes or units for molecular pathology tests that examine multiple genes or incorporate multiple types of genetic analysis in a single run or report is not permissible. Instead, OHCA considers it appropriate to bill a single CPT code for such test. If an appropriate code does not exist, then one (1) unit for an unlisted molecular pathology procedure may be billed.

(3) Covered services by a pathologist.

(A) A pathologist may be paid for the interpretation of inpatient surgical pathology specimen when 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.

(4) Non-compensable services by a pathologist. The following are non-compensable pathologist services:
(A) Experimental or investigational procedures. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.
(B) Interpretation of clinical laboratory procedures.

PART 3. HOSPITALS

317:30-5-41.2. Organ transplants
Solid organ and bone marrow/stem cell transplants are covered when appropriate and medically necessary.
(1) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.
(2) To be prior authorized all procedures are reviewed based on appropriate medical criteria.
(3) 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.
(4) Procedures considered experimental or investigational are not covered. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.
(5) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

317:30-5-42.18. Coverage for children
(a) Services, deemed medically necessary and allowable under federal Medicaid regulations, may be covered under the EPSDT/OHCA Child Health program even though those services may not be part of the Oklahoma Health Care Authority SoonerCare program. Such services must be prior authorized.
(b) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

PART 5. PHARMACIES

317:30-5-72.1. Drug benefit
The Oklahoma Health Care Authority (OHCA) administers and maintains an Open Formulary subject to the provisions of 42 U.S.C. § 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) and whose manufacturers have entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS), subject to the following exclusions and limitations.
(1) The following drugs, classes of drugs, or their medical uses are excluded from coverage:

(A) Agents used to promote fertility.
(B) Agents primarily used to promote hair growth.
(C) Agents used for cosmetic purposes.
(D) Agents used primarily for the treatment of anorexia or weight gain. Drugs used primarily for the treatment of obesity, such as appetite suppressants are not covered. Drugs used primarily to increase weight are not covered unless otherwise specified.
(E) Agents that are investigational, experimental or whose side effects make usage controversial including agents that have been approved by the FDA but are being investigated for additional indications. For more information regarding experimental or investigational including clinical trials see, OAC 317:30-3-57.1.
(F) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee.
(G) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the FDA.
(H) Agents used for the symptomatic relief of cough and colds.
(2) The drug categories listed in (A) through (D) of this paragraph are covered at the option of the state and are subject to restrictions and limitations. An updated list of products in each of these drug categories is included on the OHCA's public website.
(A) Vitamins and Minerals. Vitamins and minerals are not covered except under the following conditions:
(i) prenatalPrenatal vitamins are covered for pregnant women;
(ii) fluorideFluoride preparations are covered for persons under sixteen (16) years of age or pregnant;
(iii) vitaminVitamin D, metabolites, and analogs when used to treat chronic kidney disease or end stage renal disease are covered;
(iv) ironIron supplements may be covered for pregnant women if determined to be medically necessary;
(v) vitaminVitamin preparations may be covered for children less than twenty-one (21) years of age when medically necessary and furnished pursuant to EPSDT protocol; and
(vi) someSome vitamins are covered for a specific diagnosis when the FDA has approved the use of that vitamin for a specific indication.
(B) Coverage of non-prescription or over the counter drugs is limited to:
(i) Insulin;
(ii) certain Certain smoking cessation products;
(iii) family Family planning products;
Permanent Final Adoptions

(iv) OTC products may be covered for children if the particular product is both cost-effective and clinically appropriate; and

(v) prescription and non-prescription products which do not meet the definition of outpatient covered drugs, but are determined to be medically necessary.

(C) Coverage of food supplements is limited to PKU formula and amino acid bars for members diagnosed with PKU, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions when medically necessary and prior authorized.

(3) All covered outpatient drugs are subject to prior authorization as provided in OAC 317:30-5-77.2 and 317:30-5-77.3.

(4) All covered drugs may be excluded or coverage limited if:

(A) the prescribed use is not for a medically accepted indication as provided under 42 U.S.C. § 1396r-8; or

(B) the drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and CMS.

PART 7. CERTIFIED LABORATORIES

317:30-5-105. Non-covered procedures

The following procedures by certified laboratories are not covered:

(1) Tissue examinations of teeth and foreign objects.

(2) Tissue examination of lens after cataract surgery except when the patient is under 21 years of age.

(3) Charges for autopsy.

(4) Hair analysis for trace metal analysis.

(5) Procedures deemed experimental or investigational. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

(6) Professional component charges for inpatient clinical laboratory services.

(7) Inpatient clinical laboratory services.

PART 31. ROOM AND BOARD PROVIDERS

317:30-5-321. Coverage by category

Payment is made to Room and Board Providers as set forth in this Section.

(1) Adults. Payment is made to Room and Board Providers for room and board of an eligible adult and an escort, if necessary, when authorized by the Oklahoma Health Care Authority (OHCA). Room and Board is authorized by, Room and Board Order form, for Adults and Children. A copy of the authorization must be attached to each claim along with the dates of stay and signature of authorized escort.

(2) Children. Coverage for children is the same as for adults.

A) Services, deemed medically necessary and allowable under Federal Medicaid regulations, may be covered by the EPSDT/OHCA Child Health program even though the services may not be part of the OHCA SoonerCare program. Such services must be prior authorized.

B) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental. For more information regarding experimental or investigational including clinical trials see, Oklahoma Administrative Code 317:30-3-57.1.

PART 32. SOONERRIDE NON-EMERGENCY TRANSPORTATION (NEMT)

317:30-5-327A. Coverage for children

(a) Services, deemed medically necessary and allowable under federal Medicaid regulations, may be covered by the EPSDT/OHCA Child Health program even though the services may not be part of the OHCA SoonerCare program. Such services must be prior authorized.

(b) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

PART 33. TRANSPORTATION BY AMBULANCE

317:30-5-337. Coverage for children

(a) Services, deemed medically necessary and allowable under federal Medicaid regulations, may be covered by the EPSDT/OHCA Child Health program even though the services may not be part of the OHCA SoonerCare program. Such services must be prior authorized.

(b) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

PART 63. AMBULATORY SURGICAL CENTERS (ASC)
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 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—Oklahoma Health Care Authority (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. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

(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 #21-397; filed 6-14-21]

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

[OAR Docket #21-390]

ADOPITION:
March 17, 2021

SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:
March 18, 2021

LEGISLATIVE APPROVAL:
Approved June 11, 2021 by HJR 1046

FINAL ADOPTION:
June 11, 2021

EFFECTIVE:
September 1, 2021

SUPERSEDED EMERGENCY ACTIONS:
N/A

INCORPORATIONS BY REFERENCE:
N/A

GIST/ANALYSIS:
The proposed revisions clarify individualized treatment requirements, common applied behavior analysis (ABA)-based techniques, medical necessity criteria, and required documentation for ABA treatment extension requests. The proposed revisions will exempt licensed psychologists from ABA certification requirements, if applied behavior analysis services provided are within the scope of their training and practice. Other revisions will involve limited rewriting aimed at clarifying policy language.

CONTACT PERSON:
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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM/CHILD-HEALTH SERVICES

317:30-3-65.12. Applied behavior analysis (ABA) services
(a) Purpose and general provisions. The purpose of this Section is to establish guidelines for the provision of ABA services under the EPSDT benefit.

(1) ABA focuses on the analysis, design, implementation, and evaluation of instructional and other environmental modifications to produce meaningful changes in human behavior. ABA services include the use of direct observation, measurement, and functional analysis of the relations between the environment and behavior. Common ABA-based techniques include, but are not limited to; discrete trial training (DTT); pivotal response training; naturalist behavioral intervention (NDBI); and verbal behavioral intervention.

(2) ABA may be provided in a variety of settings, including home, community, or a clinical setting. It involves development of an individualized treatment plan that includes transition and aftercare planning, and family/caregiver involvement.
At an initial assessment, target symptoms are identified. A treatment plan is developed that identifies core deficits and aberrant behaviors, and includes designated interventions intended to address these deficits and behaviors and achieve individualized goals that are functional, meaningful, and connected to the member’s daily activities routines.

ABA services require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31 and 317:30-3-65.12(e)].

Functional behavior assessment (FBA) and treatment plan components.

The FBA serves as a critical component of the treatment plan and is conducted by a board certified behavior analyst (BCBA) to identify the specific behavioral needs of the member. The FBA consists of:

- Description of the problematic behavior (topography, onset/offset, cycle, intensity, severity);
- History of the problematic behavior (long-term and recent);
- Antecedent analysis (setting, people, time of day, events);
- Consequence analysis; and
- Impression and analysis of the function of the problematic behavior.

The treatment plan is developed by a BCBA or a licensed psychologist from the FBA. The treatment plan shall:

- Be person-centered and individualized;
- Delineate the baseline levels of target behaviors;
- Specify long and short term objectives that are defined in observable, measurable behavioral terms;
- Specify criteria that will be used to determine achievement of objectives;
- Include assessment and treatment protocols for addressing each of the target behaviors;
- Clearly identify the schedule of services planned and the individuals responsible for delivering the services, including frequent review of data on target behaviors and adjustments in the treatment plan and/or protocols by the BCBA or licensed psychologist as needed;
- Include training and supervision to enable board certified assistant behavior analysts (BCaBAs) and registered behavior technicians (RBTs) to implement assessment and treatment protocols;
- Include training and support to enable parents and other caregivers to participate in treatment planning and successfully reinforce the established treatment plan;
- Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and
- Ensure that services are consistent with applicable professional standards and guidelines relating to the practice of applied behavior analysis as well as state Medicaid laws and regulations.

Eligible ABA provider types include:

1. Board certified behavior analyst® (BCBA®) - A master’s or doctoral level independent practitioner who is certified by the national-accrediting Behavior Analyst Certification Board, Inc.® (BACB®) and licensed by the Oklahoma Department of Human Services’ (OKDHS) Developmental Disabilities Services Division (DDS) to provide behavior analysis services. A BCBA may supervise the work of board certified assistant behavior analysts and registered behavior technicians implementing behavior analytic interventions;

2. Board certified assistant behavior analyst® (BCaBA®) - A bachelor’s level practitioner who is certified by the national-accrediting BACB and certified by OKDHS DDS to provide behavior analysis services under the supervision of a BCBA;

3. Registered behavior technician™ (RBT®) - A high school level or higher paraprofessional who is certified by the national-accrediting BACB and practices under the close and ongoing supervision of a BCBA. The RBT works under the license number of a BCBA and is primarily responsible for the direct implementation of BCBA designed and prescribed behavior-analytic services;

4. Licensed psychologist - An individual who is licensed and in good standing with the Oklahoma State Board of Examiners of Psychologists and has professional experience in the use of ABA therapy may render behavior analysis services. Refer to OAC 317:30-5-275; and

5. Human services professional - A practitioner who is licensed by the State of Oklahoma pursuant to (A) - (H), and certified by the national-accrediting BACB, and who is working within the scope of his or her practice, to include:

- A licensed physical therapist;
- A licensed occupational therapist;
- A licensed clinical social worker or social worker candidate under the supervision of a licensed clinical social worker;
- A licensed psychologist;
- A licensed speech-language pathologist or licensed audiologist;
- A licensed professional counselor or professional counselor candidate under the supervision of a licensed professional counselor;
- A licensed marital and family therapist or marital and family therapist candidate under the supervision of a licensed marital and family therapist; or
- A licensed behavioral practitioner or behavioral practitioner candidate under the supervision of a licensed behavioral practitioner.

Provider criteria. To direct, supervise, and/or render ABA services, the following conditions shall be met.

A BCBA shall:

- Be currently licensed by OKDHS DDS as a BCBA;
- Have no sanctions or disciplinary actions by OKDHS DDS or the BACB;
(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
(D) Be fully contracted with SoonerCare as a provider.

(2) A BCaBA shall:
(A) Be currently certified by OKDHS DDS as a BCaBA;
(B) Work under the supervision of a SoonerCare-contracted BCBA provider;
(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
(D) Be fully contracted with SoonerCare as a provider.

(3) An RBT shall:
(A) Be currently certified by the national-accrediting BACB as an RBT;
(B) Work under the supervision of a SoonerCare-contracted BCBA provider;
(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
(D) Be fully contracted with SoonerCare as a provider.

(4) A human services professional shall:
(A) Be currently licensed or certified by the State of Oklahoma, in accordance with Section 1928 of Title 59 of the Oklahoma Statutes;
(B) Be currently certified by the national-accrediting BACB;
(C) Have no sanctions or disciplinary actions by the applicable state licensing board or the BACB;
(D) If working under supervision within the scope of his or her practice, have a documented relationship with a fully-licensed human service professional working in a supervisory capacity;
(E) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
(F) Be fully contracted with SoonerCare as a provider.

(e) Medical necessity criteria for members under twenty-one (21) years of age. ABA services are considered medically necessary when all of the following conditions are met:

(1) The member is under twenty-one (21) years of age with a definitive diagnosis of an Autism Spectrum Disorder (ASD) from the following providers:
(A) Pediatric neurologist or neurologist;
(B) Developmental pediatrician;
(C) Licensed psychologist;
(D) Psychiatrist or neuropsychiatrist; or
(E) Other licensed physician experienced in the diagnosis and treatment of autism ASD.
(2) A comprehensive diagnostic evaluation completed by one (1) of the above identified professionals must:
(A) Be completed within the last two (2) years;
(B) Include a complete pertinent medical and social history, including pre- and perinatal, medical, developmental, family, and social elements; and
(C) Be based on criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) or the most current version of the DSM for ASD and/or may also include scores from the use of formal diagnostic tests such as the Autism Diagnostic Interview-Revised (ADI-R), Autism Diagnostic Observation Schedule-2 (ADOS-2), Childhood Autism Rating Scale (CARS) or other tools with acceptable psychometric properties. Screening scales are not sufficient to make a diagnosis and will not be accepted as the only formal scale.
(3) There must be a reasonable expectation that the member will benefit from ABA. The member must exhibit:
(A) The ability/capacity to learn and develop generalized skills to assist with his or her independence; and
(B) The ability to develop generalized skills to assist in addressing maladaptive behaviors associated with ASD.
(4) The member is medically stable and does not require twenty-four (24) hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for individuals with intellectual disabilities (ICF/IID).
(5) The member exhibits atypical or disruptive behavior within the most recent thirty (30) calendar days that significantly interferes with daily functioning and activities. Such atypical or disruptive behavior may include, but is not limited to:
(A) Impulsive aggression toward others;
(B) Self-injury behaviors; .
(C) Intentional property destruction; or
(D) Severe disruption in daily functioning (e.g., the individual's inability to maintain in school, child care settings, social settings, etc.) due to changes in routine activities that have not been helped by other treatments such as occupational, speech therapy, additional psychotherapy and/or school/ daycare interventions.
(6) The focus of treatment is not custodial in nature (which is defined as care provided when the member "has reached maximum level of physical or mental function and such person is not likely to make further significant improvement" or "any type of care where the primary purpose of the type of care provided is to attend to the member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.") Interventions are intended to strengthen the individual/s/parent/s/legal guardian's capacity for self care.
and self sufficiency to decrease interventions in the home by those other than the parent(s)/legal guardian(s).

(7) It has been determined that there is no other appropriate service less intensive or more appropriate level of service which can be safely and effectively provided.

(f) Prior authorization. Eligible providers must submit an initial prior authorization request to the Oklahoma Health Care Authority (OHCA) or its designated agent. Prior authorization requests shall be granted up to six (6) months of ABA treatment services at one (1) time unless a longer duration of treatment is clinically indicated. The number of hours authorized may differ from the hours requested on the prior authorization request based on the review by an OHCA reviewer and/or physician. If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization. The prior authorization request must meet the following Sooner-Care criteria for ABA services.

(1) The criteria includes a comprehensive behavioral and FBA outlining the maladaptive behaviors consistent with the diagnosis of ASD and its associated comorbidities. In addition to completing the initial request form, providers will be required to submit documentation that will consist of the following:

(A) Information about relevant medical status, prior assessment results, response to prior treatment, and other relevant information gathered from review of records and past assessments.

(B) Information gathered from interview of family and/or caregivers, rating scales, and social validity measures to assess perceptions of the client's skill deficits and behavioral excesses, and the extent to which these deficits impede the daily life of the member and the family.

(C) Direct assessment and observation, including any data related to the identified problem behavior. The analysis of such data serves as the primary basis for identifying pretreatment levels of functioning, developing and adapting treatment protocols, and evaluating response to treatment and progress toward goals.

(D) Functional assessment of problem behavior that includes antecedent factors, skill deficits, and consequences contributing to the problem behavior. The treatment plan should address all three (3) areas, including antecedent interventions, teaching replacement skills, and modification of consequences.

(2) The prior authorization for ABA treatment will be time limited for up to thirty (30) hours per week unless other hours are deemed medically necessary and authorized through a prior authorization request and must:

(A) Be a one-on-one encounter (face to face between the member and ABA provider) except in the case of family adaptive treatment guidance;

(B) Be child-centered and based upon individualized goals that are strengths-specific, family focused, and community based;

(C) Be culturally competent and the least intrusive as possible;

(D) Clearly define in measurable and objective terms the intervention plan so it can address the specific target behaviors that are linked to the function of (or reason for) the behavior. The intervention plan should be clearly linked to the function of the maladaptive behavior and include antecedent interventions, replacement skills to be taught, and modification of consequences. Additional goals may be identified that are related to the core deficits of ASD and are prioritized based on current research and social significance for the individual.

(E) Record the frequency, rate, symptom intensity/duration, or other objective measures of baseline levels;

(F) Set quantifiable criteria for progress;

(G) Establish and record behavioral intervention techniques that are appropriate to target behaviors. The detailed treatment plan utilizes reinforcement and other behavioral principles and excludes the use of methods or techniques that lack consensus about their effectiveness based on evidence in peer-reviewed publications;

(H) Specify strategies for generalization of learned skills beyond the clinical settings such as in the home or other community settings;

(I) Document planning for transition through the continuum of interventions, services, and settings, as well as discharge criteria; Treatment (behavioral training) will be individualized and documentation will support the identified atypical or disruptive behavior.

(J) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care and support generalization of skills in the home and community settings. Frequency of parental involvement will be determined by the treatment provider and listed on the treatment plan;

(K) Document parent(s)/legal guardian(s) participation in the training of behavioral techniques in the member's medical record. Parent(s)/legal guardian(s) participation is critical to the generalization of treatment goals to the member's environment; and

(L) Ensure that recommended ABA services do not duplicate or replicate services received in a member's primary academic education setting, or provided within an Individualized Education Plan (IEP), Individualized Service Plan (ISP), or any other individual plan of care. Documentation may be requested by the OHCA to support coordination of services with other providers and to prevent overlap and duplication of services including those in school settings.

(g) ABA extension requests. Extension requests for ABA services must be submitted to the OHCA or its designated
agent. Extension requests must contain the appropriate documentation validating the need for continued treatment and establish the following:

1. Eligibility criteria in OAC 317:30-3-65.12(d) 1-6;
2. The frequency of the target behavior has diminished since last review, or if not, there has been no modification of the treatment or additional assessments have been conducted;
3. If progress has not been measurable after two (2) extension requests, a functional analysis will be completed which records the member's maladaptive, serious target behavioral symptom(s), and precipitants, as well as makes a determination of the function a particular maladaptive behavior serves for the member in the environmental context; A functional analysis shall be completed by the provider when no measurable progress has occurred, or it may be requested by the OHCA. The functional analysis should record the member's serious maladaptive target behavioral symptom(s) and precipitants, and document the modifications of the current treatment plan to address progress, as well as make a determination of the function a particular maladaptive behavior serves for the member in the environmental context;
4. Appropriate consultations from other staff or experts have occurred (psychiatric consultation, pediatric evaluation for other conditions, etc.) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);
5. The OHCA may suggest appropriate consultation from other staff or experts during the process of prior authorization;
6. Parent(s)/legal guardian(s) have received re-training on these changed approaches; and
7. The treatment plan documents a gradual tapering of higher intensities of intervention and shifting to supports from other sources (i.e., schools) as progress occurs allows.

(h) Reimbursement methodology. SoonerCare shall provide reimbursement for ABA services in accordance with the Medicaid State Plan.

1. Payment shall only be made to SoonerCare-contracted groups or qualified individual providers who are currently licensed and in good standing. Payment is not made to under supervision ABA practitioners/paraprofessionals, including but not limited to, BCaBAs and RBTs.
2. Reimbursement for ABA services is only made on a fee-for-services basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.

3. Reimbursement shall only be made for services that have been prior-authorized by OHCA or its designee; and performed on an individualized basis and not in a group setting except for family adaptive behavior treatment guidance by a qualified ABA provider [OAC 317:30-3-65.12(b)].
4. Reimbursement for ABA services shall not be made to or for services rendered by a parent, legal guardian, or other legally responsible person.

[OAR Docket #21-390; filed 6-14-21]

REFERENCE

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

[OAR Docket #21-386]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 3. General Provider Policies
Part 6. Out-Of-State Services
317:30-3-90 [AMENDED]
317:30-3-91 [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-22.1 [AMENDED]
Part 9. Long-Term Care Facilities
317:30-5-131.2 [AMENDED]
Part 18. Genetic Counselors
317:30-5-221 [AMENDED]
Part 23. Podiatrists
317:30-5-261 [AMENDED]
Part 73. Early Intervention Services
317:30-5-641.1 [AMENDED]
Part 103. Qualified Schools as Providers of Health-Related Services
317:30-5-1020 [AMENDED]
(Reference APA WF # 20-19B)

AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board

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Superseeded rules:
Subchapter 5. Individual Providers and Specialties
Part 9. Long-Term Care Facilities
317:30-5-131.2 [AMENDED]
Part 103. Qualified Schools as Providers of Health-Related Services
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n/a

GIST/ANALYSIS:   
The proposed revisions replace incorrect rule section references with the appropriate references. Additionally, revisions will remove appeals language for programs that no longer exist and will involve minor cleanup to fix grammatical and formatting errors.

CONTACT PERSON:   
Sandra Puebla, Director of Federal and State Authorities, 405-522-7270, Sandra.Puebla@okhca.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 6. OUT-OF-STATE SERVICES

317:30-3-90. Out-of-state services

(a) Consistent with Section 431.52 of Title 42 of the Code of Federal Regulations (C.F.R.), an eligible SoonerCare member who is a resident of Oklahoma but who is temporarily out of state, may receive services from an out-of-state provider to the same extent that he or she would receive such services in Oklahoma, if:

(1) Medical services are needed for a medical emergency, as determined by the attending physician or other provider (M.D., D.O., P.A., or A.P.R.N). For any provider, who is not contracted at the time the services are provided, documentation as requested from the Oklahoma Health Care Authority (OHCA) of the emergency must be submitted, including, but not limited to, emergency room reports, medical histories, discharge summaries, and all other relevant medical reports.

(2) Medical services are needed and the member's health would be endangered if he or she were required to return to Oklahoma for medical care and treatment, as determined by the attending physician or other provider (M.D., D.O., P.A., or A.P.R.N). For any provider, who is not contracted at the time the services are provided, documentation of the nature and possible extent of the endangerment must be submitted as requested from the OHCA.

(3) The Oklahoma Health Care Authority's (OHCA) Chief Medical Officer (CMO), or his or her designee, determines, on the basis of medical advice, that the needed medical services, or necessary supplemental resources, are more readily available in the state where the member is located at the time of needing medical treatment. Prior authorization must be obtained from the OHCA's CMO, or his or her designee, before the services are rendered; or

(4) The customary or general practice for members residing in a particular locality within Oklahoma is to use medical resources in another state, and the member is using a provider that is contracted with the OHCA.

(A) Except for out-of-state inpatient psychiatric services, no prior authorization is necessary for services provided in accordance with paragraph (a)(4), above, if the member obtains them from an out-of-state provider that is:

(i) Located in a border state (Arkansas, Colorado, Kansas, Missouri, New Mexico, or Texas) within fifty (50) miles of the Oklahoma border; and

(ii) Contracted with the OHCA;

(iii) Provided, however, that nothing in this paragraph shall be interpreted to eliminate or otherwise affect a prior authorization requirement established by any other OHCA rule, including, but not limited to, Oklahoma Administrative Code (OAC) 317:30-3-31, that would have to be met if the health care-related good and/or service were provided in Oklahoma.

(B) In all other instances, prior authorization must be obtained from the OHCA's CMO, or his or her designee, before the services are rendered.

(b) Except as provided in subsections (a)(1),(a)(2) and (a)(4)(A), above, SoonerCare will not pay for any services furnished by an out-of-state provider unless prior authorization has been obtained from the OHCA's CMO, or his or her designee, before the services are rendered. Prior authorization must be obtained in all instances in which the member is located in Oklahoma at the time the services are determined to be medically necessary.

(1) As part of this authorization process, the following documents must be submitted to the OHCA's CMO, or his or her designee:

(A) Documents sufficient to establish the "medical necessity" of the services requested, as that term is defined by OAC 317:30-3-1(f). See also OAC 317:30-3-31, Prior authorization for health care-related goods and services. Examples of such documents may include, but are not limited to, Histories of Present Illnesses (HPIs), physical exams, laboratory reports, imaging reports, progress notes, hospital charts, and/or other relevant medical records; and (B) Documents sufficient to establish that the health care needs of the member cannot be met in Oklahoma. Such documents shall include, but not be limited to, a letter from the referring provider that contains:

(i) A clear presentation of the member's medical condition and diagnosis for which out-of-state treatment is requested, including a summary of treatment to date that is supported by the documents in paragraph (b)(1)(A), above;
(ii) Names of physicians and/or facilities in Oklahoma that the member has previously been referred to for diagnosis and/or treatment;
(iii) Physicians consulted by the attending physician relative to diagnosis and/or availability of recommended treatment in Oklahoma;
(iv) Recommended treatment or further diagnostic work; and
(v) Reasons why medical care cannot be provided in Oklahoma or the next closest location outside Oklahoma.
(C) Except for emergency medical or behavioral health cases, prior authorization requests for out-of-state services must be made in writing with all the necessary documents that show medical necessity and details of the services provided, including but not limited to, relevant medical history, description of services and procedures to be performed, Histories of Present Illnesses (HPIs), physical exams, laboratory reports, imaging reports, and received by the OHCA at least ten (10) calendar days prior to the date services are to be provided in another state or at the discretion of the CMO or his/her designee.
(i) Emergency medical or behavioral health cases must be identified as such by the physician or provider in the prior authorization request.
(ii) Any telephone request for prior authorization of out-of-state services will only be accepted in emergency situations, and must be promptly followed by a written request.

(2) Prior authorization requirements for medically necessary lodging, transportation, and/or meals assistance associated with out-of-state services are established in other OHCA rules, including, but not limited to, OAC 317:30-3-92 and 317:30-5-327.1 and 317:35-3-2.

(c) The restrictions established in subsections (a) through (b), above, shall not apply to children who reside outside Oklahoma and for whom the Oklahoma Department of Human Services makes Title IV-E adoption assistance payments or Title IV-E foster care maintenance payments.
(d) Denials of requests for prior authorization may be appealed in accordance with OAC 317:2-1-2(d)(1)(C).
(e) Out-of-state providers shall, upon request by authorized OHCA representatives, make available fiscal and medical records as required by applicable federal regulations, OHCA rules, and the Provider Agreement. Such records shall be made available for review by authorized OHCA representatives at the OHCA’s address in Oklahoma City, Oklahoma.

317:30-3-91. Reimbursement of services rendered by out-of-state providers
(a) Before an out-of-state provider can receive reimbursement, it shall contract with SoonerCare and be subject to enrollment, including, but not limited to, providing information requested by the Oklahoma Health Care Authority (OHCA) such as name, address, Social Security Number or Tax Identification Number, and verification of licensure and insurance. Out-of-state providers are also subject to the same screening rules, policies, and procedures as in-state providers, including, but not limited to Oklahoma Administrative Code (OAC) 317:30-3-2, and 317:30-3-19.3 through 317:30-3-19.4. Once the OHCA approves enrollment, the provider will receive a SoonerCare provider number that will allow claims to be processed.

(b) While the member’s physician may suggest where the member be sent, the OHCA’s Chief Medical Officer (CMO), or his or her designee, is responsible for making the final determination based on the most cost effective institution and treatment consistent with the recognized standards of care. Reimbursement for services rendered by out-of-state providers shall be as follows:

(1) Reimbursement for inpatient hospital services shall be made in accordance with OAC 317:30-5-47.
(2) Reimbursement for outpatient hospital services shall be made in accordance with OAC 317:30-5-42.14 and 317:30-556.
(3) Reimbursement for physician services shall be the lower of the SoonerCare maximum allowable fee as of the date the service was rendered, available at www.okhca.org (SoonerCare Fee Schedules), or the provider’s actual charge. Exceptions to the above reimbursement method are payments for outpatient clinical diagnostic laboratory tests performed by a physician or independent laboratory. These tests will be reimbursed at the lower of the provider’s actual charge or a rate of reimbursement equal to the rate paid by Medicare.

(4) Unless authorized by the Oklahoma State Plan, any reimbursement shall not exceed the rate paid by Medicare.

(c) The OHCA may negotiate a higher reimbursement rate for an out-of-state service that is prior authorized, provided that:

(1) The service is not available in Oklahoma; and
(2) The negotiated reimbursement does not exceed the rate paid by Medicare, unless as authorized by the Oklahoma State Plan. Services not covered by Medicare but covered by SoonerCare may be reimbursed as determined by the OHCA.

(d) Individual cases which are adversely affected by these reimbursement procedures may be presented to the OHCA’s CMO, or his or her designee, for consideration as an exception to this rule on a case-by-case basis. The CMO’s decision, or that of his or her designee, shall be the agency’s final decision and is not otherwise appealable under these rules.

(e) Reimbursement of medically necessary lodging, transportation, and/or meals assistance associated with out-of-state services is governed by other OHCA rules, including, but not limited to, OAC 317:30-3-92 and 317:30-5-327.1 and 317:35-3-2, as well as Part 31 of OAC 317:30-5.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS
317:30-5-22.1. Enhanced services for medically high risk pregnancies

(a) **Enhanced services.** Enhanced services are available for pregnant women eligible for SoonerCare and are in addition to services for uncomplicated maternity cases. Women deemed high risk based on criteria established by the Oklahoma Health Care Authority (OHCA) must receive prior authorization for medically necessary enhanced benefits which include:

1. Prenatal at risk antepartum management;
2. A combined maximum of five (5) fetal non stress test(s) and biophysical profiles (additional units can be prior authorized for multiple fetuses) with one (1) test per week beginning at thirty-two (32) weeks gestation and continuing to thirty-eight (38) weeks; and
3. A maximum of three (3) follow-up ultrasounds not covered under OAC Oklahoma Administrative Code (OAC) 317:30-5-22(b)(2).

(b) **Prior authorization.** To receive enhanced services, the following documentation must be received by the OHCA Medical Authorization Unit for review and approval:

1. A comprehensive prenatal assessment from the American College of Obstetricians and Gynecologist (ACOG) or other comparable comprehensive prenatal assessment; and
2. Appropriate documentation supporting medical necessity from a board eligible/board certified Maternal Fetal Medicine (MFM) specialist, a board eligible/board certified Obstetrician-Gynecologist (OB-GYN), or a board eligible/board certified Family Practice Physician who has completed an Accreditation Council for Graduate Medical Education (ACGME) approved residency. The medical residency program must include appropriate obstetric training, and the physician must be credentialed by the hospital at which they provide obstetrical services in order to perform such services. The documentation must include information identifying and detailing the qualifying high risk condition. Non-MFM obstetrical providers requesting enhanced services are limited to a specific set of diagnoses as outlined on the OHCA website (www.okhca.org).

(c) **Reimbursement.** When prior authorized, enhanced benefits will be reimbursed as follows:

1. Antepartum management for high risk is reimbursed to the primary obstetrical provider. If the primary provider of obstetrical care is not the MFM and wishes to request authorization of the antepartum management fee, the treatment plan must be signed by the primary provider of OB care. Additionally, reimbursement for enhanced at risk antepartum management is not made during an in-patient hospital stay.
2. Non stress tests, biophysical profiles and ultrasounds [in addition to those covered under OAC 317:30-5-22(a)(2) subparagraphs (A) through (C) 317:30-5-22(b)(2) (A) through (C)] are reimbursed when prior authorized.
3. Reimbursement for enhanced at risk antepartum management is not available to physicians who already qualify for enhanced reimbursement as state employed physicians.

PART 9. LONG-TERM CARE FACILITIES

317:30-5-131.2. Quality of care fund requirements and report

(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise:

1. "Annualize" means that the calculations, including, for example, total patient days, gross revenue, or contractual allowances and discounts, is divided by the total number of applicable days in the relevant time period.
2. "Direct-Care Staff" means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for individuals with intellectual disabilities pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.
3. "Major Fraction Thereof" means an additional threshold for direct-care-staff-to-resident ratios at which another direct-care staff person(s) is required due to the peak in-house resident count exceeding one-half of the minimum direct-care-staff-to-resident ratio pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes.
4. "Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities" means any home, establishment, or institution or any portion thereof, licensed by the Oklahoma State Department of Health (OSDH) as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes.
5. "Peak In-House Resident Count" means the maximum number of in-house residents at any point in time during the applicable shift.
6. "Quality of Care Fee" means the fee assessment created for the purpose of quality care enhancements pursuant to Section 2002 of Title 56 of the Oklahoma Statutes upon each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in this state.
7. "Quality of Care Fund" means a revolving fund established in the State Treasury pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.
8. "Quality of Care Report" means the monthly report developed by the Oklahoma Health Care Authority (OHCA) to document the staffing ratios, total patient gross receipts, total patient days, and minimum wage compliance for specified staff for each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in the state.
9. "Service Rate" means the minimum direct-care-staff-to-resident rate pursuant to Section 1-1925.2 of Title 63 of Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.
(10) "Staff Hours Worked by Shift" means the number of hours worked during the applicable shift by direct-care staff.

(11) "Staffing Ratios" means the minimum direct-care-staff-to-resident ratios pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(12) "Total Gross Receipts" means all cash received in the current Quality of Care Report month for services rendered to all residents in the facility. Receipts should include all Medicaid, Medicare, private pay, and insurance including receipts for items not in the normal per diem rate. Charitable contributions received by the nursing facility are not included.

(13) "Total Patient Days" means the monthly patient days that are compensable for the current monthly Quality of Care Report.

(b) Quality of care fund assessments.

(1) The OHCA was mandated by the Oklahoma Legislature to assess a monthly service fee to each licensed nursing facility in the state. The fee is assessed on a per patient day basis. The amount of the fee is uniform for each facility type. The fee is determined as six percent (6%) of the average total gross receipts divided by the total days for each facility type.

(2) Annually, the Nursing Facilities Quality of Care Fee shall be determined by using the daily patient census and patient gross receipts report received by the OHCA for the most recent available twelve months and annualizing those figures. Also, the fee will be monitored to never surpass the federal maximum.

(3) The fee is authorized through the Medicaid State Plan and by the Centers for Medicare and Medicaid Services regarding waiver of uniformity requirements related to the fee.

(4) Monthly reports of Gross Receipts and Census are included in the monthly Quality of Care Report. The data required includes, but is not limited to, the Total Gross Receipts and Total Patient Days for the current monthly report.

(5) The method of collection is as follows:

(A) The OHCA assesses each facility monthly based on the reported patient days from the Quality of Care Report filed two months prior to the month of the fee assessment billing. As defined in this subsection, the total assessment is the fee times the total days of service. The OHCA notifies the facility of its assessment by the end of the month of the Quality of Care Report submission date.

(B) Payment is due to the OHCA by the 15th of the following month. Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of 10 percent (10%) of the amount and interest of 1.25 percent (1.25%) per month. The Quality of Care Fee must be submitted no later than the 15th of the month. If the payment mailing date is marked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of 10 percent (10%) of the amount and interest of 1.25 percent (1.25%) per month. The Quality of Care Fee must be submitted no later than the 15th of the month. If the 15th falls upon a holiday or weekend (Saturday-Sunday), the fee is due by 5 p.m., Central Standard Time (CST), of the following business day (Monday-Friday).

(C) The monthly assessment, including applicable penalties and interest, must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the OHCA the assessment within the time frames noted on the second invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. Adjustments to prior months' reported amounts for gross receipts or patient days may be made by filing an amended part C of the Quality of Care Report.

(D) The Quality of Care fee assessments excluding penalties and interest are an allowable cost for OHCA cost reporting purposes.

(E) The Quality of Care fund, which contains assessments collected including penalties and interest as described in this subsection and any interest attributable to investment of any money in the fund, must be deposited in a revolving fund established in the State Treasury. The funds will be used pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(c) Quality of care direct-care-staff-to-resident-ratios.

(1) All nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) subject to the Nursing Home Care Act, in addition to other state and federal staffing requirements, must maintain the minimum direct-care-staff-to-resident ratios or direct-care service rates as cited in Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(2) For purposes of staff-to-resident ratios, direct-care staff are limited to the following employee positions:

(A) Registered Nurse;

(B) Licensed Practical Nurse;

(C) Nurse Aide;

(D) Certified Medication Aide;

(E) Qualified Intellectual Disability Professional (ICFs/IID only);

(F) Physical Therapist;

(G) Occupational Therapist;

(H) Respiratory Therapist;

(I) Speech Therapist; and

(J) Therapy Aide/Assistant.

(3) The hours of direct care rendered by persons filling non-direct care positions may be used when those persons are certified and rendering direct care in the positions listed in OAC 317:30-5-131.2(c)(2) when documented in the records and time sheets of the facility.

(4) In any shift when the direct-care-staff-to-resident ratio computation results in a major fraction thereof, direct-care staff is rounded to the next higher whole number.

(5) To document and report compliance with the provisions of this subsection, nursing facilities and ICFs/IID
must submit the monthly Quality of Care Report pursuant to subsection (e) of this Section.

(d) **Quality of care reports.** All nursing facilities and intermediate care facilities for individuals with intellectual disabilities must submit a monthly report developed by the OHCA, the Quality of Care Report, for the purposes of documenting the extent to which such facilities are compliant with the minimum direct-care-staff-to-resident ratios or direct-care service rates.

(1) The monthly report must be signed by the preparer and by the owner, authorized corporate officer, or administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The owner or authorized corporate officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b.

(4) The Quality of Care Report must be submitted by 5 p.m. (CST) on the 15th of the following month. If the 15th falls upon a holiday or a weekend (Saturday-Sunday), the report is due by 5 p.m. (CST) of the following business day (Monday - Friday).

(5) The Quality of Care Report will be made available in an electronic version for uniform submission of the required data elements.

(6) Facilities must submit the monthly report through the OHCA Provider Portal.

(7) Should a facility discover an error in its submitted report for the previous month only, the facility must provide to the Long-term Care Financial Management Unit written notification with adequate, objective, and substantive documentation within five business days following the submission deadline. Any documentation received after the five business day period will not be considered in determining compliance and for reporting purposes by the OHCA.

(8) An initial administrative penalty of $150.00 is imposed upon the facility for incomplete, unauthorized, or non-timely filing of the Quality of Care Report. Additionally, a daily administrative penalty will begin upon the OHCA notifying the facility in writing that the report was not complete or not timely submitted as required. The $150.00 daily administrative penalty accrues for each calendar day after the date the notification is received. The penalties are deducted from the Medicaid facility's payment. For 100 percent (100%) private pay facilities, the penalty amount(s) is included and collected in the fee assessment billings process. Imposed penalties for incomplete reports or non-timely filing are not considered for OHCA cost reporting purposes.

(9) The Quality of Care Report includes, but is not limited to: total gross receipts, patient days, available bed days, direct care hours, Medicare days, Medicaid days, number of employees, monthly resident census, and tenure of certified nursing assistants, nurses, directors of nursing, and administrators.

(10) Audits may be performed to determine compliance pursuant to subsections (b), and (c) of this Section. Announced/unannounced on-site audits of reported information may also be performed.

(11) Direct-care-staff-to-resident information and on-site audit findings pursuant to subsection (c), will be reported to the OSDH for their review in order to determine "willful" non-compliance and assess penalties accordingly pursuant to Title 63 Section 1-1912 through Section 1-1917 of the Oklahoma Statutes. The OSDH informs the OHCA of all final penalties as required in order to deduct from the Medicaid facility's payment. Imposed penalties are not considered for OHCA Cost Reporting purposes.

(12) If a Medicaid provider is found non-compliant pursuant to subsection (d) based upon a desk audit and/or on-site audit, for each hour paid to specified staff that does not meet the regulatory minimum wage of $6.65, the facility must reimburse the employee(s) retroactively to meet the regulatory wage for hours worked. Additionally, an administrative penalty of $25.00 is imposed for each non-compliant staff hour worked. For Medicaid facilities, a deduction is made to their payment. Imposed penalties for non-compliance with minimum wage requirements are not considered for OHCA cost reporting purposes.

(412) Under OAC 317:2-1-2, long-term care facility providers may appeal the administrative penalty described in (b)(5)(B) and (c)(8) and (e)(12)(d)(8) of this section.

(413) Facilities that have been authorized by the OSDH to implement flexible staff scheduling must comply with OAC 310:675-1 et seq. The authorized facility is required to complete the flexible staff scheduling section of Part A of the Quality of Care Report. The owner, authorized corporate officer, or administrator of the facility must complete the flexible staff scheduling signature block, acknowledging their OSDH authorization for flexible staff scheduling.

**PART 18. GENETIC COUNSELORS**

317:30-5-221. **Coverage**

(a) Genetic counseling services are covered for SoonerCare members who meet the criteria for receiving medically necessary genetic testing as set forth in 317:30-5-2(a)(1)(GG) and for pregnant/postpartum SoonerCare members as set forth in this section. Services for pregnant/postpartum SoonerCare members must be referred by a provider involved in the provision of obstetric or pediatric care. Members are eligible for genetic counseling during pregnancy which includes sixty (60) days post-partum. Reasons for genetic counseling include but are not limited to the following:

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(1) advanced maternal age;
(2) abnormal maternal serum first or second screening;
(3) previous child or current fetus/infant with an abnormality;
(4) consanguinity/incest;
(5) parent is a known carrier or has a family history of a genetic condition;
(6) parent was exposed to a known or suspected reproductive hazard;
(7) previous fetal demise, stillbirth, or neonatal death involving known/suspected abnormalities;
(8) history of recurrent pregnancy loss; or
(9) parent(s) are in an ethnic or racial group associated with an increased risk for specific genetic conditions.

(b) These services may be provided in an office or outpatient setting.

**PART 23. PODIATRISTS**

317:30-5-261. Coverage by category

Payment is made to podiatrists as set forth in this Section:

(1) **Adults.** Payment is made for medically necessary surgical procedures, x-rays, and outpatient visits. Procedures which are generally considered as preventative foot care, i.e. cutting or removal of corns, warts, callouses, or nails, are not covered unless the diagnoses on the claim, i.e. diabetes, multiple sclerosis, cerebral vascular accident, peripheral vascular disease establishes the medical necessity for the service. The patient must be under the active care of a doctor of medicine or osteopathy who documents the condition. All services must be medically appropriate and related to systemic disease for which foot care is viewed as preventative in nature. Nursing home visits must be ordered by the attending physician. The nursing home record must contain appropriate documentation that the visit was not performed for screening purposes. A specific foot ailment, symptom or complaint must be documented. In instances where the examination is performed in response to specific symptoms or complaints which suggests the need for care, the visit is compensable regardless of the resulting diagnosis. All outpatient visits are subject to existing visit limitations.

(2) **Children.** Coverage of podiatric services for children is the same as for adults. Refer to OAC 317:30-3-57(c)(1) for additional coverage under the Early and Periodic Screening, Diagnosis and Treatment Program.

(3) **Individuals eligible for Part B of Medicare.** Payment for podiatric services is made utilizing the Medicaid allowable for comparable services.

**PART 73. EARLY INTERVENTION SERVICES**

317:30-5-641. Periodic and interperiodic screening examination

Refer to OAC 317:30-3-55. Refer to Oklahoma Administrative Code 317:30-3-65 through 317:30-3-65.12.

**PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH-RELATED SERVICES**

317:30-5-1020. General provisions

(a) School-based services are medically necessary health-related and rehabilitative services that are provided by a qualified school provider to a student under the age of twenty-one (21) pursuant to an Individualized Education Program (IEP), in accordance with the Individuals with Disabilities Education Act (IDEA). Payment is made to qualified school providers for delivery of school-based services, provided that such services are, among other things, medically necessary and sufficiently supported by medical records and/or other documentation, as explained below.

(b) An IEP and all relevant supporting documentation, including, but not limited to, the documentation required by OAC Oklahoma Administrative Code (OAC) 317:30-5-1020(c), below, serves as the plan of care for consideration of reimbursement for school-based services. The plan of care must contain, among other things, the signatures, including credentials, of the provider(s) and the direct care staff delivering services under the supervision of the professional; as well as a complete, signed, and current IEP which clearly establishes the type, frequency, and duration of the service(s) to be provided, the specific place of services if other than the school (e.g., field trip, home), and measurable goals for each of the identified needs. Goals must be updated to reflect the current therapy, evaluation, or service that is being provided and billed to SoonerCare.

(1) Except for those services, referenced in Oklahoma Administrative Code (OAC) 317:30-5-1023(b)(42)(H), a plan of care that meets the requirements of OAC 317:30-5-1020(b), above, shall serve as a prior medical authorization for the purpose of providing medically necessary and appropriate school-based services to students.

(2) For the purposes of occupational therapy services, and services for members with speech, hearing, and language disorders, a plan of care that meets the requirements of OAC 317:30-5-1020(b), above, may also, in accordance with sections (§§) 725.2(H) and 888.4(C) of Title 59 of the Oklahoma Statutes (O.S.) serve as a valid prescription or referral for an initial evaluation and any subsequent services, as is required by Title 42 of Code of Federal Regulations (C.F.R.), § 440.110.

(3) Physical therapy services, by contrast, shall require a signed and dated prescription from the student's physician prior to that student's initial evaluation, in accordance with OAC 317:30-5-291(1). Prescriptions for school-based physical therapy must be reauthorized at least annually, and documented within Oklahoma State...
Department of Education's (OSDE) online IEP system, as set forth in subsection (c), below.

(c) Qualified school providers must ensure that adequate documentation is maintained within the OSDE online IEP system in order to substantiate that all school-based services billed to SoonerCare are medically necessary and comply with applicable state and federal Medicaid law. Such documentation shall include, among other things:

1. Documentation establishing sufficient notification to a member's parents and receipt of adequate, written consent from them, prior to accessing a member's or parent's public benefits or insurance for the first time, and annually thereafter, in accordance with 34 C.F.R. § 300.154;
2. Any referral or prescription that is required by state or federal law for the provision of school-based services, or for the payment thereof, in whole or in part, from public funds, including, but not limited to, 42 C.F.R. § 440.110. However, any prescription or referral ordered by a physician or other licensed practitioner of the healing arts who has, or whose immediate family member has, a financial interest in the delivery of the underlying service in violation of Section 1395nn, Title 42 of United States Code shall not be valid, and services provided thereto shall not be eligible for reimbursement by the Oklahoma Health Care Authority (OHCA);
3. An annual evaluation located in or attached to the IEP that clearly demonstrates, by means of the member's diagnosis and any other relevant supporting information, that school-based services are medically necessary, in accordance with OAC 317:30-3-1(f). Evaluations completed solely for educational purposes are not compensable. Evaluations must be completed annually and updated to accurately reflect the student's current status. Any evaluation for medically necessary school-based services, including but not limited to, hearing and speech services, physical therapy, occupational therapy, and psychological therapy, must include the following information:
   A. Documentation that supports why the member was referred for evaluation;
   B. A diagnosis that clearly establishes and supports the need for school-based services;
   C. A summary of the member's strengths, needs, and interests;
   D. The recommended interventions for identified needs, including outcomes and goals;
   E. The recommended units and frequency of services; and
   F. A dated signature and the credentials of the professional completing the evaluation; and
4. Documentation that establishes the medical necessity of the school-based services being provided between annual evaluations, including, for example, professional notes or updates, reports, and/or assessments that are signed, dated, and credentialled by the rendering practitioner.

(d) All claims related to school-based services that are submitted to OHCA for reimbursement must include any numeric identifier obtained from OSDE.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #21-395]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 3. General Provider Policies
Part 6. Out-Of-State Services
317:30-3-92 [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 32. SoonerRide Non-Emergency Transportation (NEMT)
317:30-5-326 [AMENDED]
317:30-5-326.1 [AMENDED]
317:30-5-327.1 [AMENDED]
317:30-5-327.3 [AMENDED]
317:30-5-327.5 [REVOKED]
317:30-5-327.6 [AMENDED]
317:30-5-327.8 [AMENDED]
317:30-5-327.9 [AMENDED]
(Reference APA WF # 20-36A)

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The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board

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Not applicable

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n/a

GIST/ANALYSIS:
The proposed revisions update the lodging and meals policy by changing the mileage radius approval from one hundred miles or more to now fifty miles or more. This change improves access to the lodging and meals benefit and maintains access to medically necessary care. Additional changes will reformat and organize the existing policy in order to provide better clarity on how the approval process works for the lodging and meals benefit. Furthermore, the proposed revisions will update and reformat the SoonerRide Non-Emergency Transportation (NEMT) policy so that it provides more clarity to providers and members. The proposed revisions will outline the specific services that SoonerRide NEMT offers and how members and long-term care facilities can go about requesting transportation through SoonerRide NEMT. The proposed revisions to lodging and meals, as well as, SoonerRide NEMT are being done to align policy with current business practices.
PERMANENT FINAL ADOPTIONS 317:30-3-92. Payment for lodging and meals (a) Payment for lodging and/or meals assistance for an eligible member and an one (1) approved medical escort, if needed, is provided only when medically necessary in connection with transportation to and from SoonerCare compensable services. The member and any medical escort must make a reasonable effort to secure lodging at a hospital or non-profit organization. For medically necessary criteria please refer to Oklahoma Administrative Code 317:30-3-1 (f) (1) through (6). The Oklahoma Health Care Authority (OHCA) has discretion and final authority to approve or deny any lodging and/or meal services. (1) Lodging and/or meals are reimbursable when prior authorized/approved. Payment for lodging and/or meals is limited to a period of up to twenty-four (24) hours prior to the start of member's medical services and up to twenty-four (24) hours after the services end. If travel arrangements cannot meet the aforementioned stipulations, due to travel issues/restrictions and/or medically necessary services, then lodging and/or meals may be provided with approval from the OHCA. Lodging is authorized for the member and one approved medical escort, if needed. The following factors may be considered by the OHCA when approving reimbursement for a member and any medical escort: (A) Travel is to obtain specialty care; and (B) The trip cannot be completed during SoonerRide operating hours; and/or (C) The trip is one hundred (100) miles or more from the member's residence, as listed in the OHCA system, to the medical facility; and/or (D) The member's medical treatment requires an overnight stay, or the condition of the member discourages traveling. (2) Lodging and/or meals will not be provided if a suitable alternative is available at a hospital or non-profit. Factors to be considered in determining availability include, but are not limited to: (A) Type of hospital room; (B) Availability of "rooming-in"; (C) Shower facilities available for use by the medical escort; and

(D) Member's anticipated length of stay. (3) The following conditions must be met in order for lodging and/or meals to be reimbursed, unless the lodging and/or meals provision is determined to be the most cost-effective alternative: (A) Travel must be to obtain specialty care at the closest appropriate facility and be fifty (50) miles or greater from the member's home; (B) The trip cannot be completed during SoonerRide operating hours or the member's medical treatment/condition requires an overnight stay; and (C) Medical necessity must be confirmed and the medical escort must be actively engaged and participative in compensable care. (2) When a member is not required to have a Primary Care Provider (PCP) or when a PCP referral is not required to obtain a SoonerCare covered service, a member may go to any provider they choose, but SoonerCare will not reimburse for transportation, lodging, or meals if the distance is beyond what is considered the nearest appropriate facility. (3) Meals will be reimbursed if lodging criteria is met. Duration of the trip must be eighteen (18) hours or greater. (45) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three (3) meals, as required. If meals or meal vouchers are provided by either the hospital or the lodging provider, additional reimbursement will not be provided to the member. (5) During inpatient or outpatient medical stays, lodging and/or meals services are reimbursed for a period of up to fourteen (14) days without prior authorization; stays exceeding the fourteen (14) day period must be prior authorized. A member may not receive reimbursement for lodging and/or meals services for days the member is an inpatient in a hospital or medical facility. (6) For eligible members in the Neonatal Intensive Care Unit (NICU), a minimum visitation of six (6) hours per day for the approved medical escort is required for reimbursement of lodging and/or meals services. Non-emergency transportation services for medically necessary visitation may be provided for eligible medical escort. (6) During the first fourteen (14) days of a member's inpatient or outpatient stay, lodging and meals can be approved per a hospital social worker/provider without prior approval. Additional lodging and/or meals beyond the fourteen (14) days must be prior approved by the OHCA. (7) A member may not receive reimbursement for lodging and/or meals services for days the member is inpatient in a hospital or medical facility since that will be provided at the location that the member is receiving inpatient services. (b) Lodging must be with a SoonerCare contracted Room and Board provider, when available, before direct reimbursement to a member and/or medical escort can be authorized. If lodging and/or meals assistance with contracted Room and
Board providers are not available, the member and any medical escort may request reimbursement assistance by submitting the appropriate travel reimbursement forms. The travel reimbursement forms may be obtained by contacting SoonerCare Care Management division. Any lodging and/or meal expenses claimed on the travel reimbursement forms must be documented with the required receipts and medical records to document the lodging criteria have been met. Reimbursement must not exceed state per diem amounts. The OHCA has discretion and the final authority to approve or deny lodging and/or meals reimbursement. Criteria for lodging and/or meals reimbursement is as follows:

(1) Lodging must be with a SoonerCare contracted room and board provider, when available, before direct reimbursement to a member and/or medical escort can be authorized.

(2) If lodging and/or meals assistance with contracted room and board providers is not available, the member and any medical escort may request reimbursement assistance by submitting the appropriate travel reimbursement forms. The travel reimbursement forms may be obtained by contacting SoonerCare Population Care Management division.

(3) Any lodging and/or meal expenses claimed on the travel reimbursement forms must be documented with the required receipts. If the compensable service related to lodging/meals is not verifiable, reimbursement will be denied.

(4) Reimbursement for lodging will not exceed maximum state allowable amounts.

(5) In order for lodging to be reimbursed for a medical escort of a hospitalized member, the medical escort must be able to assist the member during escort and be of an age of legal majority recognized under state law. In cases where the lodging facility has additional requirements, the medical escort must comply with them. This includes, but is not limited to, being compliant with the lodging facility's required age to check in.

(c) Payment for transportation and lodging and/or meals of one medical escort may be authorized if the service is required.

(d) If the Oklahoma Department of Human Services (DHS) removes a child from his/her home, a court must appoint a temporary guardian. During this time, the temporary guardian is eligible for medical escort-related lodging and/or meals services. If the minor is in need of medical services and a temporary guardian has not been appointed, then the DHS case worker accompanying the minor is eligible for lodging and/or meal services. It is the responsibility of the OHCA to determine this necessity. The decision should be based on the following circumstances:

(1) When the individual's health or disability does not permit traveling alone; and

(2) When the individual seeking medical services is a minor child.

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 32. SOONERRIDE NON-EMERGENCY TRANSPORTATION (NEMT)**

317:30-5-326. Provider eligibility

The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible SoonerCare members who are in need of SoonerCare medical services in accordance with 42 CFR 431.53 Section 431.53 of Title 42 of the Code of Federal Regulations. The agency contracts with a broker to provide statewide curb-to-curb coverage for non-emergency transportation under the SoonerRide program. The broker provides the most appropriate, and least costly mode of transportation necessary to meet the individual needs of SoonerCare members statewide. Payment for covered services to the broker is made pursuant to the methodology described in the Oklahoma Title XIX State Plan. The agency contracts directly with ambulance and air providers for all other transportation needs for eligible members not approved by SoonerRide.

317:30-5-326.1. Definitions

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

"Attendant" means an employee of the nursing facility who is provided by and trained by the nursing facility at the nursing facility's expense. One (1) of the following:

(1) An employee of a long-term care facility who is provided by and trained by the long-term care facility at the long-term care facility's expense; or

(2) A provider of private duty nursing (PDN) services.

"Emergency/Emergent" means a serious situation or occurrence that happens unexpectedly and demands immediate action such as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the members' health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

"Medical escort" means a family member, legal guardian, or volunteer whose presence is required and medically necessary to assist a member during transport and while at the place of treatment. A medical escort voluntarily accompanies the member during transport and leaves the vehicle at its destination and remains with the member. A medical escort must be of an age of legal majority recognized under Oklahoma State law, an emancipated minor, or a minor who is escorting his or her child to treatment.

"Medically necessary" means services that meet the criteria described in Oklahoma Administrative Code 317:30-3-1 (f) (1) - (6), and are not primarily for the convenience of the member.

"Member/eligible member" means any person eligible for SoonerCare and individuals considered to be Medicare/SoonerCare fully dually eligible, dual eligible. This does not include those individuals who are categorized only as
Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualifying Individuals (QI-L), individuals who are in an institution for mental disease (IMD), inpatient, institutionalized, Home and Community-Based Waiver members, with the exception of the In-Home Supports Waiver for Children, the Advantage Waiver, the Living Choice demonstration, the Sooner Seniors Waiver, the My Life, My Choice Waiver and the Medically Fragile Waiver.

"Nearest appropriate facility" means a medical facility that is generally equipped and legally permitted to provide the needed care for the illness or injury involved that is the closest in geographical proximity to the members' residence with exceptions. In the case of approved hospital services, it also means that a physician or physician specialist is available to provide the necessary care required to treat the member's condition. The fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, non-emergency transportation service to a more distant hospital, clinic, practitioner or physicians' office solely to avail a member of the service of a specific physician or physician specialist does not make the institution in which the physician has staff privileges the nearest institution with appropriate facilities.

"Non-ambulance" means a carrier that is not an ambulance.

"Non-emergency" means all reasons for transportation that are not an emergency as defined above.

"Service animal" means an animal individually trained to work or perform tasks for an individual with a disability. The work or task an animal has been trained to provide must be directly related to the individual's disability.

"SoonerRide Non-Emergency Transportation (NET)(NEMT)" means non-emergency non-ambulance transportation provided statewide within the geographical boundaries of the State of Oklahoma.

"Standing appointments" means recurring appointments that are scheduled over a significant period of time. Examples include, but are not limited to, dialysis and chemotherapy.

317:30-5-327.1. SoonerRide NET Coverage

SoonerRide NET coverage and exclusions

(a) SoonerRide NET is available for SoonerCare covered admission and discharge into inpatient hospital care, outpatient hospital care, services from physicians/approved practitioners, diagnostic services, clinic services, pharmacy services, eye care and dental care under the following conditions:

1. Transportation is to the nearest appropriate facility or medical provider capable of providing the necessary services.

(A) The nearest appropriate facility or provider is not considered appropriate if the member's condition requires a higher level of care or specialized services available at the more distant facility. However, a legal impediment barring a member's admission would mean that the institution did not have "appropriate facilities". For example, the nearest transplant center may be in another state and that state's law precludes admission of nonresidents.

(B) The nearest appropriate facility is not considered appropriate if no bed or provider is available. However, the medical records must be properly documented.

(C) Services should be available within 45 miles of the members' residence with exceptions. The OHCA has discretion and the final authority to approve or deny travel greater than 45 miles to access services.

(i) Members seeking self-referred services are limited to the 45 mile radius.

(ii) Native Americans seeking services at a tribal or IHS facility may be transported to any facility within a 45-mile radius equipped for their medical needs with exceptions. Trips to out of state facilities require prior approval.

(iii) Dually may be transported to any facility within a 45-mile radius equipped for their medical needs with exceptions. Trips to out of state facilities require prior approval.

2. The service provided must be a SoonerCare covered service provided by a medical provider who is enrolled in the SoonerCare program.

3. Services requiring prior authorization must have been authorized (e.g., travel that exceeds the 45-mile radius, out of state travel, meals and lodging services).

(b) SoonerRide NET is available on a statewide basis to all eligible members.

(c) SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare.

(d) SoonerRide NET is available if a member is being discharged from a facility to their home. The facility is responsible for scheduling the transportation.

(e) In documented medically necessary instances, a medical escort may accompany the member.

1. SoonerRide NET is not required to transport any additional individuals other than the one approved individual providing the escort services. In the event that additional individuals request transportation, the SoonerRide broker may charge those family members according to the SoonerRide broker's policies which have been approved by the OHCA.

2. A medical escort is not eligible for direct compensation by the SoonerRide broker or SoonerCare.

(a) SoonerRide NET coverage. SoonerRide NET is available for SoonerCare compensable services under the following conditions:

1. Nearest appropriate facility.

(A) Transportation is to the nearest appropriate facility or medical provider that is capable of providing the necessary services.

(B) SoonerRide NET services to a more distant hospital, clinic, practitioner or physicians' office...
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solely to avail a member of the service of a specific physician or physician assistant does not make the institution in which the physician has staff privileges the nearest institution with appropriate facilities.
(C) The nearest facility is not considered appropriate if:
(i) The member's condition requires a higher level of care or specialized services available at a more distant facility; or
(ii) There are no beds or providers available. Medical records must be properly documented in this circumstance.
(2) Radius. Primary care and specialty SoonerCare compensable services should be available within forty-five (45) miles of the member's residence. The Oklahoma Health Care Authority (OHCA) has the final authority to approve or deny travel greater than forty-five (45) miles to access these services.
(A) Residency change. Should a member change residence then care will be established within forty-five (45) miles of the new residence.
(B) American Indians/Alaska Natives (AI/AN). AI/AN members that are seeking services at a Tribal or Indian Health Services (I.H.S.) facility may be transported to any Tribal or I.H.S. facility equipped for their medical needs. All trips to out-of-state facilities require prior authorization and approval.
(3) Services requiring prior authorization.
(A) Travel that exceeds the forty-five (45) mile radius, as mentioned in Oklahoma Administrative Code (OAC) 317:30-5-327.1 (a) (2), must be authorized and approved; and
(B) Out-of-state travel for prior authorized out-of-state medically necessary services, must also be authorized and approved.
(b) Discharge coverage. SoonerRide NEMT is available if a member is being discharged from a facility to their home. The facility is responsible for scheduling the transportation. SoonerRide NEMT is only responsible for transporting the member.
(1) Personal belongings and/or durable medical equipment (with the exception of portable oxygen or a wheelchair that is medically necessary for transportation) will not be transported through SoonerRide NEMT.
(2) Wheelchairs must be provided by the medical escort/member. This item is not provided by the SoonerRide NEMT transport.
(c) Medical escorts/service animals/additional passengers. In instances where there is documented medical necessity, a medical escort or service animal may accompany the member.
(1) Medical escort. A medical escort is not eligible for direct compensation by the SoonerRide NEMT broker or SoonerCare.
(2) Service animal. The SoonerRide NEMT broker may request additional information regarding the service animal, including but not limited to, if the animal is required because of a disability and what work or task the animal has been trained to perform.
(3) Removal of the service animal. The SoonerRide NEMT broker may ask for the service animal to be removed if it is not under the control of the handler or if it is not housebroken/trained. Additionally, the SoonerRide NEMT broker and the OHCA are not responsible for the care and supervision of the service animal.
(4) Additional passengers. SoonerRide NEMT is not required to transport any additional individuals other than the one (1) approved individual providing the escort services.
(A) Additional passengers request. In the event that additional individuals request transportation, it is the responsibility of the member to contact the transportation provider directly to request allotment of additional passengers. The SoonerRide NEMT broker will not facilitate this request.
(B) Exceptions for urgent appointments. Exceptions may be granted if the medical appointment is urgent in nature and meets the criteria outlined in Oklahoma Administrative Code (OAC) 317:30-5-327.1 (d) (1)- (3).
(d) Urgent appointments and additional passengers. An urgent appointment can be for either a sick child or sick parent/guardian. The member must make the request for additional child passengers when making the trip reservation. A maximum of three (3) children can ride with the parent/guardian. The total number of passengers, including the driver, cannot exceed more than five (5) persons for any vehicle. In addition, the following conditions must be met:
(1) Urgent medical appointment. The medical appointment must be urgent (for a sick child or sick parent) as determined by the member's doctor. The SoonerRide NEMT broker will confirm that the medical appointment is urgent with the member's doctor;
(2) Children. All children must be the member's by birth, marriage, legal adoption, foster child, or legal guardianship. Further, the additional children passengers must be younger than thirteen (13) years of age. Exception will be granted if a child has complex, medical, intellectual, or physical disabilities that requires constant care and supervision; and
(3) Car seats for children. Each child must have his or her own car seat, provided by the member, if required by Oklahoma state law.
(e) Forms of transportation. SoonerRide NEMT can include one (1) of the following forms of transportation:
(1) Authorization for transportation by private vehicle or bus. Transportation by private vehicle or bus is administered through the broker when it is necessary for an eligible member to receive medical services.
(2) Authorization for transportation by taxi. Taxi service may be authorized at the discretion of the broker.
(3) Transportation by ambulance. Transportation by ambulance is only provided for non-emergency scheduled stretcher service.
(4) Transportation by airplane. When an individual's medical condition is such that transportation out-of-state by a commercial airline is required, approval
for airfare must be secured by telephoning the OHCA who will make the necessary flight arrangements.

(f) Exclusions for SoonerRide NEMT. SoonerRide NEMT coverage excludes the following:

1. Emergency services. Transportation of members to access emergency services;
2. Ambulance. Transportation of members by ambulance for any reason, except for non-emergency scheduled stretcher service per OAC 317:30-5-327.1 (e) (3);
3. Non-compensable services. Transportation of members to services that are not covered by SoonerCare;
4. Non-medically necessary services. Transportation of members to services that are not medically necessary.

317:30-5-327.3. Coverage for residents of nursing facilities long-term care facilities

(a) An attendant must accompany members during SoonerRide Non-Emergency Transportation (NET) NEMT. An attendant must be at least at the level of a nurse’s aide, and must have the appropriate training necessary to provide any and all assistance to the member, including physical assistance needed to seat the member in the vehicle. The attendant must have the ability to interface with health care providers as appropriate. An attendant must be of an age of legal majority recognized under Oklahoma State law.

1. The nursing facility long-term care facility must provide an attendant to accompany members receiving NET NEMT services.
2. The attendant will be responsible for any care needed by the member(s) during transport and any assistance needed by the member(s) to assure the safety of all passengers and the driver of the vehicle. An attendant leaves the vehicle at its destination and remains with the member(s).
3. When multiple members residing in the same nursing facility long-term care facility are being transported to the same provider for health care services, the nursing facility long-term care facility may provide one (1) qualified attendant for each three (3) members unless other circumstances indicate the need for additional attendants. Such circumstances might include, but are not limited to:
   (A) the physical and/or mental status of the member(s);
   (B) difficulty in getting the member(s) in and out of the vehicle;
   (C) the amount of time that a member(s) would have to wait unattended, etc.
4. SoonerRide NEMT is not responsible for arranging for an attendant. The services of the attendant are not directly reimbursable by the SoonerRide program or SoonerCare. The cost for the attendant is included in the SoonerCare nursing facility long-term care facility per diem rate.
5. In certain instances, a family member or legal guardian may wish to accompany the member for health care services. In such instances, the family member or legal guardian may accompany the member in place of the attendant. Only one (1) medical escort may accompany a member and it must be declared, upon reservation, that the medical escort is accompanying the member. The medical escort must be able to provide any and all services and assistance necessary to assure the safety of the member in the vehicle.

(A) When a medical escort wishes to accompany the member in place of an attendant provided by the nursing facility long-term care facility, the medical escort must sign a release form stating that the medical escort will be traveling with the member and performing the services which would normally be performed by the attendant. This release must be faxed to the SoonerRide broker’s business office prior to the date of the transport.

(B) If a medical escort is used in place of an attendant provided by the nursing facility long-term care facility, that medical escort cannot be counted as a medical escort for any other member who is traveling in the same vehicle.

(C) SoonerRide is not required to transport any additional family members other than the one family member providing escort services. In the event that additional family members request transportation, the SoonerRide broker may charge those family members according to the SoonerRide broker’s policies approved by the OHCA. In the event that additional individuals request transportation, it is the responsibility of the member to contact the transportation provider directly to request allotment of additional passengers. The SoonerRide NEMT broker will not facilitate this request.

(D) An escort or medical escort or attendant is not eligible for direct compensation by the SoonerRide NEMT broker or SoonerCare.

(b) For members who require non-emergency transportation SoonerRide NEMT for dialysis, one (1) attendant is required to accompany a group of up to three (3) dialysis patients when they are being transported for dialysis services. The attendant must remain with the patient(s) unless the provider of the dialysis treatment and the nursing facility long-term care facility sign a release form stating that the presence of the attendant is not necessary during the dialysis treatment. The release must be faxed to the SoonerRide NEMT broker’s business office prior to the date of the dialysis service.

1. In instances when an attendant does not remain with the member(s) during dialysis treatment, SoonerRide NEMT is not responsible for transporting the attendant back to the nursing facility long-term care facility.
2. In instances when an attendant does not remain with the member(s) during dialysis treatment, the nursing facility long-term care facility is responsible for providing an attendant to accompany the member(s) on the return trip from the dialysis center. The nursing facility long-term care facility...
care facility is also responsible for transporting that attendant to the dialysis center in order to accompany the member(s) on the return trip.

(c) In the event that a member is voluntarily moving from one (1) nursing facility–long-term care facility to another, SoonerRide will provide NETNEMT to the new facility. The nursing facility–long-term care facility that the member is moving from will be responsible for scheduling the transportation and providing an attendant for the member.

(d) In the event that a nursing facility–long-term care facility’s license is terminated, SoonerRide will provide NETNEMT to a new nursing facility–long-term care facility. The nursing facility–long-term care facility that the member is moving from will be responsible for scheduling the NETNEMT through SoonerRide and providing an attendant to accompany the member. SoonerRide is only responsible for transporting the member. Personal belongings and/or durable medical equipment (with the exception of portable oxygen or a wheelchair that is medically necessary for transportation) will not be transported through SoonerRide NETNEMT.

(e) The long-term care facility is responsible for providing a wheelchair when needed. This item is not provided by the SoonerRide NETNEMT transport.

317:30-5-327.5. Exclusions from SoonerRide NET [REVOKED]
SoonerRide NET excludes:
(1) transportation of members to access emergency services;
(2) transportation of members by ambulance for any reason;
(3) transportation of members to services that are not covered by SoonerCare; and
(4) transportation of members to services that are not medically necessary.

317:30-5-327.6. Denial of SoonerRide NETNEMT services by the SoonerRide broker
(a) In addition to the exclusions listed in 317:30-5-327.5 Oklahoma Administrative Code (OAC) 317:30-5-327.1 (f) (1) - (4) of this Part, the SoonerRide NETNEMT broker may deny NETNEMT services if:

(1) the nursing facility/member The long-term care facility/member refuses to cooperate in determining the member's eligibility;
(2) the nursing facility/member The long-term care facility/member refuses to provide the documentation required to determine the medical necessity for NETNEMT services;
(3) the member or attendant The member, medical escort, attendant, or service animal exhibits uncooperative behavior or misuses/abuses NETNEMT services;
(4) the member is not ready to board NETNEMT The member is not ready to board NETNEMT at the scheduled time or within fifteen (15) minutes after the scheduled pick up time; and
(5) The member has not shown or cancelled previous appointments less than twenty-four (24) hours prior to the appointment, or has cancelled three (3) times within a ninety (90) day period, upon the SoonerRide NETNEMT transport's arrival at the member's residence; or

(b) Pursuant to Federal law, SoonerRide will provide notification in writing to nursing facilities/memberlong-term care facilities/members when members have been denied services have been denied. This notification must include the specific reason for the denial and the member's right to appeal.

(1) An appeal must be filed with the Oklahoma Health Care Authority (OHCA) in accordance with OAC 317:2-1-2.
(2) The appropriateness of transportation may be appealed only to the extent that the transportation does not meet the medical needs of the member. Dissatisfaction with the use of public transportation, shared rides, type of vehicle, etc., is not appropriate grounds for appeal.
(3) The OHCA's decision is final. This decision may be appealed to the chief executive officer of the OHCA pursuant to OAC 317:2-1-13.

(c) The agency contracts directly with ambulance and air providers for all other transportation needs for eligible members not approved by SoonerRide NETNEMT. Please refer to Subchapter 5, Part 33, Transportation by Ambulance, of this Chapter.

317:30-5-327.8. Type of services provided and duties of the SoonerRide NETNEMT driver
(a) The SoonerRide NET program is limited to curb to curb services. Curb to curb services are defined as services for which the vehicle picks up and discharges the passengers at the curb or driveway in front of their place of residence or destination. The SoonerRide NET driver does not provide assistance to passengers along walkways or steps to the door or the residence or other destination. The SoonerRide NET driver will open and close the vehicle doors, load or provide assistance with loading adaptive equipment. Additionally, the SoonerRide NET driver may fasten and unfasten safety restraints when that service is requested by the rider or on behalf of the rider.
(a) The SoonerRide NEMT program shall not exceed curb-to-curb services. This service will be determined by the SoonerRide NEMT broker.

1. Curb-to-curb services are defined as services for which the vehicle picks up and discharges the passengers at the curb or driveway in front of their place of residence or destination.
   - (A) The SoonerRide NEMT driver will open and close the vehicle doors, load or provide assistance with loading adaptive equipment.
   - (B) The SoonerRide NEMT driver may fasten and unfasten safety restraints when that service is requested by the rider or on behalf of the rider.

2. Curb-to-curb services are limited to the first thirty (30) days of NEMT eligibility. After thirty (30) days, the member may be required to utilize public transportation.

   Exceptions to this include:
   - (A) The member's residence is outside of three-fourths (3/4) of a mile from the public transportation stop; or
   - (B) The medical appointment is outside of three-fourths (3/4) of a mile from the transportation stop.

3. If a letter of medical necessity is provided by the member's medical provider as to the need of curb-to-curb services, when the exceptions listed in Oklahoma Administrative Code 317:30-5-327.8 (a) (2) (A) and (B) are applicable, the approval must be confirmed by the Oklahoma Health Care Authority (OHCA).

(b) If the member is traveling by lift van, the SoonerRide NEMT driver will load and unload the member according to established protocols for such procedures approved by the Oklahoma Health Care Authority (OHCA).

(c) The SoonerRide NEMT driver will deliver the member to the scheduled destination, and is not required to remain with the member.

(d) The SoonerRide NEMT driver does not provide assistance to passengers along walkways or steps to the door of the residence or other destination.

317:30-5-327.9. Scheduling NEMT Services through SoonerRide

(a) The nursing facility/memberlong-term care facility/member will schedule SoonerRide NEMT services for transportation to covered services. SoonerRide NEMT services may be scheduled by calling the toll free SoonerRide number or by faxing a request to SoonerRide.

(b) All SoonerRide NEMT routine services must be scheduled by advance appointment. Appointments must be made at least three (3) business days in advance of the health care appointment, but may be scheduled up to fourteen (14) business days in advance. Scheduling for members with standing appointments may be scheduled for those appointments beyond the 14 fourteen (14) days.

(c) NEMT services for eligible members will be scheduled and obtained through the SoonerRide NEMT program. The nursing facility/memberlong-term care facility/member will be financially responsible for NEMT services which are not scheduled for eligible members through the SoonerRide program. The nursing facilitylong-term care facility may not charge the member or member's family for NEMT services which were not paid for by SoonerRide because they were not scheduled through SoonerRide in the appropriate manner.

(d) The long-term care facility/member must provide wheelchairs or car seats when needed. These items will not be provided by the SoonerRide NEMT transport.

(e) Whenever possible SoonerRide will give consideration for members who request NETMNT for routine care and the request is made less than three (3) business days in advance of the appointment. However, such requests for service are not guaranteed and will depend on the available space and resources availability of space and resources, as well as, the distance to the medical appointment.

(f) If SoonerRide cannot provide NEMT for urgent care, the nursing facility/memberlong-term care facility/member may provide the NETMNT transportation and submit proper documentation to SoonerRide for reimbursement. In such cases the nursing facility/memberlong-term care facility/member must attempt to schedule the service through SoonerRide first, and obtain a reference number or the service must have become necessary during a time that SoonerRide scheduling was unavailable, such as after hours or weekends. For NETMNT for urgent services provided after hours or on weekends, the nursing facility/memberlong-term care facility/member must notify SoonerRide within two (2) business days of the date of service.

[OAR Docket #21-395; filed 6-14-21]

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

[OAR Docket #21-387]

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PERMANENT final adoption

RULES:
Subchapter 5. Individual Providers and Specialties
Part 9. Long-Term Care Facilities
317:30-5-136.1 [AMENDED] (Reference APA WF # 20-20)

AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board; Senate Bill 280

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Oklahoma Register (Volume 38, Number 23)
quality metric, listed below, is substituted or removed by Centers of Medicare and Medicaid Services (CMS), an alternative quality metric may be chosen with the support of participating partners. For the period beginning October 1, 2019 and until changed by amendment, qualifying facilities participating in the PFP program have the potential to earn an average of the five dollars ($5.00) quality incentive per Medicaid patient per day. Facility(s) baseline is calculated annually and will remain the same for the twelve (12) month period. Facility(s) will meet or exceed five-percent (5%) relative improvement or the Centers for Medicare and Medicaid Services CMS' national average each quarter for the following metrics:

1. Decrease percent of high risk/unstageable pressure ulcers for long stay-long stay residents.
2. Decrease percent of unnecessary weight loss for long stay-long stay residents.
3. Decrease percent of use of anti-psychotic medications for long stay-long stay residents.
4. Decrease percent of urinary tract infection for long stay-long stay residents.

(d) Payment. Payment to long-term care facilities for meeting the metrics will be awarded quarterly. A facility may earn a minimum of $1.25 (one dollar and twenty-five cents ($1.25) per Medicaid patient per day for each qualifying metric. A facility receiving a deficiency of "I" or greater related to a targeted quality measure in the program is disqualified from receiving an award related to that measure for that quarter.

1. Distribution of Payment. OHCA will notify the PFP facility of the quality reimbursement amount on a quarterly basis.
2. Penalties. Facilities shall have performance review(s) and provide documentation upon request from OHCA to maintain program compliance. Program payments will be withheld from facilities that fail to submit the requested documentation within fifteen (15) business days of the request.
3. Timeframe. To qualify for program reimbursement by meeting a specific quality measure, facilities are required to provide metric documentation within thirty (30) days after the end of each quarter to the OHCA.

(e) Appeals. Facilities can file an appeal with the Quality Review Committee and in accordance, with the grievance procedures found at OAC 317:2-1-2(e) and 317:2-1-16.317:2-1-17.

[OAR Docket #21-387; filed 6-14-21]

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

[OAR Docket #21-399]
Permanent Final Adoptions

317:30-5-6 [AMENDED]
Part 3. Hospitals
317:30-5-50 [AMENDED]
(Reference APA WF # 20-40)

AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of
Oklahoma Statutes; the Oklahoma Health Care Authority Board; 63 O.S.
Section 1-741.1

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n/a

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
The proposed revisions align policy with Title 63 Oklahoma Statutes
Section 1-741.1 and require the Certification for Medicaid Funded Abortion
form to be completed by the physician and the patient.

CONTACT PERSON:
Sandra Pueba, Director of Federal and State Authorities, 405-522-7270,
Sandra.Pueba@okhca.org.

PUISUANT TO THE ACTIONS DESCRIBED HEREIN,
THE FOLLOWING RULES ARE CONSIDERED
FINALLY ADOPTED AS SET FORTH IN 75 O.S.,
SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE
DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS
AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-6. Abortions
(a) Payment is made only for abortions in those instances
where the abortion is necessary due to a physical disorder, in-
jury or illness, including a life-endangering physical condition
caused by or arising from the pregnancy itself, that would, as
certified by a physician, place the woman in danger of death
unless an abortion is performed, or where the pregnancy is
the result of an act of rape or incest. Medicaid coverage for
abortions to terminate pregnancies that are the result of rape
or incest will only be provided as long as Congress considers
abortions in cases of rape or incest to be medically necessary
services and federal financial participation is available specif-
ically for these services.

(1) For abortions necessary due to a physical disorder,
injury or illness, including a life-endangering physical condition
caused by or arising from the pregnancy itself, that would place
the woman in danger of death unless an abortion is performed,
the physician must complete the Certification for Medicaid Funded Abortion and
certify in writing that the abortion is being performed
due to a physical disorder, injury or illness, including a
life-endangering physical condition caused by or arising
from the pregnancy itself, that would place the woman
in danger of death unless an abortion is performed. The
mother's name and address must be included in
the certification and the certification must be signed
and dated by the physician. The certification must be attached
to the claim.

(2) For abortions in cases of rape or incest, there are
two requirements for the payment of a claim. First, the
patient physician must fully complete the Patient Certification For
Medicaid Funded Abortion. Second, the patient
must have made a police report or counselor's re-
port of the rape or incest. In cases where an official report
of the rape or incest is not available, the physician must
certify in writing and provide documentation that in his
or her professional opinion, the patient was unable, for
physical or psychological reasons, to comply with the
requirement. The statement explains the reason the rape
or incest was not reported. The mother's name and
address must be included in the certification and the certi-
fication must be signed and dated by the physician and the
patient. In cases where a physician provides certification
and documentation of a client's inability to file a
report, the Authority will perform a prepayment review of
all records to ensure there is sufficient documentation
to support the physician's certification.

(b) The Oklahoma Health Care Authority performs a
"look-behind" procedure for abortion claims paid from Medic-
icaid funds. This procedure will require that this Agency obtain
the complete medical records for abortions paid under Med-
icaid. On a post-payment basis, this Authority will obtain the
complete medical records for abortions paid under Medi-
caid. This procedure will require that this Agency obtain
a "look-behind" procedure for abortion claims paid from Medic-
icaid. On a post-payment basis, this Authority will obtain the
complete medical records for abortions paid under Medi-
caid.

(c) Claims for spontaneous abortions, including dilation and
curettage do not require certification. The following situations
also do not require certification:

(1) If the physician has not induced the abortion, coun-
seled or otherwise collaborated in inducing the abortion;
and
(2) If the process has irreversibly commenced at the
point of the physician's medical intervention.

(d) Claims for the diagnosis "incomplete abortion" require
medical review.

(e) The appropriate diagnosis codes should be used indicat-
ing spontaneous abortion, etc., otherwise the procedure will be
denied.

PART 3. HOSPITALS
317:30-5-50. Abortions
(a) Payment is made only for abortions in those instances where the abortion is necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, or where the pregnancy is the result of an act of rape or incest. SoonerCare coverage for abortions to terminate pregnancies that are the result of rape or incest are considered to be medically necessary services and federal financial participation is available specifically for these services.
(1) For abortions necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, the physician must complete the Certification for Medicaid Funded Abortion and certify in writing that the abortion is being performed due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed. The mother's name and address must be included in the certification and the certification must be signed and dated by the physician. The certification must be attached to the claim.
(2) For abortions in cases of rape or incest, there are two requirements for the payment of a claim. First, the patient must fully complete the Patient Certification for Medicaid Funded Abortion. Second, the patient must have made a police report or counselor's report of the rape or incest. In cases where an official report of the rape or incest is not available, the physician must certify in writing and provide documentation that in his or her professional opinion, the patient was unable, for physical or psychological reasons, to comply with the requirement. The statement explains the reason the rape or incest was not reported. The mother's name and address must be included in the certification and the certification must be signed and dated by the physician and the patient. In cases where a physician provides certification and documentation of a client's inability to file a report, the Authority, Oklahoma Health Care Authority (OHCA) will perform a prepayment review of all records to ensure there is sufficient documentation to support the physician's certification.
(b) The Oklahoma Health Care Authority OHCA performs a look-behind procedure for abortion claims paid from SoonerCare funds. This procedure will require that this agency obtain the complete medical records for abortions paid under SoonerCare. On a post payment basis, this Authority will obtain the complete medical records on all claims paid for abortions.
(c) Claims for spontaneous abortions, including Dilation and Curettage do not require certification. The following situations also do not require certification:
(1) If the physician has not induced the abortion, counseled or otherwise collaborated in inducing the abortion, and
(2) If the process has irreversibly commenced at the point of the physician's medical intervention.
(d) Claims for the diagnosis incomplete abortion require medical review. The appropriate diagnosis codes should be used indicating spontaneous abortion, etc.; otherwise the procedure will be denied.

[OAR Docket #21-399; filed 6-14-21]

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

[OAR Docket #21-396]

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PERMANENT final adoption

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Subchapter 5. Individual Providers and Specialties
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317:30-5-22 [AMENDED]
(Reference APA WF # 20-37)

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The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board

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n/a

GIST/ANALYSIS:
The proposed revisions update the obstetrical (OB) ultrasound policy to allow for both an abdominal and vaginal ultrasound to be performed in the first trimester when clinically appropriate and medically necessary. Policy currently only allows for either an abdominal or vaginal ultrasound.

CONTACT PERSON:
Sandra Puebla, Director of Federal and State Authorities, 405-522-7270, Sandra.Puebla@okhca.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-22. Obstetrical care
(a) Obstetrical (OB) care is billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery is used as the date of service for charges for total obstetricalOB care. Inclusive dates of care should be indicated on the claim form as part of the description. Payment for total obstetricalOB care includes all routine care, and any ultrasounds performed by the attending physician provided during the maternity cycle unless otherwise specified in this Section. For payment of total OB care, a physician must have provided care for more than one (1) trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB physician outside of the antepartum visits. The antepartum care during the prenatal care period includes all care by the OB attending physician except major illness distinctly unrelated to the pregnancy.

(b) Procedures paid separately from total obstetricalOB care are listed in (1) - (8) of this subsection.

(1) The completion of an American College of Obstetricians and Gynecologists (ACOG) assessment form or form covering same elements as ACOG and the most recent version of the Oklahoma Health Care Authority's (OHCA) Prenatal Psychosocial Assessment are reimbursable when both documents are included in the prenatal record. SoonerCare allows one (1) assessment per provider and no more than two (2) per pregnancy.

(2) Medically necessary real time antepartum diagnostic ultrasounds will be paid in addition to antepartum care, delivery and postpartum obstetricalOB care under defined circumstances. To be eligible for payment, all ultrasound reports must meet the guideline standards published by the American Institute of Ultrasound Medicine (AIUM).

(A) One (1) abdominal or vaginal ultrasound will be covered in the first trimester of an uncomplicated pregnancy. Both an abdominal and vaginal ultrasound may be allowed when clinically appropriate and medically necessary. The ultrasound must be performed by a Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Certified Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with a certification in obstetricalOB ultrasonography.

(B) One (1) ultrasound after the first trimester will be covered. This ultrasound must be performed by a Board Eligible/Board Certified OB-GYN, Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Certified Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with a certification in obstetricalOB ultrasonography.

(c) One (1) additional detailed ultrasound is allowed by a Board Eligible/Board Certified Maternal Fetal Specialist or general obstetrician with documented specialty training in performing detailed ultrasounds. This additional ultrasound is allowed to identify or confirm a suspected fetal/maternal anomaly. This additional ultrasound does not require prior authorization. Any subsequent ultrasounds will require prior authorization.

(3) Standby attendance at Cesarean Section (C-Section), for the purpose of attending the baby, is compensable when billed by a physician or qualified health care provider not participating in the delivery.

(4) Anesthesia administered by the attending physician is a compensable service and may be billed separately from the delivery.

(5) Amniocentesis is not included in routine obstetricalOB care and is billed separately. Payment may be made for an evaluation and management service and a medically indicated amniocentesis on the same date of service. This is an exception to general information regarding surgery found at OAC Oklahoma Administrative Code (OAC) 317:30-5-8.

(6) Additional payment is not made for the delivery of multiple gestations. If one (1) fetus is delivered vaginally and additional fetus(es) are delivered by C-section by the same physician, the higher level procedure is paid. If one (1) fetus is delivered vaginally and additional fetus(es) are delivered by C-Section, by different physicians, each should bill the appropriate procedure codes without a modifier. Payment is not made to the same physician for both standby and assistant at C-Section.

(7) Reimbursement is allowed for nutritional counseling in a group setting for members with gestational diabetes. Refer to OAC 317:30-5-1076(5).

(c) Assistant surgeons are paid for C-Sections which include only in-hospital post-operative care. Family practitioners who provide prenatal care and assist at C-Section bill separately for the prenatal and the six (6) weeks postpartum office visit.

(d) Procedures listed in (1) - (5) of this subsection are not paid or not covered separately from total obstetricalOB care.

(1) Non stress test, unless the pregnancy is determined medically high risk. See OAC 317:30-5-22.1.

(2) Standby at C-Section is not compensable when billed by a physician participating in delivery.

(3) Payment is not made for an assistant surgeon for obstetricalOB procedures that include prenatal or postpartum care.

(4) An additional allowance is not made for induction of labor, double set-up examinations, fetal stress tests, or pudendal anesthetic. Providers must not bill separately for these procedures.

(5) Fetal scalp blood sampling is considered part of the total OB care.
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(e) Obstetric OR coverage for children is the same as for adults. Additional procedures may be covered under EPSDT/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions if determined to be medically necessary.

(1) Services deemed medically necessary and allowable under federal Medicaid regulations are covered by the EPSDT/OHCA Child Health Program even though those services may not be part of the Oklahoma Health Care Authority/OHCA SoonerCare program. Such services must be prior authorized.

(2) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental. For more information regarding experimental or investigational and clinical trials see OAC 317:30-3-57.1.

[OAR Docket #21-396; filed 6-14-21]

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

[OAR Docket #21-393]

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PERMANENT final adoption

RULES:
Subchapter 5. Individual Providers and Specialties
Part 10. Bariatric Surgery
317:30-5-137 [AMENDED]
317:30-5-137.1 [REVOKED]
317:30-5-137.2 [REVOKED]
317:30-5-140 [AMENDED]
317:30-5-141 [REVOKED]
(Reference APA WF # 20-33)

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n/a

GIST/ANALYSIS:
The proposed revisions update bariatric surgery requirements and guidelines to reflect current business practice. Additional revisions will involve fixing grammatical and/or formatting errors, as well as, revoking obsolete sections.

CONTACT PERSON:
Sandra Puebla, Director of Federal and State Authorities, 405-522-7270, Sandra.Puebla@okhc.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 10. BARIATRIC SURGERY

317:30-5-137. Eligible providers to perform bariatric surgery. Bariatric surgery

The Oklahoma Health Care Authority (OHCA) covers bariatric surgery under certain conditions as defined in this section. Bariatric surgery is not covered for the treatment of obesity alone. To be eligible for reimbursement, bariatric surgery providers must be certified by the American College of Surgeons (ACS) as a Level I Bariatric Surgery Center or certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (BSCOE) or the surgeon and facility are currently participating in a bariatric surgery quality assurance program and a clinical outcomes assessment review. All qualifications must be met and approved by the OHCA. Bariatric surgery facilities and their providers must be contracted with OHCA.

(a) Bariatric surgery. Gastric bypass and other types of weight-loss surgery, known as bariatric surgery, makes surgical changes to the stomach and digestive system, limits food intake and nutrient absorption, which leads to weight loss.

(b) Eligible providers. Bariatric surgery providers must be:

(1) Certified by the American College of Surgeons (ACS) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) as a Comprehensive Bariatric Surgery Center; or

(2) Currently participating in a comprehensive multidisciplinary bariatric surgery quality assurance program and a clinical outcomes assessment review as a pathway to accreditation; and

(3) Completed a fellowship training in bariatric surgery or be a fellow of the American Society of Metabolic and Bariatric Surgery (ASMBS) or a MBSAQIP verified surgeon; and

(4) Contracted with the Oklahoma Health Care Authority (OHCA); and

(5) Have a demonstrated record of quality assurance.

(c) Documentation. All documentation submitted to request services must demonstrate, through adequate objective
medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(1).

Documentation requirements include, but are not limited to:

1. Documents sufficient to show that member is between the ages of fifteen (15) to sixty-five (65);
2. Psychosocial evaluation;
3. Independent medical evaluation by a health care professional with dedicated expertise in the care of bariatric surgery patients;
4. Surgical evaluation by an OHCA-contracted surgeon who is credentialed to perform bariatric surgery;
5. Record on participation in a nutrition and lifestyle modification program under the supervision of an OHCA contracted medical provider; and
6. For full guidelines, please refer to www.okhca.org/mau.

(d) Non-covered services.

1. Procedures considered experimental or investigational are not covered.
2. The OHCA may withdraw authorization of payment for the bariatric surgery at any time if the OHCA determines that the member, provider, or bariatric program is not in compliance with any of the requirements.

(e) Reimbursement.

1. Reimbursement shall only be made for services that have been prior-authorized by OHCA or its designee.
2. To be eligible for reimbursement, bariatric surgery providers must meet the requirements listed in (b) (1) through (5) of this Section.
3. Payment shall be made at the lower of the provider's usual and customary charge or the OHCA fee schedule for Medicaid compensable services and in accordance with the Oklahoma Medicaid State Plan.

317:30-5-137.1. Member candidacy [REVOKED]

Documentation must be submitted to the OHCA prior authorization unit prior to beginning any treatment program to ensure all requirements are met and the member is an appropriate candidate for bariatric surgery. This is the first of two prior authorizations required to approve a member for bariatric surgery. To be considered, members must meet the following candidacy criteria:

1. be 18-65 years of age;
2. have body mass index (BMI) of 35 or greater;
3. be diagnosed with one of the following:
   (A) diabetes mellitus;
   (B) degenerative joint disease of a major weight bearing joint(s). The member must be a candidate for joint replacement surgery when optimal weight loss is achieved; or
   (C) a rare co-morbid condition in which there is medical evidence that bariatric surgery is medically necessary to treat such a condition and that the benefits of bariatric surgery outweigh the risk of surgical mortality;
4. have presence of obesity that has persisted for at least 5 years;
5. have attempted weight loss in the past without successful long-term weight reduction, which must be documented by a physician;
6. have absence of other medical conditions that would increase the member's risk of surgical mortality or morbidity; and
7. the member is not pregnant or planning to become pregnant in the next two years.

317:30-5-137.2. General coverage [REVOKED]

(a) After receiving member candidacy prior authorization from OHCA and the determination that member candidacy requirements are met (see OAC 317:30-5-137.1), the primary care provider coordinates a pre-operative assessment and weight loss process to include:

1. a comprehensive psychosocial evaluation including:
   (A) evaluation for substance abuse;
   (B) evaluation for psychiatric illness which would preclude the member from participating in pre-surgical weight loss and evaluation program or successfully adjusting to the post surgical lifestyle changes;
   (C) if applicable, documentation that the member has been successfully treated for a psychiatric illness and has been stabilized for at least six months; and
   (D) if applicable, documentation that the member has been rehabilitated and is free from drug and/or alcohol for a period of at least one year.

(b) an independent medical evaluation performed by an internist experienced in bariatric medicine who is contracted with the OHCA to assess the member's operative morbidity and mortality risks.

(c) a surgical evaluation by an OHCA contracted surgeon who has the credentials to perform bariatric surgery.

(d) participation in a six month weight loss program prior to surgery, under the supervision of an OHCA contracted medical provider. The member must, within 180 days from the initial or member candidacy prior authorization approval, lose at least five percent of member's initial body weight.

(b) When all requirements have been met, a prior authorization for surgery must be obtained from OHCA. This authorization can not be requested before the initial 180 day weight loss program has been completed.

1. If the member does not meet the weight loss requirement in the allotted time the member will not be approved for bariatric surgery;
2. The member's provider must restart the prior authorization process if this requirement is not met.

(c) The bariatric surgery facility or surgeon must, on an annual basis, provide to the OHCA the members statistical data which includes but is not limited to, mortality, hospital readmissions, re-operation, morbidity and average weight loss data.

(d) OHCA considers surgery to correct complications from bariatric surgery, such as obstruction or stricture, medically necessary.
OHCA considers repeat bariatric surgery medically necessary for a member whose initial bariatric surgery was medically necessary, and member meets either of the following criteria:

(1) has not lost more than fifty percent of excess body weight two years following the primary bariatric surgery procedure and is in compliance with prescribed nutrition and exercise programs following the procedure; or

(2) failure due to dilation of the gastric pouch if the initial procedure was successful in inducing weight loss prior to the pouch dilation and the member is in compliance with prescribed nutrition and exercise programs following the initial procedure.

(f) OHCA may withdraw authorization of payment for the bariatric surgery at any time if the OHCA determines that the member or provider is not in compliance with any of the requirements.

317:30-5-140. Coverage for children
(a) Services, deemed medically necessary and allowable under federal Medicaid regulations, may be covered by the EPSDT/OHCA Child Health program even though those services may not be part of the OHCA Medicaid program. Such services must be prior authorized.
(b) Federal Medicaid regulations also require the state to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the state determines are not safe, effective or which are considered experimental.

Bariatric surgery services are currently allowed for members aged fifteen (15) to sixty-five (65), per OAC 317:30-5-137 (e) (1). Exceptions may be granted for member's younger than fifteen (15) if they are proven to be medically necessary and are prior authorized. State and Federal Medicaid law, including, but not limited to, Oklahoma's federally-approved State Medicaid Plan, require the State to make the determination as to whether services are medically necessary and does not allow for reimbursement of any items or services that the State determines are not safe and effective or which are considered experimental. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

317:30-5-141. Reimbursement [REVOKED]

Payment is made at the lower of the provider's usual and customary charge or the OHCA fee schedule for Medicaid compensable services.

[OAR Docket #21-393; filed 6-14-21]
Part 51. Habilitation Services
317:30-5-482 [AMENDED]
Part 73. Early Intervention Services
317:30-5-641 [AMENDED]
Part 77. Speech and Hearing Services
Speech-Language Pathologists, Speech-Language Pathology Assistants, Clinical Fellows, and Audiologists
317:30-5-675 [AMENDED]
317:30-5-676 [AMENDED]
317:30-5-677 [AMENDED]
317:30-5-680 [AMENDED]
Part 103. Qualified Schools as Providers of Health-Related Services
317:30-5-1023 [AMENDED]

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INCORPORATIONS BY REFERENCE:

GIST/ANALYSIS:
The proposed revisions add physical therapy assistants, occupational therapy assistants, speech-language pathology assistants (SLPAs), and speech-language pathology clinical fellows as eligible providers that can render therapy services to SoonerCare members. Additionally, the proposed revisions will outline provider qualifications and other requirements for provision of these therapy services. Finally, revisions will be made to clarify that these providers will be reimbursed at the rate established per the Oklahoma Medicaid State Plan.

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., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 27. INDEPENDENT LICENSED PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

317:30-5-290. Eligible providers
(a) Eligible physical therapists must be appropriately licensed in the state in which they practice.
(b) All eligible providers of physical therapy services must have entered into a Provider Agreement with the Oklahoma Health Care Authority to perform physical therapy services.

(a) Physical therapists.
(1) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Oklahoma Physical Therapy Practice Act or other applicable statute(s); and
(2) Entered into a provider agreement with the Oklahoma Health Care Authority (OHCA) to provide physical therapy services.

(b) Physical therapist assistants.

(1) Must be working under the supervision of a fully licensed physical therapist;
(2) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Oklahoma Physical Therapy Practice Act or other applicable statute(s);
(3) Entered into a provider agreement with the OHCA to provide physical therapy services; and
(4) Provided the name of their OHCA-contracted supervising physical therapist upon enrollment.

317:30-5-291. Coverage by category
Payment is made to registered physical therapists as set forth in this Section.

(1) Children. Initial therapy evaluations do not require prior authorization and must be provided by a fully licensed physical therapist. All therapy services following the initial evaluation must be prior authorized for continuation of service. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral. (2) Adults. There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in Oklahoma Administrative Code 317:30-5-42.1.
(3) Individuals eligible for Part B of Medicare. Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

317:30-5-291.1. Payment rates
Payment is made in accordance with the current allowable Medicaid fee schedule. All physical therapy services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

317:30-5-293. Team therapy (Co-treatment)
Therapists, or therapy assistants, working together as a team to treat one (1) or more members cannot each—bill separately for the same or different service provided at the same time to the same member.

(1) Current Procedural Terminology (CPT) codes are used for billing the services of one (1) therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.
(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one (1) member at the same time, only one (1) therapist can bill for the entire service, or each therapist can divide the service units.
(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two (2) therapists, each service unit of time the member is being treated can count as only one (1) unit of each code. The service units billed must equal the total time the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any reason, must not be billed.

PART 28. OCCUPATIONAL THERAPY SERVICES; OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS

317:30-5-295. Eligible providers
(a) Eligible occupational therapists must be appropriately licensed in the state in which they practice.
(b) All eligible providers of occupational therapy services must have entered into a Provider Agreement with the Oklahoma Health Care Authority to perform occupational therapy services.

(a) Occupational therapists.
(1) Must be appropriately licensed in good standing in the state in which they practice with the Oklahoma Occupational Therapy Practice Act or other applicable statute(s); and
(2) Entered into a provider agreement with the Oklahoma Health Care Authority (OHCA) to provide occupational therapy services.

(b) Occupational therapy assistants.
(1) Must be working under the supervision of a fully licensed occupational therapist;
(2) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Oklahoma Occupational Therapy Practice Act or other applicable statute(s);
(3) Entered into a provider agreement with the OHCA to provide occupational therapy services; and
(4) Provided the name of their OHCA-contracted supervising occupational therapist upon enrollment.

317:30-5-296. Coverage by category
Payment is made for occupational therapy services as set forth in this Section.
(1) Children. Initial therapy evaluations do not require prior authorization and must be provided by a fully licensed occupational therapist. All therapy services following the initial evaluation must be prior authorized for continuation of service. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(2) Adults. There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in Oklahoma Administrative Code 317:30-5-42.1.

(3) Individuals eligible for Part B of Medicare. Services provided to Medicare eligible recipients are billed directly with the fiscal agent.

317:30-5-297. Payment rates
Payment is made in accordance with the current allowable Medicaid fee schedule. All occupational therapy services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

317:30-5-299. Team therapy (Co-treatment)
Therapists, or therapy assistants, working together as a team to treat one (1) or more members cannot each bill separately for the same or different service provided at the same time to the same member.

(1) CPT Current Procedural Terminology (CPT) codes are used for billing the services of one (1) therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.

(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one (1) member at the same time, only one (1) therapist can bill for the entire service, or each therapist can divide the service units.

(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two (2) therapists, each service unit of time the member is being treated can count as only one (1) unit of each code. The service units billed must equal the total time the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any reason, must not be billed.
PART 51. HABILITATION SERVICES

317:30-5-482. Description of services
Habilitation services include the services identified in (1) through (15) of this Section. Habilitation services providers must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services (DDS) Home and Community-Based Services (HCBS).

(1) Dental services. Dental services are provided per Oklahoma Administrative Code (OAC) 317:40-5-112.
   (A) Minimum qualifications. Dental services providers must have non-restrictive licensure by the Oklahoma State Board of Dentistry to practice dentistry in 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) Bitewing X-rays;
      (iii) Dental cleaning;
      (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 an improved ability to chew;
      (vi) Routine training of member or primary caregiver regarding oral hygiene; and
      (vii) Preventive, restorative, replacement, and repair services to achieve or restore functionality provided after appropriate review when 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 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.

(3) Occupational therapy services.
   (A) Minimum qualifications. Occupational therapists and occupational therapy assistants must have current, non-restrictive licensure by the Oklahoma Board of Medical Licensure and Supervision. Occupational therapy assistants must be employed, supervised by occupational therapists, per OAC 317:30-5-295 (b) (1).
   (B) Description of services. Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, and mealt ime assistance. Occupational therapy services may include the use of occupational therapy assistants, within the limits of the occupational therapist’s 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 practitioner’s prescription.

(ii) For purposes of this Section, a practitioner is defined as medical and osteopathic physicians, physician assistants, and other licensed health care professionals with prescriptive authority to order occupational therapy services in accordance with the rules and regulations governing the SoonerCare program.

(iii) The provision of services includes a 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 therapist assistant, within the occupational therapist’s employment. Payment is made in 15-minute units, with a limit of four hundred eighty (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 therapist assistants must have current, non-restrictive licensure with the Oklahoma Board of Medical Licensure and Supervision. The physical therapist must employ the physical therapist assistant, per OAC 317:30-5-290.1 (b) (1).
   (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 therapist assistants, within the limits of the physical therapist’s 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 practitioner’s prescription. For purposes of this Section, practitioners are defined as licensed medical and osteopathic physicians, and physician assistants in accordance with the rules and regulations covering the OHCA SoonerCare program.

(ii) For purposes of this Section, a practitioner is defined as a licensed medical and osteopathic physicians, and physician assistants in accordance with the rules and regulations covering the OHCA SoonerCare program.

(iii) The provision of services includes a 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 therapist assistant within the physical therapist's employment. Payment is made in 15-minute units with a limit of four hundred and eighty (480) units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification as a provider of psychological services requires current, non-restrictive licensure as a psychologist by the Oklahoma State Board of Examiners of Psychologists or licensing board in the state in which service is provided. Psychological technicians who have completed all board certification and training requirements may provide services under a licensed psychologist's supervision.

(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. The provider must develop, implement, evaluate and revise the Protective Intervention Protocol (PIP) corresponding to the relevant outcomes identified 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 formats, with a six-person maximum.

(ii) Approval of services is based upon assessed needs per OAC 340:100-5:51.

(C) **Coverage limitations.**

(i) Payment is made in fifteen (15) minute units. A minimum of fifteen (15) minutes for each individual and group encounter is required.

(ii) Psychological services are authorized for a period, not to exceed twelve (12) months.

(I) Initial authorization must not exceed 192 one hundred and ninety-two (192) units, forty-eight (48) hours of service.

(II) Authorizations may not exceed 288 two hundred and eighty-eight (288) units per plan of care year unless an exception is made by the DDS director of Support Services or his or her designee.

(iii) No more than twelve (12) hours of services, forty-eight (48) units, may be billed for PIP preparation. Any clinical document must be prepared within sixty (60) calendar days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(iv) When revising a PIP to accommodate recommendations of a required committee review, the provider may bill for only one (1) revision. The time for preparing the revision must be clearly documented and must not exceed four (4) hours.

(6) **Psychiatric services.**

(A) **Minimum qualifications.** Qualification as a psychiatric services provider requires a current, non-restrictive license to practice medicine in Oklahoma. Certification by the American 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, medication and prescription management and consultation, and are provided to eligible members. Services are provided in community setting specified in the member's IP.

(i) Services are intended to contribute to the member's psychological well-being.

(ii) A minimum of thirty (30) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is thirty (30) minutes, with a limit of two hundred (200) units, per Plan of Care year.

(7) **Speech/language pathology services.**

(A) **Minimum qualifications.** Qualification as a speech and language pathology services provider requires current, non-restrictive licensure as a speech and language pathology provider, speech-language pathology assistant, or speech-language pathology clinical fellow, by the Oklahoma Board of Examiners for Speech-Language Pathology and Audiology, per OAC 317:30-5-675.

(B) **Description of services.** Speech therapy includes evaluation, treatment, and consultation in communication and oral motor and/or feeding activities provided to eligible members. Services are intended to maximize the member's community living skills and may be provided in the community setting specified in the member's IP. The IP must include a practitioner's prescription.

(i) The IP must include a practitioner's prescription. For purposes of this Section, practitioners are defined as licensed medical and osteopathic physicians, physician assistants, and other licensed professionals with prescriptive authority to order speech and/or language services in accordance with rules and regulations covering the OHCA SoonerCare program.

(ii) A minimum of fifteen (15) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is fifteen (15) minutes, with a limit of two hundred and eighty-eight (288) units, per Plan of Care year.
(8) **Habilitation training specialist (HTS) services.**

(A) **Minimum qualifications.** Providers must complete the Oklahoma Department of Human Services (DHS) DDS-sanctioned training curriculum. Residential habilitation providers:

(i) must be at least eighteen (18) years of age;

(ii) must be specifically trained to meet members' unique needs;

(iii) must be not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per Section (8) 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) must receive supervision and oversight from contracted-agency staff with a minimum of four (4) 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 is not made for:

(I) routine care and supervision 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 forty (40) hours per week. Members requiring more than forty (40) hours per week of HTS services, 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 necessary support staff hours. Exceptions may be authorized, when needed, for members who receive services through the Homeward Bound Waiver.

(iii) Payment does not include room and board or maintenance, upkeep, or 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) Review and approval by the DDS plan of care reviewer 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 OHCA-approved oversight agency. For pre-authorized HTS services, the service:

(I) may provide

(II) must be pre-approved by the DDS director or his or her designee.

(C) **Coverage limitations.** HTS services are authorized per OAC 317:40-5-110, 317:40-5-111, 317:40-7-13, and 340:100-3-33.1.

(i) A unit is fifteen (15) minutes.

(ii) Payment cannot be made for services provided by more than one HTS provider per day.

(iii) More than one HTS provider may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two (2) or more HTS providers to the same member during the same hours of a day.

(v) A HTS service provider may receive reimbursement for providing services to only one (1) 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 HS services.

(9) **Self Directed HTS (SD HTS).** SD HTS are provided per OAC 317:40-9-1.

(10) **Self Directed Goods and Services (SD GS).** SD GS are provided per OAC 317:40-9-1.

(11) **Audiology services.**

(A) **Minimum qualifications.** Audiologists must have licensure as an audiologist by the Oklahoma Board of Examiners for Speech Pathology and Audiology per OAC 317:30-5-675 (d)(1).

(B) **Description of services.** Audiology services include individual evaluation, treatment, and consultation in hearing to eligible members. Services are intended to maximize the member's auditory receptive abilities. The member's IP must include a practitioner's prescription.

(i) The member's IP must include a practitioner's prescription. For purposes of this Section, practitioners are defined as licensed medical and osteopathic physicians, and physician assistants in accordance with rules and regulations covering the OHCA SoonerCare program.

(ii) A minimum of fifteen (15) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** Audiology services are provided in accordance with the member's IP.

(12) **Prevocational services.**

(A) **Minimum qualifications.** Prevocational services providers:
(i) are at least eighteen (18) years of age;
(ii) complete the DHS DDS-sanctioned training curriculum;
(iii) were not convicted of, pled guilty to, 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 (4) 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 the Individuals with Disabilities Education Act (IDEA) per Section 1401 et seq. of Title 20 of the United States Code.

(i) Prevocational services are learning and work experiences where the individual can develop general, non-job, task-specific strengths that contribute to employability in paid employment in integrated community settings.

(ii) Activities include teaching concepts, such as communicating effectively with supervisors, co-workers, and customers, attendance, task completion, problem solving, and safety. These activities are associated with building skills necessary to perform work.

(iii) Prevocational services are delivered for the purpose of furthering habilitation goals that lead to greater opportunities for competitive, integrated employment. All prevocational services are reflected in the member's IP. Documentation must be maintained in the record of each member receiving this service, noting the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.

(iv) Services include:
   (I) center-based prevocational services, per OAC 317:40-7-6;
   (II) community-based prevocational services per, OAC 317:40-7-5;
   (III) enhanced community-based prevocational services per, 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 (1) hour and payment is based on the number of hours the member participates in the service. All prevocational services and supported-employment services combined may not exceed $27,000, per Plan of Care year. The services that may not be provided to the same member at the same time as prevocational services are:

(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, or 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, per OAC 317:40-7-6.

(13) **Supported employment.**

(A) **Minimum qualifications.** Supported employment providers:

(i) are at least eighteen (18) years of age;
(ii) complete the DHS DDS-sanctioned training curriculum;
(iii) were not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per Section 1025.2 of Title 56 of the Oklahoma Statutes (O.S. § 1025.2) unless a waiver is granted, per 56 O.S. § 1025.5; and
(iv) receive supervision and oversight by a person with a minimum of four (4) 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 worksites 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 Waivers, including supervision and training. The outcome of supported employment is sustained paid employment at or above minimum wage, but not less than the customary wage and benefit level paid by the employer for the same or similar work performed by individuals without disabilities. The paid employment occurs in an integrated setting in the general workforce in a job that meets personal and career goals.

(i) When supported-employment services are provided at a worksite in which persons without disabilities are employed, payment:

   (I) does make 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 per OAC 317:40-7-7;
   (II) enhanced job coaching per OAC 317:40-7-12;
   (III) training specialist services per OAC 317:40-7-8; and
(IV) stabilization

(iii) Supported-employment services furnished under HCBS Waivers are not available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act (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 the 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 passed through to users of supported-employment programs; or

(III) payments for vocational training not directly related to a member's supported-employment program.

(C) Coverage limitations. A unit is fifteen (15) minutes and payment is made per OAC 317:40-7-1 through 317:40-7-21. All prevocational services and supported-employment services combined cannot exceed $27,000, per Plan of Care year. The DDS case manager assists the member to identify other alternatives to meet identified needs above the limit.

The services that may not be provided to the same member, at the same time as supported-employment services are:

(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, or 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.

(14) Intensive personal supports (IPS).

(A) Minimum qualifications. IPS provider agencies must have a current provider agreement with OHCA and DHS DDS. Providers:

(i) are at least eighteen (18) years of age;

(ii) complete the DHS DDS-sanctioned training curriculum;

(iii) were not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per Section 1025.2 of Title 56 of the Oklahoma Statutes (O.S. § 1025.2).

(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, and recreational and habilitation activities.

(ii) The member's Individual Plan (IP) must clearly specify the role of HTS and the person providing IPS to ensure there is no duplication of services.

(iii) Review and approval by the DDS plan of care reviewer is required.

(C) Coverage limitations. IPS are limited to twenty-four (24) hours per day and must be included in the member's IP, per OAC 317:40-5-151 and 317:40-5-153.

(15) Adult day services.

(A) Minimum qualifications. Adult day services provider agencies must:

(i) meet the licensing requirements, per 63 O.S. § 1-873 et seq. and comply with OAC 310:605; and

(ii) be approved by the DHS DDS director 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 a maximum level of independence and function. Services are provided in a non-residential setting away from the home or facility where the member resides.

(C) Coverage limitations. Adult day services are furnished four or more hours per day on a regularly scheduled basis, for one (1) or more days per week. A unit is fifteen (15) minutes for up to a maximum of six (6) hours daily, at which point a unit is one (1) day. All services must be authorized in the member's IP.

PART 73. EARLY INTERVENTION SERVICES
Permanent Final Adoptions

317:30-5-641. Coverage by category

Payment is made for early intervention services as set forth in this Section.

(1) **Adults.** There is no coverage for services rendered to adults.

(2) **Children.** Payment is made for compensable services rendered by the [OSDHOklahoma State Department of Health (OSDH)] and its contractors, pursuant to the State's plan for Early Intervention services required under Part C of the IDEIAIDEA.

(A) **Child health screening examination.** An initial screening may be requested by the family of an eligible individual at any time and must be provided without regard to whether the individual's age coincides with the established periodicity schedule. Coordination - referral is made to the SoonerCare provider to assure at a minimum, that periodic screens are scheduled and provided in accordance with the periodicity schedule following the initial screening.

(B) **Child health encounter (EPSDT partial screen).** The child health encounter (the EPSDT partial screen) may include a diagnosis and treatment encounter, a follow-up health encounter, or a home visit. A child health encounter may include:

- (i) **child health history,**
- (ii) **physical examination,**
- (iii) **developmental/assessment,**
- (iv) **nutrition assessment and counseling,**
- (v) **social assessment and counseling,**
- (vi) **indicated laboratory and screening tests,**
- (vii) **screening for appropriate immunizations,**
- (viii) **health counseling,** and
- (ix) **treatment of common childhood illnesses and conditions.**

(C) **Hearing and Hearing Aid evaluation.** Hearing evaluations must meet guidelines found at OAC 317:30-5-675 and OAC Oklahoma Administrative Code (OAC) 317:30-5-676.

(D) **Audiometry test.** Audiometric test (Imittance [Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state licensed audiologist who is listed in OAC 317:30-5-675 (d) (1) and (2).

- (i) **holds a certificate of clinical competence from the American Speech-Language Hearing Association (ASHA); or**
- (ii) **has completed the equivalent educational requirements and work experience necessary for the certificate; or**
- (iii) **has completed the academic program and is acquiring supervised work experience to qualify for the certificate.**

(E) **Ear impression (for earmold).** Ear impression (for earmold) includes taking impression of client's ear and providing a finished earmold which is used with the client's hearing aid by a state licensed audiologist who is listed in OAC 317:30-5-675 (d) (1) and (2).

- (i) **holds a certificate of clinical competence from ASHA; or**
- (ii) **has completed the equivalent educational requirements and work experience necessary for the certificate; or**
- (iii) **has completed the academic program and is acquiring supervised work experience to qualify for the certificate.**

(F) **Speech language evaluation.** Speech language evaluation must be provided by a State licensed speech-language pathologist.

(G) **Physical therapy evaluation.** Physical therapy evaluation must be provided by a State licensed physical therapist.

(H) **Occupational therapy evaluation.** Occupational therapy evaluation must be provided by a State licensed occupational therapist.

(I) **Psychological evaluation and testing.** Psychological evaluation and testing must be provided by State-licensed, board certified, psychologists.

(J) **Vision testing.** Vision testing examination must be provided by a State licensed Doctor of Optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). At a minimum, vision services include diagnosis and treatment for defects in vision.

(K) **Treatment encounter.** A treatment encounter may occur through the provision of individual, family or group treatment services to infants and toddlers who are identified as having specific disorders or delays in development, emotional or behavioral problems, or disorders of speech, language, vision, or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of the Individual Family Services Plan (IFSP), and may include the following:

- (i) **Hearing and Vision Services.** These services include assisting the family in managing the child's vision and/or hearing disorder such as auditory training, habilitation training, communication management, orientation and mobility, and counseling the family. This encounter is designed to assist children and families with management issues that arise as a result of hearing and/or vision loss. These services are usually provided by vision impairment teachers or specialists and orientation specialists, and mobility specialists. These services may be provided in the home or community setting, such as a specialized day care center. Hearing services must be provided by:

- (i) **a State licensed, Master's Degree, ASHA certified audiologist or a state-licensed audiologist; or**
(II) a State fully licensed, Master's degree, ASHA certified speech-language pathologist; or

(III) An audiologist or speech-language pathologist who has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(i) **Speech-language therapy services.** Speech-language therapy services must be provided by a State licensed, speech-language pathologist who:

   (I) holds a certificate of clinical competence from ASHA; or

   (II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

   (III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(ii) **Speech-language therapy services.** Speech-language therapy services must be provided by:

   (I) A fully licensed, speech-language pathologist who meets the requirements found at OAC 317:30-5-675 (a) (1) through (3);

   (II) A licensed speech-language pathology assistant who is working under the supervision of a speech-language pathologist and meets the requirements found at OAC 317:30-5-675 (b) (1) through (4); or

   (III) A licensed speech-language pathology clinical fellow, who is working under the supervision of a fully licensed speech-language pathologist and meets the requirements found at OAC 317:30-5-675 (c) (1) through (4).

(iii) **Physical therapy services.** Physical therapy services must be provided by a State fully licensed physical therapist or physical therapist assistant, per OAC 317:30-5-290.1.

(iv) **Occupational therapy services.** Occupational therapy may include provision of services to improve, develop or restore impaired ability to function independently and must be provided by a State fully licensed occupational therapist or occupational therapy assistant, per OAC 317:30-5-295.

(v) **Nursing services.** Nursing services may include the provision of services to protect the health status of infants and toddlers, correct health problems, and assist in removing or modifying health related barriers and must be provided by a registered nurse or licensed practical nurse under supervision of a registered nurse. Services may include medically necessary procedures rendered in the child's home.

(vi) **Psychological services.** Psychological and counseling services are planning and managing a program of psychological services, including the provision of counseling or consultation to the family of the infant or toddler, when the service is for the direct benefit of the child and assists the family to better understand and manage the child's disabilities. Psychological services must be provided by a State-licensed psychologist.

(vii) **Psychotherapy counseling services.** Psychotherapy counseling services are the provision of counseling for children and parents. All services must be for the direct benefit of the child. Psychotherapy counseling services must be provided by a State licensed Social Worker, a State Licensed Professional Counselor, a State licensed Psychologist, State licensed Marriage and Family Therapist, or a State licensed Behavioral Practitioner, or under Board Supervision to be licensed in one of the above stated areas.

(viii) **Family Training and Counseling for Child Development.** Family Training and Counseling for Child Development services are the provision of training and counseling regarding concerns and problems in development. Services integrate therapeutic intervention strategies into the daily routines of a child and family in order to restore or maintain function and/or to reduce dysfunction resulting from a mental or physical disability or developmental delay. All services must be for the direct benefit of the child. Family Training and Counseling for Child Development services must be provided by a Certified Child Development Specialist.

(L) **Immunizations.** Immunizations must be coordinated with the Primary Care Physician for those infants and toddlers enrolled in SoonerCare. An administration fee, only, can be paid for immunizations provided by the OSDH.

(M) **Assistive Technology.** Assistive technology is the provision of services that help to select a device and assist a student with a disability(ies) to use an Assistive Technology device including coordination with other therapies and training of the child and caregiver. Services must be provided by a:

   (i) State fully licensed Speech-Language Pathologists who: speech-language pathologist as listed in OAC 317:30-5-675 (a) (1) through (3);

   (II) holds a certificate of clinical competence from the American Speech and Hearing Association; or

   (III) has completed the equivalent educational requirements and work experience necessary for the certificate; or

   (III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;
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(ii) A fully licensed Physical Therapist, otophysical therapist as listed in OAC 317:30-5-290.1 (a); or
(iii) A fully licensed Occupational Therapist, occupational therapist as listed in OAC 317:30-5-295 (a).

PART 77. SPEECH AND HEARING SERVICES
SPEECH-LANGUAGE PATHOLOGISTS, SPEECH-LANGUAGE PATHOLOGY ASSISTANTS, CLINICAL FELLOWS, AND AUDIOLOGISTS

317:30-5-675. Eligible providers
(a) Eligible speech and hearing providers must be either state licensed speech/language pathologists or state licensed audiologists who:
   (1) hold a certificate of clinical competence from the American Speech and Hearing Association; or
   (2) have completed the equivalent educational requirements and work experience necessary for the certificate; or
   (3) have completed the academic program and are acquiring supervised work experience to qualify for the certificate.
(b) All eligible providers of speech and hearing services must have entered into a contract with the Oklahoma Health Care Authority to perform speech and hearing services.
(a) Speech-language pathologist (SLP).
   (1) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Speech-Language Pathology and Audiology Licensing Act or other applicable statute(s); and
   (2) Entered into a Provider Agreement with the Oklahoma Health Care Authority (OHCA) to provide speech-language pathology services.
(b) Speech-language pathology assistant (SLPA).
   (1) Must be working under the supervision of a fully licensed speech-language pathologist;
   (2) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Speech-Language Pathology and Audiology Licensing Act or other applicable statute(s);
   (3) Entered into a provider agreement with the OHCA to provide speech-language pathology services; and
   (4) Provided the name of their OHCA-contracted supervising speech-language pathologist upon enrollment.
(c) Clinical fellow.
   (1) Must be working under the supervision of a fully licensed speech-language pathologist;
   (2) Must have a clinical fellow license in good standing in the state in which they practice and working in accordance with the Speech-Language Pathology and Audiology Licensing Act or other applicable statute(s);
   (3) Entered into a provider agreement with the OHCA to provide speech-language pathology services; and
   (4) Provided the name of their OHCA-contracted supervising speech-language pathologist upon enrollment.

(d) Audiologists.
   (1) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Speech-Language Pathology and Audiology Licensing Act or other applicable statute(s); and
   (2) Entered into a provider agreement with the Oklahoma Health Care Authority (OHCA) to provide speech-language pathology and audiology services.

317:30-5-676. Coverage by category
Payment is made for speech and hearing services as set forth in this Section.

(1) Children. Coverage for children is as follows:
   (A) Preauthorization required. All therapy services, including the initial evaluation, must be prior authorized. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.
   (B) Speech/Language ServicesSpeech-language pathology services. Speech-language therapy services may include speech/language evaluations, individual and group therapy services provided by a state licensed speech-language pathologist.
      (i) Speech-language pathology services may include speech-language evaluations, individual and group therapy services provided by a fully licensed and certified speech-language pathologist, a licensed speech-language pathology clinical fellow, and services within the scope of practice of a speech-language pathology assistant as directed by the supervising speech-language pathologist as listed in Oklahoma Administrative Code (OAC) 317:30-5-675 (a) through (c).
      (ii) Initial evaluations must be prior authorized and provided by a fully licensed speech-language pathologist.
   (C) Hearing aids. Hearing and hearing aid evaluations include pure tone air, bone and speech audiometry by a state licensed audiologist. Payment is made for a hearing aid following a recommendation by a Medical or Osteopathic physician and a hearing aid evaluation by a state licensed audiologist.
(2) Adults. There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in 30-5-42.1 OAC 317:30-5-42.1.
(3) Individuals eligible for Part B of Medicare. Services provided to Medicare eligible recipients are filed directly with the fiscal agent.
317:30-5-677. Payment rates
Payment is made in accordance with the current allowable Medicaid fee schedule. All speech-language pathology and hearing services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

317:30-5-680. Team therapy (Co-treatment)
Therapists, or therapy assistants, working together as a team to treat one (1) or more members cannot each—bill separately for the same or different service provided at the same time to the same member.

(1) CPTCurrent Procedural Terminology (CPT) codes are used for billing the services of one (1) therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.

(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one (1) member at the same time, only one (1) therapist can bill for the entire service, or each therapist can divide the service units.

(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two (2) therapists, each service unit of time the member is being treated can count as only one (1) unit of each code. The service units billed must equal the total time the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any reason, must not be billed.

PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH-RELATED SERVICES

317:30-5-1023. Coverage by category
(a) Adults. There is no coverage for services rendered to adults twenty-one (21) years of age and older.

(b) Children. For non-Individualized Education Program (IEP) medical services that can be provided in a school setting, refer to Part 4, Early and Periodic Screening, Diagnostic and Treatment program, of Oklahoma Administrative Code at 317:30-3-65 through 317:30-3-63.12. Payment is made for the following compensable services rendered by qualified school providers:

(1) Diagnostic encounters. Diagnostic encounters are defined as those services necessary to fully evaluate defects, physical or behavioral health illnesses, or conditions discovered by the screening. Approved diagnostic encounters may include the following:

(A) Hearing and hearing aid evaluation. Hearing evaluation includes pure tone air, bone, and speech audiometry. Hearing evaluations must be provided by a state-licensed audiologist who is listed in OAC 317:30-5-675 (d) (1) and (2).

(i) Holds a Certificate of Clinical Competence from the American Speech-Language-Hearing Association (ASHA); or
(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or
(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(B) Audiology test. Audiometric test (Impedance audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state-licensed audiologist who is listed in OAC 317:30-5-675 (d) (1) and (2).

(i) Holds a Certificate of Clinical Competence from ASHA; or
(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or
(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(C) Ear impression (for earmold). Ear impression (for earmold) includes taking an impression of a member's ear and providing a finished earmold, to be used with the member's hearing aid as provided by a state-licensed audiologist who is listed in OAC 317:30-5-675 (d) (1) and (2).

(i) Holds a Certificate of Clinical Competence from the ASHA; or
(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or
(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(D) Vision screening. Vision screening in schools includes application of tests and examinations to identify visual defects or vision disorders. The vision screening may be performed by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the supervision of an RN. The service can be billed when a SoonerCare member has an individualized documented concern that warrants a screening. A vision examination must be provided by a state-licensed Doctor of Optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). This vision examination, at a minimum, includes diagnosis and treatment for defects in vision.
(E) Speech-language evaluation. Speech-language evaluation is for the purpose of identification of children or adolescents with speech or language disorders and the diagnosis and appraisal of specific speech and language services. Speech-language evaluations must be provided by a state-licensed speech-language pathologist who, as listed in OAC 317:30-5-675 (a) (1) through (3),

(i) Holds a Certificate of Clinical Competence from the ASHA; or
(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or
(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(F) Physical therapy evaluation. Physical therapy evaluation includes evaluating the student's ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems. It must be provided by a state-licensed physical therapist as listed in OAC 317:30-5-290.1 (a) (1) and (2). Physical therapy evaluations must adhere to guidelines found at OAC 317:30-5-291.

(G) Occupational therapy evaluation. Occupational therapy evaluation services include determining what therapeutic services, assistive technology, and environmental modifications a student requires for participation in the special education program and must be provided by a state-licensed occupational therapist as listed in OAC 317:30-5-295 (a) (1) and (2). Occupational therapy evaluations must adhere to guidelines found at OAC 317:30-5-296.

(H) Evaluation and testing. Evaluation and testing by psychologists and certified school psychologists are for the purpose of assessing emotional, behavioral, cognitive, or developmental issues that are affecting academic performance and for determining recommended treatment protocol. Evaluation or testing for the sole purpose of academic placement (e.g., diagnosis of learning disorders) is not a compensable service. These evaluations and tests must be provided by a state-licensed, board-certified psychologist or a certified school psychologist certified by the State Department of Education (SDE).

(2) Child-guidance treatment encounter. A child-guidance treatment encounter may occur through the provision of individual, family, or group treatment services to children and adolescents who are identified as having specific disorders or delays in development, emotional or behavioral problems, or disorders of speech, language, or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of a treatment plan, or as a result of an IEP and may include the following:

(A) Hearing and vision services. Hearing and vision services may include provision of habilitation activities, such as: auditory training; aural and visual habilitation training including Braille, and communication management; orientation and mobility; and counseling for vision and hearing losses and disorders. Services must be provided by or under the direct guidance of one (1) of the following individuals practicing within the scope of his or her practice under state law:

(i) state-licensed master's degree audiologist who, as listed in OAC 317:30-5-675 (d) (1) and (2),
(ii) Holds a Certificate of Clinical Competence from the ASHA; or
(iii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(ii) State-licensed fully licensed master's degree speech-language pathologist who, as listed in OAC 317:30-5-675 (a) (1) through (3),

(i) Holds a Certificate of Clinical Competence from the ASHA; or
(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or
(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate; and

(iii) Certified orientation and mobility specialists; and,

(B) Speech-language therapy services. Speech-language therapy services include provisions of speech and language services for the habilitation or prevention of communicative disorders. Speech-language therapy services must be provided by or under the direct guidance and supervision of a state-licensed fully-licensed speech-language pathologist within the scope of his or her practice under state law who, as listed in OAC 317:30-5-675 (a) (1) through (3),

(i) Holds a Certificate of Clinical Competence from the ASHA; or
(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or
(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate; or

(C) Physical therapy services. Physical therapy services are provided for the purpose of preventing or alleviating movement dysfunction and related functional problems that adversely affect the member's education. Physical therapy services must adhere to guidelines found at OAC 317:30-5-291 and must
be provided by or under the direct guidance and supervision of a state-licensed occupational therapist; services may also be provided by a licensed physical therapy assistant who has been authorized by the Board of Examiners working under the supervision of a fully licensed physical therapist. The licensed physical therapist may not supervise more than three (3) physical therapy assistants.

(D) Occupational therapy services. Occupational therapy may include provision of services to improve, develop, or restore impaired ability to function independently. Occupational therapy services must be provided by or under the direct guidance and supervision of a state-licensed occupational therapist; services may also be provided by any licensed occupational therapy assistant who has been authorized by the Board of Examiners, working under the supervision of a licensed occupational therapist.

(E) Nursing services. Nursing services may include provision of services to protect the health status of children and adolescents, correct health problems and assist in removing or modifying health-related barriers, and must be provided by a RN or LPN under supervision of a RN. Services include medically necessary procedures rendered at the school site, such as catheterization, suctioning, tube feeding, and administration and monitoring of medication.

(F) Counseling services. All services must be for the direct benefit of the member. Counseling services must be provided by a state-licensed social worker, a state-licensed professional counselor, a state-licensed psychologist or SDE-certified school psychologist, a state-licensed marriage and family therapist, or a state-licensed behavioral health practitioner, or under Board supervision to be licensed in one (1) of the above-stated areas.

(G) Assistive technology. Assistive technology is the provision of services that help to select a device and assist a student with disability(ies) to use an assistive technology device, including coordination with other therapies and training of member and caregiver. Services must be provided by a:

(i) State-licensed speech-language pathologist who is state-licensed speech-language pathologist as listed in OAC 317:30-5-675 (a) (1) through (3).

(ii) State-licensed occupational therapist as listed in OAC 317:30-5-290.1 (a) (1) and (2); or

(iii) State-fully licensed occupational therapist as listed in OAC 317:30-5-295 (a) (1) and (2).

(H) Personal care. Provision of personal care services (PCS) allow students with disabilities to safely attend school. Services include, but are not limited to: dressing, eating, bathing, assistance with transferring and toileting, positioning, and instrumental activities of daily living such as preparing meals and managing medications. PCS also includes assistance while riding a school bus to handle medical or physical emergencies. Services must be provided by registered paraprofessionals that have completed training approved or provided by SDE, or personal care assistants, including LPNs, who have completed on-the-job training specific to their duties. PCS does not include behavioral monitoring. Paraprofessionals are not allowed to administer medication, nor are they allowed to assist with or provide therapy services to SoonerCare members. Tube feeding of any type may only be reimbursed if provided by a RN or LPN. Catheter insertion and Catheter/Ostomy care may only be reimbursed when done by a RN or LPN. All PCS must be prior authorized.

(I) Therapeutic behavioral services (TBS). Services are goal-directed activities for each client to restore, retain and improve the self-help, socialization, communication, and adaptive skills necessary to reside successfully in home and community-based settings. It also includes problem identification and goal setting, medication support, restoring function, and providing support and redirection when needed. TBS activities are behavioral interventions to complement more intensive behavioral health services and may include the following components: basic living and self-help skills; social skills; communication skills; organization and time management; and transitional living skills. This service must be provided by a behavioral health school aide (BHSA) who has a high school diploma or equivalent and has successfully completed training approved by the SDE, and in collaboration with the Oklahoma Department of Mental Health and Substance Abuse Services, along with corresponding continuing education. BHSA must be supervised by a bachelor's level individual with a special education certification. BHSA must have CPR and First Aid certification. Six (6) additional hours of related continuing education are required per year.

(c) Members eligible for Part B of Medicare. EPSDT school health-related services provided to Medicare eligible members are billed directly to the fiscal agent.
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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #21-385]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-9 [AMENDED]
Part 21. Outpatient Behavioral Health Agency Services
317:30-5-241.7 [NEW]

(Reference APA WF # 20-16)

AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board; the 2018 Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, HR 6, Section 1006

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
December 22, 2020

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SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-9 [AMENDED]
Part 21. Outpatient Behavioral Health Agency Services
317:30-5-241.7 [NEW]

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INCORPORATIONS BY REFERENCE:

n/a

GIST/ANALYSIS:
The proposed revisions comply with the SUPPORT Act, HR 6, Section 1006, and establish coverage and reimbursement of medically necessary medication-assisted treatment (MAT) services and/or medications for SoonerCare members with opioid use disorder (OUD) in opioid treatment programs (OTPs) and within office-based opioid treatment (OBOT) settings.

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., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-9. Medical services
(a) Use of medical modifiers. The Physician's Current Procedural Terminology (CPT) and the second level HCPCS Healthcare Common Procedure Coding System (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 (4) office visits (or home) per month per member, for adults (over age twenty-one [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 (4) per month limitation.
(3) Payment is allowed for 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) Contraceptive devices; and
   (D) IV fluids.
(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 twenty one (21) and sixty five (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 twenty one (21) years of age.
(9) IPPB (Intermittent Positive Pressure Breathing) is covered when performed in physician's office.
(10) Payment is made for an office visit in addition to allergy testing.
(11) Separate payment is made for antigen.
(12) Eye exams are covered for members between ages twenty one (21) and sixty five (65) for medical diagnosis only.
(13) 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.

(14) The Professional Component for electrocardiograms, electroencephalograms, electromyograms, and similar procedures are covered on an inpatient basis as
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long as the interpretation is not performed by the attending physician.
(16) Cast removal is covered only when the cast is removed by a physician other than the one who applied the cast.
(17) Payment may be made for medication-assisted treatment (MAT) medications prescribed and/or administered by a physician.

(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 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 sixty-five (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.
(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.

(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 (1) 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 (2) nursing facility visits per month. The appropriate CPT code is used.
(3) When payment is made for "Evaluation of arrhythmia" or "Evaluation of sinus node" 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 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.7. Medication-assisted treatment (MAT) services for eligible individuals with opioid use disorder (OUD)

(a) Definitions. The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:
(1) "Medication-assisted treatment (MAT)" means an evidence-based practice approved by the Food and Drug Administration (FDA) to treat opioid use disorder, including methadone and all biological products licensed under federal law for such purpose. MAT also includes the provision of counseling and behavioral therapy.
(2) "Office-based opioid treatment (OBOT)" means a fully contracted SoonerCare provider that renders MAT services in OBOT settings. OBOT providers must have capacity to provide all drugs approved by the FDA for the treatment of opioid use disorder, directly or by referral, including for maintenance, detoxification, overdose reversal, and relapse prevention, and appropriate counseling and other appropriate ancillary services.
(3) "Opioid treatment program (OTP)" means a program or provider:
(A) Registered under federal law;
(B) Certified by the Substance Abuse and Mental Health Services Administration (SAMHSA);
(C) Certified by ODMHAS, unless deemed an exempted entity as defined by federal law;
(D) Registered by the Drug Enforcement Agency (DEA);
(E) Registered by the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD); and
(F) Engaged in opioid treatment of individuals by use of an opioid agonist treatment medication, including methadone.
(4) "Opioid use disorder (OUD)" means a cluster of cognitive, behavioral, and physiological symptoms in which the individual continues use of opioids despite significant opioid-induced problems.
(5) "Phase I" means a minimum ninety (90) day period in which the member attends the opioid treatment
program for observation of medication assisted treatment
daily or at least six (6) days a week.
(6) "Phase II" means the phase of treatment for mem-
bers who have been admitted for more than ninety (90)
days and who have successfully completed Phase I.
(7) "Phase III" means the phase of treatment for mem-
bers who have been admitted for more than six (6) months
and who have successfully completed Phase II.
(8) "Phase IV" means the phase of treatment for mem-
bers who have been admitted for more than nine (9)
months and who have successfully completed Phase III.
(9) "Phase V" means the phase of treatment for mem-
bers who have been admitted for more than one (1) year.
(10) "Phase VI" means the phase of treatment for mem-
bers who voluntarily seek medically supervised
withdrawal and abstinence from all drugs, including
methadone as prescribed. A member may enter this phase
at any time in the treatment and rehabilitation process.

(b) Coverage. The SoonerCare program provides coverage
of medically necessary MAT services in OTPs, including but
not limited to, methadone treatment, to eligible individuals
with OUD. An OTP must have the capacity to provide the full
range of services included in the definition of MAT and must
document both medication dosing and supporting behavioral
health services, including but not limited to, individual, family
and group therapy and rehabilitation services. MAT services
and/or medications may also be provided in OBOT settings per
OAC 317:30-5-9(b)(17).

(c) OTP requirements. Every OTP provider shall:
(1) Have a current contract with the OHCA as an OTP
provider;
(2) Hold a certification as an OTP from ODMHSAS,
unless deemed an exempted entity as defined by federal
law;
(3) Hold a certification from the Substance Abuse and
Mental Health Services Administration (SAMHSA);
(4) Be appropriately accredited by a SAMHSA-ap-
proved accreditation organization;
(5) Be registered with the DEA and the OBNDD; and
(6) Meet all state and federal opioid treatment stan-
dards, including all requirements within OAC 450:70.

(d) Individual OTP providers. OTP providers include:
(1) MAT provider is a physician, physician's assistant
(PA), or advanced practice registered nurse (APRN) who
may prescribe, dispense, and administer medications in
accordance with state and federal law and the Oklahoma
Medicaid State Plan.
(2) OTP behavioral health services practitioner is
a practitioner that meets the qualifications in OAC
317:30-5-240.3, except for family support and training
providers, qualified behavioral therapy aide providers,
multi-systemic therapy providers, and case manager
providers, for the provision of outpatient behavioral
health services.

(e) Intake and assessment. OTPs shall conduct intake and
assessment procedures in accordance with OAC 450:70-3-5
through OAC 450:70-3-7.

(f) Service phases. In accordance with OAC 450:70-6-17.2
through OAC 450:70-6-17.8, the OTP shall have structured
phases of treatment and rehabilitation to support member
progress and to establish requirements regarding member
attendance and service participation. Treatment requirements
for each phase shall include, but not limited to, the following:
(1) During phase I, the member shall participate in a
minimum of four (4) sessions of therapy or rehabilitation
services per month with at least one (1) session being in-
dividual therapy, rehabilitation, or case management.
(2) During phase II the member shall participate in at
least two (2) therapy or rehabilitation service sessions per
month during the first ninety (90) days, with at least one
(1) of the sessions being individual therapy, rehabilitation,
or case management. After the initial ninety (90) days in
Phase II, the member shall participate in at least one (1)
session of individual therapy or rehabilitation service per
month.
(3) During phase III, phase IV and phase V, the member
shall participate in at least one (1) session of individual
therapy, rehabilitation, or case management per month.
(4) During phase VI, the LBHP, licensure candidate or
certified alcohol and drug counselor (CADC) determines
the frequency of therapy or rehabilitation service sessions
with input from the member.
(5) If an OTP is providing MAT medications to mem-
bers receiving residential substance use disorder services,
the required minimum services for the OTP may be de-
ivered by the residential substance use disorder provider.
The OTP provider shall document the provision of these
services and the provider delivering such services in the
member's service plan.

(g) Service plans. In accordance with OAC 450:70-3-8, a
service plan shall be completed for each member upon com-
pletion of the admission evaluation. The service plan shall be
based on the patient's presenting problems or diagnosis, intake
assessment, biopsychosocial assessment, and expectations of
their recovery.
(1) Service plan development. Service plans shall
be completed by an LBHP or licensure candidate. Ser-
vice plans completed by a licensure candidate must be
cosigned and dated by a fully-licensed LBHP.
(2) Service plan content. Service plans shall address,
but not limited to, the following:
(A) Presenting problems or diagnosis;
(B) Strengths, needs, abilities, and preferences of
the member;
(C) Goals for treatment with specific, measurable,
attainable, realistic and time-limited;
(D) Type and frequency of services to be provided;
(E) Dated signature of primary service provider;
(F) Description of member's involvement in, and
responses to, the service plan and his or her signature
and date;
(G) Individualized discharge criteria or mainte-
nance;
(H) Projected length of treatment;
(I) Measurable long and short term treatment goals;
(J) Primary and supportive services to be utilized with the patient;
(K) Type and frequency of therapeutic activities in which patient will participate;
(L) Documentation of the member’s participation in the development of the plan; and
(M) Staff who will be responsible for the member’s treatment.

(3) Service plan updates. Service plan updates shall be completed by an LBHP or licensure candidate. Service updates completed by a licensure candidate must be co-signed and dated by a fully-licensed LBHP. Service plan review and updates shall occur no less than every six (6) months and shall occur more frequently if required based upon the service phase or certain circumstances:
(A) During phase I, the service plan shall be reviewed and updated a minimum of one monthly.
(B) During phase II, the service plan shall be reviewed and updated a minimum of once every three (3) months.
(C) A service plan review shall be completed for the following situations:
   (i) Change in goals and objectives based upon member’s documented progress, or identification of any new problem(s);
   (ii) Change in primary therapist or rehabilitation service provider assignment;
   (iii) Change in frequency and types of services provided;
   (iv) Critical incident reports;
   (v) Sentinel events; or
   (vi) Phase change.

(4) Service plan timeframes. Service plans shall be completed by the fourth therapy or rehabilitation service visit after admission.

(h) Progress notes. Progress notes shall be completed in accordance with OAC 317:30-5-248(3).

(i) Discharge planning. All members shall be assessed for biopsychosocial appropriateness of discharge from each level of care using ASAM criteria that includes a list of symptoms for all six (6) dimensions and each of the levels of care, to determine a clinically appropriate placement in the least restrictive level of care. This organized process involves a professional determination by an LBHP or licensure candidate for appropriate placement to a specific level of care based on the following symptoms and situations:
(1) Acute intoxication and/or withdrawal potential;
(2) Biomedical conditions and complications;
(3) Emotional, behavioral or cognitive conditions and complications;
(4) Readiness to change;
(5) Relapse, continued use or continued problem potential; and
(6) Recovery/living environment.

(i) Service exclusions. The following services are excluded from coverage:

(1) Components that are not provided to or exclusively for the treatment of the eligible individual;
(2) Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a person receiving covered services;
(3) Telephone calls or other electronic contacts (not inclusive of telehealth);
(4) Field trips, social, or physical exercise activity groups; and
(k) Reimbursement. In order to be eligible for payment, OTPs shall:

(1) Have an approved provider agreement on file with the OHCA. Through this agreement, the OTP assures that they are in compliance with all applicable federal and State Medicaid law and regulations, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, and the Oklahoma Medicaid State Plan.
(2) Obtain prior authorization for applicable drugs and services by the OHCA or its designated agent before the service is rendered by an eligible provider. Without prior authorization for applicable drugs and services, payment is not authorized.
(3) Record the National Drug Code (NDC) number for each drug used in every encounter at the time of billing.
(4) Be reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan.

[OAR Docket #21-385; filed 6-14-21]

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

[OAR Docket #21-384]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 5. Individual Providers and Specialties
Part 6. Inpatient Psychiatric and Substance Use Disorder Services
317:30-5-95 [AMENDED]
317:30-5-95.1 [AMENDED]
317:30-5-95.42 [AMENDED]
317:30-5-95.43 [NEW]
317:30-5-95.44 [NEW]
317:30-5-95.45 [NEW]
317:30-5-95.46 [NEW]
317:30-5-95.47 [NEW]
317:30-5-95.48 [NEW]
317:30-5-95.49 [NEW]
317:30-5-95.50 [NEW]
317:30-5-96.3 [AMENDED]
Part 21. Outpatient Behavioral Health Agency Services
317:30-5-241.6 [AMENDED]
Part 24. Certified Community Behavioral Health Clinics
317:30-5-268 [AMENDED]
(Reference APA WF # 20-15B)

AUTHORITY: The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board; 42 CFR 440.130(d); Section 1115 of the Social Security Act

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317:30-5-95.49 [NEW]
317:30-5-96.3 [AMENDED]
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INCORPORATIONS BY REFERENCE:
na

GIST/ANALYSIS:
The proposed revisions add residential SUD treatment coverage for
Medicaid-eligible adults, ages twenty-one (21) to sixty-four (64), and
members under the age of twenty-one (21) in residential SUD treatment
facilities with seventeen (17) beds or more and/or residential SUD treatment
facilities with sixteen (16) beds or less. Additionally, the proposed revisions
will remove references to non-Medicaid reimbursable services and align
covered services with the Oklahoma Medicaid State Plan. Further revisions
will revise assessment and service plan timeframes and certain treatment
hour requirements. Other revisions will involve limited rewriting aimed at
clarifying policy language.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN,
THE FOLLOWING RULES ARE CONSIDERED
FINALLY ADOPTED AS SET FORTH IN 75 O.S.,
SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE
DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS
AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC AND
SUBSTANCE USE DISORDER SERVICES

317:30-5-95. General provisions and eligible providers
(a) Eligible settings for inpatient psychiatric services.
The following individuals may receive SoonerCare-reimbursable inpatient psychiatric services in the following eligible settings:
(1) Individuals twenty-one (21) to sixty-four (64) years of age may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical dependency substance use/detoxification services in a psychiatric unit of a general hospital, provided that such hospital is not an IMD.
(2) Individuals sixty-five (65) years of age or older may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, or in a psychiatric hospital.
(3) Individuals under twenty-one (21) years of age, in accordance with OAC 317:30-5-95.23, may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, a psychiatric hospital, or a PRTF, and may receive chemical dependency detoxification/withdrawal management services in a psychiatric unit of a general hospital or in a psychiatric hospital.
(b) Psychiatric hospitals and psychiatric units of general hospitals. To be eligible for payment under this Part, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that:
(1) Is a psychiatric hospital that:
(A) Successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital per 42 C.F.R. § 482.60; or
(B) Is accredited by a national organization whose psychiatric accrediting program has been approved by CMS; or
(2) Is a general hospital with a psychiatric unit that:
(A) Successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital as specified in 42 C.F.R. Part 482; or
(B) Is accredited by a national accrediting organization whose accrediting program has been approved by CMS; and
(3) Meets all applicable federal regulations, including, but not limited to:
(A) Medicare Conditions of Participation for Hospitals (42 C.F.R. Part 482), including special provisions applying to psychiatric hospitals (42 C.F.R. § 482.60-.62);
(B) Medicaid for Individuals Age 65 or over in Institutions for Mental Diseases (42 C.F.R. Part 441, Subpart C);
(C) Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. Part 441, Subpart D); and/or
(D) Utilization Control [42 C.F.R. Part 456, Subpart C (Utilization Control: Hospitals) or Subpart D (Utilization Control: Mental Hospitals)]; and
(4) Is contracted with the OHCA; and
(5) If located within Oklahoma and serving members under eighteen (18) years of age, is appropriately licensed by the Oklahoma Department of Human Services (OKDHS) as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168.

c) PRTF. Every PRTF must:
(1) Be individually contracted with OHCA as a PRTF;
(2) Meet all of the state and federal participation requirements for SoonerCare reimbursement, including, but not limited to, 42 C.F.R. § 483.354, as well as all requirements in 42 C.F.R. 483 Subpart G governing the use of restraint and seclusion;
(3) Be appropriately licensed by OKDHS as a residential child care facility (10 O.S. § 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168;
(4) Be appropriately certified by the State Survey Agency, the Oklahoma State Department of Health (OSDH) as meeting Medicare Conditions of Participation; and
(5) Be accredited by TJC, the Council on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).

d) Out-of-state PRTF. Any out-of-state PRTF must be appropriately licensed and/or certified in the state in which it does business, and must provide an attestation to OHCA that the PRTF is in compliance with the condition of participation for restraint and seclusion, as is required by federal law. Any out-of-state PRTF must also be accredited in conformance with OAC 317:30-5-95(c)(5).

e) Required documents. The required documents for enrollment for each participating provider can be downloaded from the OHCA’s website.

317:30-5-95.1. Medical necessity criteria and coverage for adults aged twenty-one (21) to sixty-four (64) for psychiatric disorders. An inpatient admission of an adult aged twenty-one (21) to sixty-four (64) that is attributable to a psychiatric disorder must meet the terms or conditions contained in (1), (2), (3), (4), one of (5)(A) to (5)(D), and one of (6)(A) to (6)(C) of this subsection.

(1) A primary diagnosis from the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis.
(2) Conditions are directly attributable to a psychiatric disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, and/or status offenses). Adjustment or substance related disorder may be a secondary diagnosis.
(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not have been managed or have not been manageable in a less intensive treatment program.
(4) Adult must be medically stable.
(5) Within the past forty-eight (48) hours, the behaviors present an imminent life-threatening emergency such as evidenced by:
   (A) Specifically described suicide attempts, suicidal intent, or serious threat by the patient.
   (B) Specifically described patterns of escalating incidents of self-mutilating behaviors.
   (C) Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.
   (D) Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.
(6) Requires secure twenty-four (24) hour nursing/medical supervision as evidenced by:
   (A) Stabilization of acute psychiatric symptoms.
   (B) Needs extensive treatment under physician direction.
   (C) Physiological evidence or expectation of withdrawal symptoms which require twenty-four (24) hour medical supervision.

c) Medical necessity criteria for admission of adults aged twenty-one (21) to sixty-four (64) for inpatient chemical dependency detoxification/withdrawal management. An inpatient admission of an adult aged twenty-one (21) to sixty-four (64) for chemical dependency/ substance use/ detoxification must meet the terms and conditions contained in (1), (2), (3), and one of (4)(A) through (D) of this subsection.
(1) Any psychoactive substance dependency disorder described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.
(2) Conditions are directly attributable to a substance dependency disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, and/or status offenses).
(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not be managed or have not been manageable in a less intensive treatment program.
(4) Requires secure twenty-four (24) hour nursing/medical supervision as evidenced by:
   (A) Need for active and aggressive pharmacological interventions.
   (B) Need for stabilization of acute psychiatric symptoms.
   (C) Need extensive treatment under physician direction.
   (D) Physiological evidence or expectation of withdrawal symptoms which require twenty-four (24) hour medical supervision.

317:30-5-95.42. Service quality review (SQR) of psychiatric facilities and residential substance use disorder (SUD) facilities
(a) The service quality review (SQR) SOR conducted by the OHCA or its designated agent meets the utilization control requirements as set forth in 42 C.F.R. Part 456.
(b) There will be an SQR of each in-state psychiatric facility and residential SUD facility that provides services to SoonerCare members which will be performed by the OHCA or its designated agent. Out-of-state psychiatric facilities that provide services to SoonerCare members will be reviewed according to the procedures outlined in the Medical Necessity Manual. Ad hoc reviews may be conducted at the discretion of the agency.
(c) The OHCA will designate the members of the SQR team. The SQR team will consist of one (1) to three (3) team members and will be comprised of LBHPs or registered nurses (RNs).
(d) The SQR will include, but not be limited to, review of facility and clinical record documentation as well as may include observation and contact with members. The clinical record review will consist of those records of members present or listed as facility residents at the beginning of the visit currently at the facility as well as records of members on file which have been filed with OHCA for acute or PRTF, or residential SUD levels of care. The SQR includes validation of compliance with policy, which must be met for the services to be compensable.
(e) Following the SQR, the SQR team will report its findings in writing to the facility. The facility will be provided with written notification if the findings of the review have resulted in any deficiencies. A copy of the final report will be sent to the facility’s accrediting agency, as well as the State Survey Agency, if applicable, and any licensing agencies.
(f) Deficiencies identified during the SQR may result in full or partial recoupment of paid claims. The determination of whether to assess full or partial recoupment shall be at the discretion of the OHCA based on the severity of the deficiencies.
(g) Any days during which the facility is determined to be out of compliance with Federal Conditions of Participation, excluding residential SUD facilities, or in which a member does not meet medical necessity criteria will result in full recoupment. Full recoupment may also result from a facility’s failure to provide requested documentation within the timeframes indicated on requests for such documents or if the SQR team is denied timely admittance to a facility and/or access to facility records during the on-site portion of the SQR.
(h) Items which may result in full or partial recoupment of paid claims shall include, but not be limited to:
   (1) Assessments and evaluations. Assessments and evaluations must be completed, with dated signature(s), by qualified staff within the timeframes outlined in Oklahoma Administrative Code (OAC) 317:30-5-95.6 and 317:30-5-95.7, and 317:30-5-95.47(1).
   (2) Plan of care. Plans of care must be completed, with all required dated signatures within the timeframes described in OAC 317:30-5-95.4 and 317:30-5-96.33, and 317:30-5-95.47(2).
   (3) Certification of need (CON). CONs for psychiatric facilities must be completed by the appropriate team and in the chart within the timeframes outlined in 42 C.F.R. §§ 441.152, 456.160, and 456.481.
   (4) Active treatment. Treatment must be documented in the chart at the required frequency by appropriately qualified staff as described in OAC 317:30-5-95.5, 317:30-5-95.7, 317:30-5-95.8, 317:30-5-95.9, 317:30-5-95.10 and 317:30-5-95.34, and 317:30-5-95.46(b).
   (5) Documentation of services. Services must be documented in accordance with OAC 317:30-5-95.5, 317:30-5-95.8, 317:30-5-95.10, 317:30-5-95.41, and 317:30-5-95.47 and 42 C.F.R. §§ 412.27(c)(4) and 482.61. Documentation with missing elements or documentation that does not clearly demonstrate the therapeutic appropriateness and benefit of the service may result in recoupment.
   (6) Staffing. Staffing must meet the ratios described in OAC 317:30-5-95.24(b)(d) & (h) and 317:30-5-95.38 per unit/per shift, and credentialing requirements as outlined in OAC 317:30-5-95.8, 317:30-5-95.9, 317:30-5-95.35, 317:30-5-95.36, 317:30-5-95.46 (b) and 42 C.F.R. §§ 412.27(d), 441.153, 441.156, and 482.62.
   (7) Restraint/seclusion. Orders for restraint and seclusion must be completely and thoroughly documented with all required elements as described in OAC 317:30-5-95.39 and 42 C.F.R. § 482.13(e) & (f) and 42 C.F.R. Part 483. Documentation must support the appropriateness and necessity for the use of restraint/seclusion. For PRTFs, documentation must include evidence that staff and resident debriefings occurred as required by OAC 317:30-5-95.39 and 42 C.F.R. Part 483. For residential SUD facilities, restraint may only be used when less restrictive interventions, according to facility policy, have been attempted or when an immediate intervention is required to protect the resident, a staff member, or others. A written incident report must be completed within
twenty-four (24) hours following each use of physical restraint.
(i) If the review findings have resulted in a recoupment, the days and/or services involved will be reported in the notification.
(j) In the event that CMS recoups from OHCA an amount that exceeds the provider's liability for findings described in this Section, the provider will not be held harmless and will be required to reimburse OHCA the total federal amount identified by CMS and/or its designated audit contractor, limited to the amount of the original paid claim less any previously recouped amounts.
(k) 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 the member's family.
(l) Facilities that are determined to owe recoupment of paid claims will have the ability to request a reconsideration of the findings. Details and instructions on how to request a reconsideration will be part of the report documentation sent to the facility.
(m) Facilities that are determined by the SQR process to be out of compliance in significant areas will be required to submit a Corrective Action Plan (CAP) detailing steps being taken to bring performance in line with requirements. Facilities that are required to submit a CAP may be further assessed through a formal, targeted post-CAP review process.

317:30-5-95.43. Residential substance use disorder (SUD) treatment

(a) Purpose. The purpose of sections OAC 317:30-5-95.43 - 317:30-5-95.49 is to establish the procedures and requirements for residential treatment facilities providing SUD treatment services.
(b) Definitions. The following words and terms, when used in the aforementioned sections, shall have the following meanings unless the context clearly indicates otherwise.

1. "ASAM" means the American Society of Addiction Medicine.
2. "ASAM criteria" means the most recent edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.
3. "ASAM levels of care" means the different options for treatment as described below and in the current edition of the ASAM criteria that vary according to the intensity of the services offered. Each treatment option is a level of care.

   A. "ASAM level 3" means residential and inpatient services and encompasses ASAM levels 3.1, 3.3, 3.5 and 3.7.
   B. "ASAM level 3.1" means clinically managed low-intensity residential services for adolescents and adults. This level of care typically provides at least five (5) hours of clinical services a week and provides a twenty-four (24) hour living support and structure with trained personnel. The corresponding service description for this level of care is halfway house services.
   C. "ASAM level 3.3" means clinically managed population-specific high-intensity residential services. This level of care is for adults only and typically offers twenty-four (24) hour care with trained personnel and is designed to accommodate individuals with cognitive or other impairments. The corresponding service description for this level of care is residential treatment for adults with co-occurring disorders.
   D. "ASAM level 3.5" means clinically managed medium-intensity residential services for adolescents and clinically managed high-intensity residential services for adults. This level of care provides twenty-four (24) hour care and offers a wide range of therapeutic services. The corresponding service descriptions for this level of care are residential treatment and intensive residential treatment.
   E. "ASAM level 3.7" means medically monitored high-intensity inpatient services for adolescents and medically monitored intensive inpatient withdrawal management for adults. This level of care provides twenty-four (24) hour nursing care with physician supervision and medication availability. This level of care is appropriate for individuals withdrawing from alcohol or other drugs with subacute biomedical and emotional, behavioral, or cognitive problems severe enough to require inpatient treatment but for whom hospitalization is not necessary. The corresponding service description for this level of care is medically supervised withdrawal management.

4. "Care management services" means an assessment of a member, development of a care plan, and referral and linkage to SUD community supports and community-based or lower level of care services to promote continued recovery after the individual discharges from the treatment facility.
5. "Co-occurring disorder (COD)" means any combination of mental health symptoms and SUD symptoms or diagnoses that affect a member and are typically determined by the Diagnostic and Statistical Manual of Mental Disorders (DSM).
6. "DSM" means the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.
7. "ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services (ODMH-SAS).
8. "Rehabilitation services" means face-to-face individual or group services provided by qualified staff to develop skills necessary to perform activities of daily living and successful integration into community life. Rehabilitation services for substance use disorders are also referred to as skill development services.
9. "Service plan" means the document used during the process by which an LBHP or a licensure candidate
Permanent Final Adoptions

and the member together and jointly identify and rank problems, establish agreed-upon immediate short-term and long-term goals, and decide on the treatment process and resources to be utilized.

(10) "Substance use disorder (SUD)" means alcohol or drug dependence, or psychoactive SUD as defined by the most recent DSM criteria.

(11) "Therapeutic services" means professional services during which members engage in identifying, addressing and/or resolving issues identified in the member's service plan.

(12) "Treatment hours - residential" means the structured hours in which a member is involved in receiving professional services to assist in achieving recovery.

317:30-5-95.44. Residential substance use disorder (SUD) - Eligible providers and requirements

(a) Eligible providers shall:

(1) Have and maintain current certification from the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a residential level of care provider of SUD treatment services, unless exempt from state jurisdiction or an exempted entity as defined in Section 3-415 of Title 43A of the Oklahoma Statutes;

(2) Have a contract with the OHCA;

(3) Have a Certificate of Need, if required by ODMHSAS in accordance with OAC 450:18-17-2 or OAC 450:24-27-2;

(4) Have a current accreditation status appropriate to provide residential behavioral health services from:

(A) The Joint Commission; or

(B) The Commission on Accreditation of Rehabilitation Facilities (CARF); or

(C) The Council on Accreditation (COA).

(b) Providers certified by ODMHSAS as a residential level of care provider of SUD treatment services prior to October 1, 2020 shall have until January 1, 2022 to obtain accreditation as required in (4) above.

(c) Residential treatment facilities providing SUD treatment services to individuals under the age of eighteen (18) must have a residential child care facility license from the Oklahoma Department of Human Services (DHS). Residential treatment facilities providing child care services must have a child care center license from DHS.

317:30-5-95.45. Residential substance use disorder (SUD) - Coverage by category

(a) Adults. Members age twenty-one (21) to sixty-four (64) who meet eligibility and clinical criteria may receive medically necessary residential treatment for SUD.

(1) The member must meet residential level of care as determined through completion of the designated ASAM level of care tool as required in the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Prior Authorization Manual.

(2) Each presenting member for SUD treatment shall be assessed, according to ASAM criteria, which includes a list of symptoms for all six (6) dimensions and each level of care to determine a clinically appropriate placement in the least restrictive level of care.

(b) Children. Coverage for children is the same as adults.

(c) Individuals with dependent children. Coverage for individuals with dependent children is the same as adults and/or children.

317:30-5-95.46. Residential substance use disorder (SUD) - Covered services and medical necessity criteria

(a) In order for the services described in this Section to be covered, individuals shall:

(1) Be diagnosed with an SUD as described in the most recent edition of the DSM; and

(2) Meet residential level of care in accordance with the American Society of Addiction Medicine (ASAM) criteria, as determined by the ASAM level of care determination tool designated by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).


(b) Coverage includes the following services:

(1) Clinically managed low intensity residential services (ASAM Level 3.1).

(A) Halfway house services - Individuals age thirteen (13) to seventeen (17).

(i) Service description. This service places a major emphasis on continuing SUD care and community ancillary services in an environment supporting continued abstinence. The facility shall have scheduled services to assess and address the individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, case management, crisis intervention, and for members age sixteen (16) and older, community recovery support services. Group therapy is limited to a total of six (6) individuals. Rehabilitation services shall not exceed a staffing ratio of eight (8) individuals to one (1) qualified provider.

(ii) Staffing requirements. A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. A minimum of two (2) direct care and/or clinical staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3.153.2. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) Treatment hours. A minimum of six (6) treatment hours per week shall be provided. A week begins on Sunday and ends on Saturday.
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(B) **Halfway house services - Individuals age eighteen (18) to sixty-four (64).**

(i) **Service description.** This service places a major emphasis on continuing SUD care and community ancillary services in an environment supporting continued abstinence. The facility shall have scheduled services to assess and address the individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, care management, crisis intervention, and community recovery support services. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A minimum of six (6) treatment hours per week shall be provided. A week begins on Sunday and ends on Saturday.

(C) **Halfway house services - Individuals with minor dependent children or women who are pregnant.**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours, seven (7) days a week, supervised living arrangements, to include professionally directed evaluation, care, and treatment. The facility shall have scheduled services to assess and address the individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, care management, crisis intervention, and community recovery support services. Group therapy is limited to a total of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment services for dependent children.** Services are available to the child when provided to address the impacts related to the parent's addiction, including, but not limited to, individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) **Treatment hours.** A minimum of six (6) treatment hours per week shall be provided to the individual with minor dependent children and women who are pregnant. A week begins on Sunday and ends on Saturday. Dependent children shall be provided treatment services in accordance with the child's service plan if services are provided by the residential SUD provider.

(2) **Clinically managed, population specific, high intensity residential services (ASAM Level 3.3).** This service includes residential treatment for adults with co-occurring disorders.

(A) **Service description.** This service provides a planned regimen of twenty-four (24) hours, seven / (7) days a week, structured evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of the member. Services include individual, family, and group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Psychiatric and/or psychological and/or mental health evaluations shall be completed on all members. In addition to the requirements in OAC 317:30-5.95.47, the service plan shall address the member's mental health needs and medications. The member's medications shall be re-assessed a minimum of once every thirty (30) days and monitoring of medications shall be provided. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider. Treatment services must address both mental health and SUD needs as identified in the service plan.

(B) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(C) **Treatment hours.** A weekly minimum of twenty-four (24) service hours shall be provided, which shall include a minimum of one (1) hour of individual, group, or family therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A week begins on Sunday and ends on Saturday. A maximum of seven (7) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours.
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(3) Clinically managed medium and high intensity (ASAM Level 3.5).

(A) Residential treatment, medium intensity - individuals age thirteen (13) to seventeen (17).

(i) Service description. This service provides a planned regimen of twenty-four (24) hours / seven (7) days a week, professionally directed evaluation, care, and treatment. A multidisciplinary team approach shall be utilized in providing daily treatment services to assess and address the individual needs of each member, including individual, family, and/or group therapy, individual and/or group rehabilitation services, care management, crisis intervention, and, for members age sixteen (16) or older, community recovery support services. Group therapy is limited to a total of six (6) individuals. Rehabilitation services shall not exceed a staffing ratio of eight (8) individuals to one (1) qualified provider.

(ii) Staffing requirements. A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. A minimum of two (2) direct care and/or clinical staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) Treatment hours. A weekly minimum of fifteen (15) treatment hours for members attending academic training and twenty-four (24) treatment hours for members not attending academic training shall be provided. Weekly treatment hours shall include a minimum of one (1) hour of individual, family and/or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of seven (7) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday.

(B) Residential treatment, high intensity - adults.

(i) Service description. This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) Staffing requirements. A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) Treatment hours. A weekly minimum of twenty-four (24) service hours shall be provided, which shall include a minimum of one (1) hour of individual, family, and/or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of seven (7) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday.

(C) Intensive residential treatment, high intensity - adults.

(i) Service description. This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) Staffing requirements. A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) Treatment hours. A weekly minimum of thirty-seven (37) service hours shall be provided, which shall include a minimum of four (4) hours of individual, family, and/or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of eleven (11) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday.

(D) Intensive residential treatment, high intensity - individuals age thirteen (13) to seventeen (17).
(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) days a week, professionally directed evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of each member. Services include individual, family, and/or therapy, individual and/or group rehabilitation services, crisis intervention, care management, and, for members age sixteen (16) or older, community recovery support services. Group therapy is limited to a total of six (6) individuals. Rehabilitation services shall not exceed a staffing ratio of eight (8) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of thirty-seven (37) service hours shall be provided, which shall include a minimum of four (4) hours of individual, family, or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of eleven (11) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday.

(E) **Residential treatment for individuals with minor dependent children and women who are pregnant.**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) days a week, professionally directed evaluation, care, and treatment. The facility shall provide SUD treatment services to assess and address individual needs of each member. Services include individual, family, and/or therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Group therapy is limited to a total of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment for dependent children.** Services are available to the child when provided to address the impacts related to the parent's addiction, including but not limited to individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) **Treatment hours.** A minimum of twenty-four (24) service hours shall be provided to the individual with minor dependent children and women who are pregnant. Treatment hours shall include a minimum of one (1) hour of individual, family, and/or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of seven (7) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday. Dependent children shall be provided treatment services in accordance with the child's service plan if services are provided by the residential SUD provider.

(F) **Intensive residential treatment for individuals with dependent children and women who are pregnant.**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. The facility shall provide SUD treatment services to assess and address individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Group therapy is limited to a total of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.
(iii) Treatment services for dependent children. Services are available to the child when provided to address the impacts related to the parent's addiction, including but not limited to individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) Treatment hours. A weekly minimum of thirty-five (35) service hours shall be provided to the individual with minor dependent children and women who are pregnant. Treatment hours shall include a minimum of four (4) hours of individual, family, and/or group therapy and a minimum of seven (7) hours of individual and/or group rehabilitation services. A maximum of eleven (11) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday. Dependent children shall be provided treatment services in accordance with the child's service plan if services are provided by the residential SUD provider.

(4) Medically monitored high intensity withdrawal management (ASAM Level 3.7).
(A) Medically supervised withdrawal management - individuals age thirteen (13) to seventeen (17).
(i) Service description and requirements. This service is provided under the direction of a licensed physician and a licensed registered nurse supervisor, for members who are withdrawing or are intoxicated from alcohol or other drugs. Members shall be assessed as currently experiencing no apparent medical or neurological symptoms that would require hospitalization. Daily SUD withdrawal management treatment services shall be provided, which include, but are not limited to, taking of vital signs (temperature, pulse, respiration rate, blood pressure), documentation of fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the member's condition. Medications shall be prescribed if needed during withdrawal management. The medications are to include those needed for physical health issues and mental impairment if acquired during the withdrawal process.
(ii) Staffing requirements. A licensed physician providing supervision of withdrawal management must be available on site or on call twenty-four (24) hours a day, seven (7) days a week. A licensed nurse must provide twenty-four (24) hours a day, seven (7) days a week monitoring and statutorily approved personnel administer medication. A minimum of two (2) medical and/or clinical/direct care staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2.
(B) Medically supervised withdrawal management - adults.
(i) Service description and requirements. This service is provided under the direction of a licensed physician and a licensed registered nurse supervisor, for members who are withdrawing or are intoxicated from alcohol or other drugs. Members shall be assessed as currently experiencing no apparent medical or neurological symptoms that would require hospitalization. Daily SUD withdrawal management treatment services shall be provided, which include, but are not limited to, taking of vital signs (temperature, pulse, respiration rate, blood pressure), documentation of fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the member's condition. Medications prescribed if needed during withdrawal management. The medications are to include those needed for physical health issues and mental impairment if acquired during the withdrawal process.
(ii) Staffing requirements. A licensed physician providing supervision of withdrawal management must be available on site or on call twenty-four (24) hours a day, seven (7) days a week. A licensed nurse must provide twenty-four (24) hours a day, seven (7) days a week monitoring and statutorily approved personnel administer medication.

317:30-5.95.47. Residential substance use disorder (SUD) - Individualized service plan requirements

All SUD services provided in residential treatment facilities are rendered as a result of an individual assessment of the member's needs and documented in the service plan.
(1) Assessment. A biopsychosocial assessment shall be completed for members receiving ASAM Level 3.1, 3.3, or 3.5 services, including dependent children receiving services from the residential SUD provider, to gather sufficient information to assist the member in developing an individualized service plan. The assessment must also list the member's past and current psychiatric medications. The assessment must be completed by an LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. Assessments for ASAM Level 3.7 services shall be completed in accordance with (E) below.
(A) Assessments for adolescents. A biopsychosocial assessment using the Teen Addiction Severity Index (T-ASI) shall be completed. A physical examination shall be conducted by a licensed physician to include, at a minimum, a physical assessment, health
history, immunization status, and evaluation of motor development and function, speech, hearing, visual, and language functioning.

(B) **Assessments for adults.** A biopsychosocial assessment using the Addiction Severity Index (ASI) shall be completed.

(C) **Assessments for dependent children.** In accordance with OAC 450:18-7-25, assessments of children (including infants) accompanying their parent into treatment and receiving services from the residential SUD provider shall include the following items:

(i) Parent-child relationship;
(ii) Physical and psychological development;
(iii) Educational needs;
(iv) Parent related issues; and
(v) Family issues related to the child.

(D) **Assessments for parents/pregnant women.** In accordance with OAC 450:18-7-25, assessments of the parent and/or pregnant women bringing their children into treatment shall include the following items:

(i) Parenting skills;
(ii) Knowledge of age appropriate behaviors;
(iii) Parental coping skills;
(iv) Personal issues related to parenting; and
(v) Family issues as related to the child.

(E) **Assessments for medically supervised withdrawal management.** In accordance with OAC 450:18-13-61, a medical assessment for the appropriateness of placement shall be completed and documented by a licensed physician during the admission process.

(F) **Assessment timeframes.** Biopsychosocial assessments shall be completed within two (2) days of admission or during the admission process for medically supervised withdrawal management.

(2) **Service plan.** Pursuant to OAC 450:18-7-81, a service plan shall be completed for each member receiving ASAM Level 3.1, 3.3, or 3.5 services, including dependent children receiving services from the residential SUD provider. The service plan is performed with the active participation of the member and a support person or advocate, if requested by the member. In the case of children under the age of sixteen (16), it is performed with the participation of the parent or guardian, if allowed by law, and the child as age and developmentally appropriate. Service plans for ASAM Level 3.7 services shall be developed in accordance with (D) below.

(A) **Service plan development.** The service plan shall:

(i) Be completed by an LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing.

(ii) Provide the formation of measurable service objectives and reflect ongoing changes in goals and objectives based upon member's progress or preference or the identification of new needs, challenges, and problems.

(iii) Be developed after and based on information obtained in the assessment and includes the evaluation of the assessment information by the clinician and the member.

(iv) Have an overall general focus on recovery which, for adults, may include goals like employment, independent living, volunteer work, or training, and for children, may include areas like school and educational concerns and assisting the family in caring for the child in the least restrictive level of care.

(B) **Service plan content.** Service plans must include dated signatures for the member [if over fourteen (14)], the parent/guardian [if under sixteen (16) and allowed by law], and the primary service practitioner. Signatures must be obtained after the service plan is completed. The contents of a service plan shall address the following:

(i) Member strengths, needs, abilities, and preferences;
(ii) Identified presenting challenges, needs, and diagnosis;
(iii) Goals for treatment with specific, measurable, attainable, realistic, and time-limited objectives;
(iv) Type and frequency of services to be provided;
(v) Description of member's involvement in, and response to, the service plan;
(vi) The service provider who will be rendering the services identified in the service plan; and
(vii) Discharge criteria that are individualized for each member and beyond that which may be stated in the ASAM criteria.

(C) **Service plan updates.** Service plan updates shall occur a minimum of once every thirty (30) days while services are provided. Service plan updates must include dated signatures for the member [if over fourteen (14)], the parent/guardian [if under sixteen (16) and allowed by law], and the LBHP and licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. Signatures must be obtained after the service plan is completed. Service plan updates shall address the following:

(i) Progress on previous service plan goals and/or objectives;
(ii) A statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
(iii) Change in goals and/or objectives based upon member's progress or identification of new needs and challenges;
(iv) Change in frequency and/or type of services provided;
(v) Change in staff who will be responsible for providing services on the plan; and
(vi) Change in discharge criteria.

(D) Service plans for medically supervised withdrawal management. Pursuant to OAC 450:18-7-84, a service plan shall be completed for each member receiving ASAM Level 3.7 services that addresses the medical stabilization treatment and services needs of the member. Service plans shall be completed by a licensed physician or licensed registered nursing staff.

(E) Service plan timeframes. Service plans shall be completed within four (4) days of admission, except for service plans for individuals receiving medically supervised withdrawal management services, which must be completed within three (3) hours of admission.

(3) Progress notes. Progress notes shall chronologically describe the services provided, the member's response to the services provided, and the member's progress in treatment.

(A) Content. Progress notes shall address the following:
(i) Date;
(ii) Member's name;
(iii) Start and stop time for each timed treatment session or service;
(iv) Signature of the service provider;
(v) Credentials of the service provider;
(vi) Specific service plan needs, goals and/or objectives addressed;
(vii) Services provided to address needs, goals, and/or objectives;
(viii) Progress or barriers to progress made in treatment as it relates to the goals and/or objectives;
(ix) Member (and family, when applicable) response to the session or service provided; and
(x) Any new needs, goals and/or objectives identified during the session or service.

(B) Frequency. Progress notes shall be completed in accordance with the following timeframes:
(i) Progress notes for therapy, crisis intervention and care management must be documented in an individual note and reflect the content of each session provided.
(ii) Documentation for rehabilitation and community recovery support services must include daily member sign-in/sign-out record of member attendance (including date, time, type of service and service focus), and a daily progress note or a summary progress note weekly.

(4) Transition/discharge planning. All facilities shall assess each member for appropriateness of discharge from a treatment program. Each member shall be assessed using ASAM criteria to determine a clinically appropriate placement in the least restrictive level of care.

(A) Transition/discharge plans. Transition/discharge plans shall be developed with the knowledge and cooperation of the member. The transition/discharge plan shall be included in the discharge summary. The discharge plan is to include, at a minimum, recommendations for continued treatment services and other appropriate community resources. Appointments for outpatient therapy and other services, as applicable, should be scheduled prior to discharge from residential care. Development of the transition/discharge plan shall begin no later than two (2) weeks after admission.

(B) Discharge summary. The discharge summary shall document the member's progress made in treatment and response to services rendered. A completed discharge summary shall be entered in each member's record within fifteen (15) days of the member completing, transferring, or discontinuing services. The summary must be signed and dated by the staff member completing the summary.

317:30-5-95.48. Staff training
(a) All clinical and direct care staff shall have non-physical intervention training in techniques and philosophies addressing appropriate non-violent interventions for potentially physical interpersonal conflicts, staff attitudes which promote dignity and enhanced self-esteem, keys to effective communication skills, verbal and non-verbal interaction and non-violent intervention within thirty (30) days of being hired with updates each calendar year thereafter.
(b) All staff shall receive training in accordance with OAC 450:18-9-3(1).

317:30-5-95.49. Medication policies and records
(a) The facility shall have policies in place addressing the safe storage, handling, and administration of medications.
(b) Medication records shall be maintained in accordance with OAC 450:18-7-144.

317:30-5-95.50. Residential substance use disorder (SUD) - Reimbursement
(a) In order to be eligible for payment, residential treatment providers of SUD treatment services must have an approved provider agreement on file with the OHCA. Through this agreement, the residential provider assures that they are in compliance with all applicable federal and State Medicaid law and regulations, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, and the Oklahoma Medicaid State Plan.
(b) Covered SUD treatment services for adolescents and adults in SUD residential treatment shall be reimbursed utilizing the per diem rates for each level of care. All SUD residential treatment services must be prior authorized by the OHCA or its designated agent before the service is rendered by an eligible provider. Without prior authorization, payment is not authorized.
(c) Covered SUD treatment services for adolescents and adults in SUD residential treatment shall be reimbursed utilizing the per diem rates for each level of care. Separate payment may be made for medications, physician services, and treatment services provided to dependent children in accordance with the Oklahoma Medicaid State Plan. Separate payment for such services will follow existing prior authorization requirements, if applicable.

(d) Treatment services for dependent children accompanying a parent to treatment shall be reimbursed on a fee-for-service basis in accordance with the Oklahoma Medicaid State Plan. Outpatient services rendered to dependent children may be provided by the residential facility if appropriately certified or a separate outpatient provider. Such services shall not duplicate any services provided by the residential provider that are reimbursed through the residential per diem rate.

(e) The following services are excluded from coverage/reimbursement:

1. Room and board;
2. Services or components that are not provided to or exclusively for the treatment of the member;
3. Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a member receiving covered services;
4. Physician directed services and medications (these services are reimbursed outside of the residential SUD per diem);
5. Telephone calls or other electronic contacts (not inclusive of telehealth); and
6. Field trips, social, or physical exercise activity groups.

317:30-5-96.3. Methods of payment

(a) Reimbursement.

1. Covered inpatient psychiatric and/or substance use disorder, chemical dependency detoxification/withdrawal management services will be reimbursed using one (1) of the following methodologies:
   A. Diagnosis related group (DRG);
   B. Cost-based; or
   C. A predetermined per diem payment.

2. For members twenty-one (21) to sixty-four (64) years of age, payment shall not be made to any inpatient psychiatric facility that qualifies as an IMD, except as provided by OAC 317:30-5-95.23 and 317:30-5-95.11. For members twenty-one (21) to sixty-four (64) years of age, payment shall not be made for any inpatient psychiatric episodes over sixty (60) days in a facility that qualifies as an IMD.

(b) Levels of care.

1. Acute.
   A. Payment will be made to psychiatric units within general medical surgical hospitals and critical access hospitals utilizing a DRG methodology. [See OAC 317:30-5-41]. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the DRG paid to the hospital;
   B. Payment will be made to psychiatric hospitals utilizing a predetermined statewide per diem payment 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.

2. Acute II.
   A. Payment will be made to in-state psychiatric hospitals or inpatient psychiatric programs utilizing a predetermined all-inclusive per diem payment for routine, ancillary, and professional services.
   B. 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.

3. PRTFs.

   A. A pre-determined per diem payment will be made to private PRTFs with sixteen (16) beds or less for routine services. All other services are separately billable.
   B. A predetermined all-inclusive per diem payment will be made for routine, ancillary, and professional services to private facilities with more than sixteen (16) beds.
   C. 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.

(c) Out-of-state services.

   1. Border and "border status" placements. Facilities are reimbursed in the same manner as in-state hospitals or PRTFs. Refer to OAC 317:30-3-90 and 317:30-3-91.
   2. 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. An incremental payment adjustment may be made for one (1): one (1) staffing (if clinically appropriate and prior authorized). Payment may be up to, but no greater, than usual and customary charges. The one (1): one (1) staffing adjustment is limited to sixty (60) days annually. Refer to OAC 317:30-3-90 and 317:30-3-91.

(d) Add-on payments.

   1. Additional payment shall only be made for services that have been prior authorized by OHCA or its designee and determined to be medically necessary. For medical necessity criteria applicable for the add-on payment(s), refer to the SoonerCare Medical Necessity Criteria Manual for Inpatient Behavioral Health Services found on the OHCA website.
   2. SoonerCare shall provide additional payment for the following services rendered in an Acute II and PRTF, as per the Oklahoma Medicaid State Plan.
(A) Intensive treatment services (ITS) add-on. Payment shall be made for members requiring intensive staffing supports.

(B) Prospective complexity add-on. Payment shall be made to recognize the increased cost of serving members with a mental health diagnosis complicated with non-verbal communication.

(C) Specialty add-on. Payment shall be made to recognize the increased cost of serving members with complex needs.

(e) Services provided under arrangement.

(4) Health home transitioning services.

(A) Services for the provision of comprehensive transitional care to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for health home transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to the health home outside of the facility’s per diem or DRG rate.

(21) Case management transitioning services.

(A) Services for the provision of case management transitioning services to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for case management transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to a qualified community-based provider.

(32) Evaluation and psychological testing by a licensed psychologist.

(A) Services for the provision of evaluation and psychological testing by a licensed psychologist to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for evaluation and psychological testing by a licensed psychologist for services provided under arrangement with the inpatient provider will be directly reimbursed to a qualified provider in accordance with the Oklahoma Medicaid State Plan.

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.6. Behavioral health targeted case management

Payment is made for behavioral health targeted case management services as set forth in this Section. The limitations set forth in this Section do not apply to case management provided in programs and service delivery models which are not reimbursed for case management on a fee-for-service basis.

(1) Description of behavioral health case management services. 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. Services under behavioral health targeted case management are not comparable in amount, duration and scope. The target groups for behavioral health case management services are persons under age twenty-one (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 authorized based on established medical necessity criteria.

(A) 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 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 ODMHSAS. In order to be compensable, the service must be performed utilizing the 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.

(B) The provider will coordinate transition services with the member and family (if applicable) by phone or face to face, to identify immediate needs for return to home/community no more than seventy-two (72) hours after notification that the member/family requests case management services. For members discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and
family (if applicable) for transition from the higher level of care other than outpatient back to the community, within seventy-two (72) hours of discharge, and then conduct a follow-up appointment/contact within seven (7) days. The case manager will provide linkage/referral to physicians/medication services, psychotherapy services, rehabilitation and/or support services as described in the case management service plan.

(C) 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 two (2) 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 (1) 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.

(D) 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.

(E) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized plan of care.

(F) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian [if the member is under eighteen (18)], the behavioral health case manager, and an LBHP or licensure candidate as defined in OAC 317:30-5-240.3(a) and (b).

(G) 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 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 member and/or parent/guardian/family member.

(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) Behavioral health targeted case management is available to individuals transitioning from institutions to the community [except individuals ages twenty-two (22) to sixty-four (64) who reside in an IMD or individuals who are inmates of public institutions]. Individuals are considered to be transitioning to the community during the last thirty (30) consecutive days of a covered institutional stay. This time is 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. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(2) Levels of case management.

(A) Standard case management/resource coordination services are targeted to adults with serious mental illness or children with serious emotional disturbance, or who have or are at-risk for mental disorders, including substance use disorders (SUD), and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard case managers have caseloads of thirty (30) to thirty-five (35) members. Standard case management/resource coordination is limited to twelve (12) units per member per month. Additional units may be authorized up to twenty-five (25) units per member per month if medical necessity criteria for transitional case management are met.

(B) Intensive case management (ICM) is targeted to adults with serious and persistent mental illness in
PACT programs. To ensure that these intense needs are met, caseloads are limited to between ten (10) to fifteen (15) members. The ICM shall: be a certified behavioral health case manager II; have a minimum of two (2) years' behavioral health case management experience; have crisis diversion experience; have attended the ODMHSAS six (6) hour ICM training and be available twenty-four (24) hours a day. ICM is limited to fifty-four (54) units per member per month.

(C) Wraparound facilitation case management (WFCM) is targeted to children with significant mental health conditions being treated in a System of Care (SOC) Network who are deemed at imminent risk of out-of-home placement due to psychiatric or SUD reasons and in need of more intensive case management 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 produce a high fidelity wraparound process, a facilitator can facilitate between eight (8) and ten (10) families. Staff providing WFCM must meet the requirements for the SOC/WFCM. WFCM is limited to fifty-four (54) units per member per month.

(3) Excluded services. SoonerCare reimbursable behavioral health case management does not include the following activities:

(A) Physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment;
(B) Managing finances;
(C) Providing specific services such as shopping or paying bills;
(D) Delivering bus tickets, food stamps, money, etc.;
(E) Counseling, rehabilitative services, psychiatric assessment, or discharge planning;
(F) Filling out forms, applications, etc., on behalf of the member when the member is not present;
(G) Filling out SoonerCare forms, applications, etc.;
(H) Mentoring or tutoring;
(I) Provision of behavioral health case management services to the same family by two (2) separate behavioral health case management agencies;
(J) Non-face-to-face time spent preparing the assessment document and the service plan paperwork;
(K) Monitoring financial goals;
(L) Leaving voice or text messages for clients and other failed communication attempts.

(4) Excluded individuals. The following SoonerCare members who are receiving similar services through another method are not eligible for behavioral health case management services without special arrangements with the Oklahoma Department of Human Services (OKDHS), OJA, OHCA or ODMHSAS as applicable, in order to avoid duplication in payment. Services/programs include, but may not be limited to:

(A) Members/families (when applicable) for whom at-risk case management services are available through OKDHS and OJA staff;
(B) Members in out-of-home placement and receiving targeted case management services through staff in a foster care or group home setting, unless transitioning into the community;
(C) Residents of ICF/IIDs and nursing facilities unless transitioning into the community;
(D) Members receiving targeted case management services under a Home and Community Based Services (HCBS) waiver program;
(E) Members receiving services in the health home program;
(F) Members receiving case management through the ADvantage waiver program;
(G) Members receiving targeted case management available through a Certified Community Behavioral Health Center (CCBHC);
(H) Members receiving case management services through Programs of All-Inclusive Care for the Elderly (PACE);
(I) Members receiving Early Intervention case management (EICM);
(J) Members receiving case management services through certified school-based targeted case management (SBTCM) providers;
(K) Members receiving partial hospitalization services; or
(L) Members receiving MST.

(5) Filing requirements. Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

(6) Documentation requirements. 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 member and it must be reviewed and signed by the member, the behavioral health case manager, and an LBHP or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:

(A) Date;
(B) Person(s) to whom services are rendered;
(C) Start and stop times for each service;
(D) Original signature or the service provider [original signatures for faxed items must be added to the clinical file within thirty (30) days];
(E) Credentials of the service provider;
(F) Specific service plan needs, goals, and/or objectives addressed;
(G) Specific activities performed by the behavioral health case manager on behalf of the member related to advocacy, linkage, referral, or monitoring used to address needs, goals, and/or objectives;
(H) Progress and barriers made towards goals, and/or objectives;
(I) Member/family (when applicable) response to the service;
(J) Any new service plan needs, goals, and/or objectives identified during the service; and
(K) Member satisfaction with staff intervention.
(7) **Case management travel time.** The rate for case management services assumes that the case manager will spend some amount of space traveling to the member for the face-to-face service. The case manager must only bill for the actual face-to-face time that they spend with the member and not bill for travel time. This would be considered duplicative billing since the rate assumes the travel component already.

**PART 24. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS**

317:30-5-268. **Limitations**

(a) The following are non-billable opportunities for CCBHCs serving eligible members:
   (1) Employment services;
   (2) Personal care services;
   (3) Childcare;
   (4) Respite services; and
   (5) Care coordination.

(b) The following SoonerCare members are not eligible for CCBHC services:
   (1) Members receiving care in an IM;
   (2) Members residing in a nursing facility or ICF/IID;
   (2) Inmates of a public correctional institution; and
   (3) SoonerCare members being served by a PACE provider.

(e) SoonerCare members receiving services from a CCBHC are not eligible for enrollment in a SoonerCare behavioral health home.

[OAR Docket #21-384; filed 6-14-21]

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**

**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

[OAR Docket #21-400]

**RULEMAKING ACTION:**
PERMANENT final adoption

**RULES:**
Subchapter 5. Individual Providers and Specialties

**PART 22. HEALTH HOMES [REVOLED]**

317:30-5-250. **Purpose [REVOKED]**

Health Homes for Individuals with Chronic Conditions are created to promote enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness. The purpose of the Health Home is to improve the health status of SoonerCare members with Serious Mental Illness or Serious Emotional Disturbance by promoting wellness and prevention and to improve access and continuity in health care for these members by supporting coordination and integration of primary care services in specialty behavioral health settings.
317:30-5-251. Eligible providers [REVOKED]
(a) Agency requirements. Providers of Health Home (HH) services are responsible for providing HH services to qualifying individuals within the provider’s specified service area. Qualifying providers must be:
(1) Certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a Community Mental Health Center under OAC 450:17; or
(2) Accredited as a provider of outpatient behavioral health services from one of the national accrediting bodies; or
(3) Certified by ODMHSAS as a Mental Illness Service Program pursuant to OAC 450:27; or
(4) Certified by ODMHSAS as a Program of Assertive Community Treatment (PACT) pursuant to OAC 450:55.
(5) In addition to the accreditation/certification requirements in (1) B (4), providers must also have provider specific credentials from ODMHSAS for Health Home Services (OAC 450:17, OAC 450:27, OAC 450:55).
(b) Health Home team. Health Homes will utilize an interdisciplinary team of professionals and paraprofessionals to identify an individual’s strengths and needs, create a unified plan to empower persons toward self-management and coordinate the individual’s varied healthcare needs. HH teams will vary in size depending on the size of the member panel and acuity of members. HH team composition will vary slightly between providers working with adults and children.
(1) Health Homes working with adults with Serious Mental Illness (SMI) will utilize a multidisciplinary team consisting of the following:
   (A) Health Home-Director;
   (B) Nurse Care Manager (RN or LPN);
   (C) Consulting Primary Care Practitioner (PCP);
   (D) Psychiatric Consultant (317:30-5-11);
   (E) Certified Behavioral Health Case Manager (CM) (OAC 450:50, 317:30-5-505);
   (F) Wellness Coach credentialed through ODMHSAS; and
   (G) Administrative support.
(2) In addition to the individuals listed in (1) (A) through (G) above, teams working with adults with SMI (PACT teams only) will also have at least one of the following team members:
   (A) Licensed Behavioral Health Professional or Licensure Candidate (317:30-5-240.3);
   (B) Substance abuse treatment specialist (Licensed Alcohol and Drug Counselor (LADC) or Certified Alcohol and Drug Counselor (CADC); or
   (C) Employment specialist.
(3) Health Homes working with children with Serious Emotional Disturbance (SED) will utilize a multidisciplinary team consisting of the following:
   (A) Health Home-Director;
   (B) Nurse Care Manager (RN or LPN);
   (C) Consulting Primary Care Practitioner (PCP);
   (D) Psychiatric Consultant (317:30-5-11);
   (E) Care Coordinator (CM II Wraparound Facilitator as defined in 317:30-5-595(2)(C); (F) Family Support Provider (317:30-5-240.3); (G) Youth/Peer Support Specialist (OAC 450:53; 317:30-5-240.3); (H) Children’s Health Home Specialist (Behavioral Health Aide or higher, with additional training in WellPower or credentialed as a Wellness Coach through ODMHSAS); and
   (I) Administrative Support.

317:30-5-252. Covered Services [REVOKED]
Health Home services are covered for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED) as set forth in this Section unless specified otherwise, and when provided in accordance with a documented care plan. The care plan must be client directed, integrated, and reflect the input of the team (including the involvement of the consulting primary care physician or APRN in managing the medical component of the plan), as well as others the client chooses to involve. Coverage includes the following services:
(1) Comprehensive Care Management.
   (A) Definition. Comprehensive care management services consist of developing a Comprehensive Care Plan to address needs of the whole person and involve the active participation of the Nurse Care Manager, certified Behavioral Health Case Manager, Primary Care Practitioner, the Health Home clinical support staff with participation of other team members, family and caregivers.
   (B) Service requirements. Comprehensive care management services include the following, but are not limited to:
      (i) Identifying high-risk members and utilizing member information to determine level of participation in care management services;
      (ii) Assessing preliminary service needs; participating in comprehensive person centered service plan development; responsible for member physical health goals, preferences and optimal clinical outcomes;
      (iii) Developing treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;
      (iv) Monitoring individual and population health status and service use to determine adherence to or variance from best practice guidelines; and
      (v) Developing and disseminating reports that indicate progress toward meeting outcomes for member satisfaction, health status, service delivery and cost.
   (C) Qualified professionals. Comprehensive care management services are provided by a health care team with participation from the client, family and caregivers. The following team members are eligible to provide comprehensive care management:
      (i) Nurse Care Manager (RN or LPN within scope of practice);
(i) Certified Behavioral Health Case Manager;
(ii) Primary Care Practitioner;
(iii) Psychiatric consultant; and
(iv) Licensed Behavioral Health Professional (LBHP).

(2) Care coordination.
(A) Definition. Care coordination is the implementation of the Comprehensive Care Plan with active member involvement through appropriate linkages, referrals, coordination, and follow-up to needed services and supports.

(B) Service requirements. Care coordination services include the following, but are not limited to:

(i) Care coordination for primary health care, specialty health care, and transitional care from emergency departments, hospitals and Psychiatric Residential Treatment Facilities (PRTFs);
(ii) Ensuring integration and compatibility of mental health and physical health activities;
(iii) Providing ongoing service coordination and link members to resources;
(iv) Tracking completion of mental and physical health goals in member’s Comprehensive Care Plan;
(v) Coordinating with all team members to ensure all objectives of the Comprehensive Care Plan are progressing;
(vi) Appointment scheduling;
(vii) Conducting referrals and follow-up monitoring;
(viii) Participating in hospital discharge processes; and
(ix) Communicating with other providers and members/family.

(C) Qualified professionals. Team members are responsible to ensure implementation of the Comprehensive Care Plan, which includes mental health goals, physical health goals, and other life-domain goals for achievement of clinical outcomes. Care coordination services are provided by a primary care practitioner led team which includes the following professionals and paraprofessionals:

(i) Nurse Care Manager (RN or LPN);
(ii) Certified Behavioral Health Case Manager,
(iii) Health Home Director;
(iv) Family Support Provider;
(v) Peer/Youth Support Provider; and
(vi) Health Home Specialist/Hospital Liaison.

(3) Health promotion.
(A) Definition. Health promotion consists of providing health education specific to the member’s chronic condition.

(B) Service requirements. Health promotion will minimally consist of the following, but is not limited to:

(i) Providing health education specific to member’s condition;
(ii) Developing self-management plans with the member;
(iii) Providing support for improving social networks and providing health promoting lifestyle interventions including:
- Substance use prevention;
- Smoking prevention and cessation;
- Obesity reduction and prevention;
- Nutritional counseling; and
- Increasing physical activity.

(C) Qualified professionals. Health promotion services must be provided by the Primary Care Practitioner, Registered Nurse Care Manager (or LPN without full scope of practice) and the Wellness Coach or Health Home Specialist at the direction of the Health Home Director.

(4) Comprehensive transitional care.
(A) Definition. Care coordination services for comprehensive transitional care are designed to streamline plans of care, reduce hospital admissions and interrupt patterns of frequent hospital emergency department use.

(B) Service requirements. The duties of the qualified team members providing transitional care services include, but are not limited to the following:

(i) Developing contracts or Memorandums of Understanding (MOUs) with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of Health Home members;
(ii) Maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that may benefit from connection with a Health Home site; and
(iii) Motivate hospital staff to notify the Health Home staff of such opportunities.

(C) Qualified individuals. Comprehensive transitional care services can be provided by the following team members:

(i) Nurse Care Manager;
(ii) Certified behavioral health case manager; and
(iii) Family Support provider.

(5) Individual and family support services.
(A) Definition. Individual and family support services assist individuals in accessing services that will reduce barriers and improve health outcomes, with a primary focus on increasing health literacy, the ability of the member to self-manage their care, and facilitate participation in the ongoing revision of their Comprehensive Care Plan.

(B) Service requirements. Individual and family support services include, but are not limited to:

(i) Teaching individuals and families self-advocacy skills;
(ii) Providing peer support groups;
(iii) Modeling and teaching how to access community resources;
(iv) Assisting with obtaining and adhering to medications and other prescribed treatments; and
(v) Identifying resources to support the member in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services.

(C) Qualified individuals. Individual and family support service activities must be provided by one of the following:
(i) Wellness Coaches, Recovery support specialist, Children’s Health Home specialist; or
(ii) Care coordinators; or
(iii) Family Support Providers; or
(iv) Nurse-Care Manager.

(6) Referral to community and social support services.

(A) Definition. Provide members with referrals to community and social support services in the community.

(B) Service requirements. Providing assistance for members to obtain and maintain eligibility for the following services as applicable, including but not limited to:
(i) Healthcare;
(ii) Disability benefits;
(iii) Housing;
(iv) Transportation;
(v) Personal needs; and
(vi) Legal services.

(C) Limitations. For members with Developmental Disabilities, the Health Home will refer to and coordinate with the approved Developmental Disabilities case management entity for these services.

(D) Qualified individuals. Referral to community and social support services may be provided by a certified behavioral health case manager, Family Support Provider or a nurse-care manager.

317:30-5-253. Reimbursement [REVOKED]
(a) In order to be eligible for payment, HHs must have an approved Provider Agreement on file with OHCA. Through this agreement, the HH assures that OHCA’s requirements are met and assures compliance with all applicable Federal and State regulations. These agreements are renewed annually with each provider.
(b) A Health Home may bill up to three months for outreach and engagement to a member attributed to but not yet enrolled in a Health Home. The reimbursement for outreach and engagement is limited to once per month and is not reimbursable in the same month that the HH receives reimbursement for qualified HH services.
(c) The HH will be reimbursed a monthly care coordination payment upon successful submission of a claim for one or more of the covered services listed in 317:30-5-254.

317:30-5-254. Limitations [REVOKED]
(a) Children/families for whom case management services are available through OKDHS/OJA staff are not eligible for concurrent Health Home services.
(b) The following services will not be reimbursed separately for individuals enrolled in a Health Home:

1. Targeted case management;
2. Service Plan Development, low complexity;
3. Medication training and support;
4. Peer to Peer support (family support);
5. Medication management and support and coordination linkage when provided within a Program of Assertive Community Treatment (PACT);
6. Medication reminder;
7. Medication administration;
8. Outreach and engagement.

PART 113. LIVING CHOICE PROGRAM

317:30-5-1207. Benefits for members ages sixteen (16) through eighteen (18) in a psychiatric residential treatment facility

(a) Living Choice program participants, ages sixteen (16) through eighteen (18), may receive a range of necessary home and community based services for one (1) year after transitioning to the community from a psychiatric residential treatment facility (PRTF) setting. In order to be eligible for the Living Choice program, the member must:
1. Have been in a PRTF facility for ninety (90) or more days during an episode of care; and
2. Meet Level 3 criteria on the Individual Client Assessment Record; or
3. Meet the criteria for Serious Emotional Disturbance as defined in OAC 317:30-5-240.1; or
4. Show critical impairment on a caregiver rated Ohio Scales (score of 25 and above on the Problems Subscale or a score of 44 and below on the Functioning Subscale).

(b) Services must be billed using the appropriate Healthcare Common Procedure Code System and must be medically necessary.
(c) All services must be necessary for the individual to live successfully in the community, must be documented in the individual care plan and require prior authorization.
(d) Services that may be provided to members transitioning from a PRTF are found in OAC 347:30-5-25317:30-5-241.6(1)(B).
(e) Reimbursement will be for a monthly care coordination payment upon successful submission of a claim for one (1) or more of the covered services listed in OAC 317:30-5-252317:30-5-96.3(e)(2).

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CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

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Subchapter 5. Individual Providers and Specialties
Part 35. Rural Health Clinics
317:30-5-354 [AMENDED]
317:30-5-355 [AMENDED]
317:30-5-356 [AMENDED]
317:30-5-357 [AMENDED]
317:30-5-361 [AMENDED]
Part 75. Federally Qualified Health Centers
317:30-5-659 [NEW]
317:30-5-660 [AMENDED]
317:30-5-661.1 [AMENDED]
317:30-5-661.2 [REVOKED]
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317:30-5-661.7 [AMENDED]
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The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63
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Not applicable

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GIST/ANALYSIS:
The proposed revisions align rural health clinics (RHC) and federally
qualified health centers (FQHC) policy language with the Oklahoma Medicaid
State Plan, federal regulations and OHCA's current business practices. Other
revisions will involve limited rewriting aimed at clarifying policy language,
including basic laboratory services that may be reimbursed at a RHC; mid-level
professional staff requirements in RHCs; and claims' requirements to indicate
the setting in which a service was provided.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN,
THE FOLLOWING RULES ARE CONSIDERED
FINALLY ADOPTED AS SET FORTH IN 75 O.S.,
SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE
DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS
AND SPECIALTIES

PART 35. RURAL HEALTH CLINICS

317:30-5-354. Definitions
The following words and terms, when used in this Chapter,
shall have the following meaning, unless the context clearly
indicates otherwise:
"APRN" means advanced practice registered nurse.
"CLIA" means the Clinical Laboratory Improvement
Amendments.
"CMS" means the Centers for Medicare and Medicaid
Services.
"CNM" means certified nurse midwife.
"Core services" means outpatient services that may be
covered when furnished to a patient at the rural health clinic
(RHC) or other location, including the patient's place of resi-
dence.
"CP" means clinical psychologist.
"CPT" means current procedural terminology.
"CSW" means clinical social worker.
"EPSDT" means the Early and Periodic Screening, Diag-
nostic and Treatment program for members under twenty-one
(21).
"FFS" means the current OHCA's fee-for-service reim-
bursement rate.
"HCPCS" means Healthcare Common Procedure Coding
System.
"OAC" means the Oklahoma Administrative Code.
"OHCA" means the Oklahoma Health Care Authority.
"Other ambulatory services" means other outpatient
health services covered under the Oklahoma Medicaid State
Plan other than core services.
"PA" means physician assistant.
"Physician" means:
(A) A doctor of medicine or osteopathy legally au-
thorized to practice medicine and surgery by the State
in which the function is performed or who is a li-
censed physician employed by the Public Health Ser-
vice;
(B) Within limitations as to the specific services
furnished, a doctor of dentistry or dental, a doctor of
optometry, or a doctor of podiatry.
"Physicians' services" means professional services that
are performed by a physician at the RHC (or are performed
away from the Center, excluding inpatient hospital services)
whose agreement with the RHC provides that he or she will be
paid by the RHC for such services.
"PPS" means prospective payment system all-inclusive per visit rate method specified in the Oklahoma Medicaid State Plan.

"RHC" means rural health clinic.

"Visit" means a face-to-face encounter between a clinic patient and a physician, PA, APRN, CNM, CP or CSW whose services are reimbursed under the RHC payment method. Encounters with more than one (1) health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

317:30-5-355. Eligible providers and staffing requirements

Rural Health Clinics (RHCs) certified for participation in the Medicare Program are eligible for participation in the Medicaid Program. RHCs may be provider-based (i.e., clinics that are an integral part of a hospital, skilled nursing facility, or home health agency that participates in Medicare) or independent (freestanding), and may include Indian Health Clinics. To participate, a RHC must have a current contract on file with the Oklahoma Health Care Authority (OHCA).

(a) Eligible providers. RHCs certified for participation in the Medicare Program are eligible for participation in the Medicaid Program. RHC conditions for certification are found in 42 C.F.R. Part 491. RHCs may be provider-based (i.e., clinics that are an integral part of a hospital, skilled nursing facility, or home health agency that participates in Medicare) or independent (freestanding) and may include Indian Health Clinics. To participate, an RHC must have a current contract on file with the OHCA.

(b) Staffing requirements. Eligible providers must follow all staffing and staff responsibilities in accordance with 42 C.F.R. § 491.8. Additional requirements for mid-level practitioners at the clinic include:

(1) A nurse practitioner, a physician assistant, or certified nurse-midwife must be available to furnish patient care services at least fifty percent (50%) of the time the clinic operates.

(2) An existing clinic may request a temporary waiver of these staffing requirements for a one (1) year period, if it demonstrates that it has been unable to hire a physician assistant, nurse-practitioner, or a certified nurse-midwife in the previous ninety (90) day period.

(3) A subsequent request for a waiver cannot be made less than six (6) months after the expiration date of any previous waiver of the mid-level staffing requirements for the clinic.

317:30-5-355.1. Definition of services

RHC professional staff

The Rural Health Clinic (RHC) benefit package, as described in Title 42 of the Code of Federal Regulations (C.F.R.), § 440.20, consists of two (2) components: RHC services and other ambulatory services.

(1) RHC services. RHC services are covered when furnished to a member at the clinic or other location, including the member’s place of residence. These services are described in this Section.

(A) Core services. As set out in 42 C.F.R. § 440.20(b), RHC "core" services include, but are not limited to:

(i) Physician's services;

(ii) Services and supplies incident to a physician's services;

(iii) Services of advanced practice registered nurses (APRNs), physician assistants (PAs), certified nurse-midwives (CNMs), or specialized advanced practice nurse practitioners;

(iv) Services and supplies incident to the services of APRNs and PAs (including services furnished by CNMs);

(v) Visiting nurse services to the homebound;

(vi) Clinical psychologist (CP) and clinical social worker (CSW) services;

(vii) Services and supplies incident to the services of CPs and CSWs.

(B) Physicians' services. In addition to the professional services of a physician, and services provided by an APRN, PA, and CNM which would be covered as RHC services under Medicare, certain primary preventive services are covered under the Soonercare RHC benefit. The services must be furnished by or under the direct supervision of an RHC practitioner who is a clinic employee:

(i) Prenatal and postpartum care;

(ii) Screening examination under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program for members under twenty-one (21);

(iii) Family planning services;

(iv) Medically necessary screening mammography and follow-up mammograms.

(C) Services and supplies "incident to." Services and supplies incident to the service of a physician, PA, APRN, CP, or CSW are covered if the service or supply is:

(i) A-type commonly furnished in physicians' offices;

(ii) A-type commonly rendered without charge or included in the rural health clinic's bill;

(iii) Furnished as an incidental, although integral, part of a physician's professional services; or

(iv) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, sera and toxoids are not billed separately.

(D) Visiting nurse services. Visiting nurse services are covered if:
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(i) The RHC is located in an area in which the Centers for Medicare and Medicaid Services (CMS) has determined there is a shortage of home health agencies;
(ii) The services are rendered to members who are homebound;
(iii) The member is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and
(iv) The services are furnished under a written plan of treatment.

(E) RHC encounter. RHC "core" services (including preventive services, i.e., prenatal, EPSDT, or family planning) are part of an all-inclusive visit. A "visit" means a face-to-face encounter between a clinic patient and an RHC health professional (physicians, PA's, APRNs, CNMs, CPs, and CSWs). Encounters with more than one (1) health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Payment is made for one (1) encounter per member per day. Medical review will be required for additional visits for children. Payment is also limited to four (4) visits per member per month for adults.

(F) Off-site services. RHC services provided off-site of the clinic are covered as long as the RHC has a compensation arrangement with the RHC practitioner that SoonerCare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The RHC must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the RHC services provided off-site are to be billed to SoonerCare. It is expected that services provided in off-site settings are, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

(2) Other ambulatory services. An RHC must provide other items and services which are not "RHC services" as described in (1) of this Section, and are separately billable within the scope of the SoonerCare fee-for-service (FFS) contract. Coverage of services are based upon the scope of coverage under the SoonerCare program.

(A) Other ambulatory services include, but are not limited to:
(i) Dental services for members under the age of twenty-one (21);
(ii) Optometric services;
(iii) Clinical lab tests performed in the RHC lab, including the lab tests required for RHC certification;
(iv) Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC-physician is included in the encounter rate);
(v) Durable medical equipment;
(vi) Transportation — by — ambulance [refer to Oklahoma Administrative Code (OAC) 317:30.5335];
(vii) Prescribed drugs;
(viii) Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;
(ix) Specialized laboratory services furnished away from the clinic;
(x) Inpatient services;
(xi) Outpatient hospital services; and
(xii) Applied behavior analysis (ABA) [refer to OAC 317:30.3.65.12];
(xiii) Diabetes self-management training (DSMT) (refer to OAC 317:30.5.1080 B.1084).

(B) Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist or optometric services by a licensed optometrist for members under the age of twenty-one (21). Encounters are billed as one (1) of the following:

(i) EPSDT—dental screening. An EPSDT dental screening includes oral examination, prophylaxis and fluoride treatment, charting of needed treatment, and, if necessary, x-rays (including two bite-wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.

(ii) Dental—encounter. A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.

(iii) Visual analysis. Visual analysis (initial or yearly) for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Glasses must be billed separately. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(C) Services listed in (2)(A), (v)-(viii), of this Section, furnished on-site, require separate provider agreements with the Oklahoma Health Care Authority (OHCA). Service item (2)(A)(iv) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30.5.361 for conditions.)

(D) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the SoonerCare
program by the provider rendering the service. Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.

(a) RHCs must either directly employ or contract the services of professional staff who is licensed or certified and in good standing in the state in which services are provided. Services must be within the scope of the professional's license or certification for which claims are submitted to OHCA or its designated agent.

(b) Professional staff contracted or employed by the RHC recognized by the OHCA for direct reimbursement are required to individually enroll with the OHCA and will be affiliated with the organization which contracts or employs them. Participating RHCs are required to submit a list of names upon request of all practitioners working within the RHC and a list of all individual OHCA provider numbers. Reimbursement for services rendered at or on behalf of the RHC is made to the organization. Practitioners eligible for direct reimbursement for providing services to a clinic patient outside of the clinic may bill with their individual assigned number if they are not compensated under agreement by the RHC.

(c) Other providers who are not eligible for direct reimbursement may be recognized by the OHCA for the provision and payment of RHC services to an RHC as long as they are licensed or certified in good standing and meet OHCA enrollment requirements.

317:30-5-355.2. Covered services

The RHC benefit package, as described in 42 C.F.R. § 440.20, consists of RHC services and other ambulatory services.

(1) RHC services. RHC services are covered when medically necessary and furnished at the clinic or other outpatient setting, including the member's place of residence.

(A) Core services. RHC "core" services include, but are not limited to:

(i) Services furnished by a physician, PA, APRN, CNM, CP, or CSW;

(ii) Services and supplies incident to services provided by a physician, PA, APRN, CNM, CP, or CSW are covered in accordance with 42 C.F.R. §§ 405.2413 and 405.2415, if the service or supply is:

(I) Furnished in accordance with State law;

(II) A type commonly furnished in physicians’ offices;

(III) A type commonly rendered either without charge or included in the RHC’s bill;

(IV) Furnished as an incidental, although integral, part of a physician’s professional services, PA, APRN, CNM, CP or CSW; or

(V) Furnished under the direct supervision of a contracted physician PA, APRN, or CNM; and

(VI) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antihistamines, and narcotics and sedatives are not billed separately.

(iii) Visiting nurse services to the homebound are covered if:

(I) The RHC is located in an area in which the Secretary of Health and Human Services has determined there is a shortage of home health agencies;

(II) The services are rendered to members who are homebound;

(iii) The member is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and

(IV) The services are furnished under a written plan of treatment as required by 42 C.F.R. § 405.2416.

(iv) Certain virtual communication services.

(B) Preventive services. In addition to the professional services of a physician, and services provided by an APRN, PA, and CNM which would be covered as RHC services under Medicare, certain primary preventive services are covered under the Soonercare RHC benefit. The services must be furnished by or under the direct supervision of an RHC practitioner who is a clinic employee:

(i) Prenatal and postpartum care;

(ii) Screening examination under the EPSDT program for members under twenty-one (21);

(iii) Family planning services; and

(iv) Medically necessary screening mammography and follow-up mammograms.

(C) Off-site services. RHC services provided off-site of the clinic are covered if the RHC has a compensation arrangement with the RHC practitioner. Soonercare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The RHC must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the RHC services provided off-site are to be billed to Soonercare. It is expected that services provided in off-site settings are, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

(2) Other ambulatory services. Other ambulatory services that may be provided by an RHC include non-primary care services covered by the Oklahoma Medicaid State Plan but are not included in the RHC's core services. These services are separately billable and may be provided by the RHC if the RHC meets the same standards as other contracted providers of those services.
(A) Other ambulatory services include, but are not limited to:
   (i) Dental services for members under the age of twenty-one (21) provided by other than a licensed dentist;
   (ii) Optometric services provided by other than a licensed optometrist;
   (iii) Laboratory tests performed in the RHC lab, including the lab tests required for RHC certification;
   (iv) Chemical examinations of urine by stick or tablet method or both (including urine ketones);
   (v) Hemoglobin or hematocrit;
   (vi) Blood glucose;
   (vii) Examination of stool specimens for occult blood;
   (viii) Pregnancy tests; and
   (v) Primary culturing for transmittal to a certified laboratory.
   (v) Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);
   (vi) Durable medical equipment;
   (vii) Transportation by ambulance;
   (viii) Prescribed drugs;
   (ix) Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;
   (x) Specialized laboratory services furnished away from the clinic;
   (xi) Inpatient services; and
   (xii) Outpatient hospital services and
   (xiii) Applied behavior analysis (ABA); and
   (xiv) Diabetes self-management education and support (DSMES) services.

(B) Services listed in (2)(A) of this Section, furnished on-site, require a separate provider agreement(s) with the OHCA. Service item (2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

317:30-5-356. Coverage for adults

Payment is made to rural health clinics (RHCs) for adult services as set forth in this Section.

(1) RHC services. Payment is made for one (1) encounter per member per day. Payment is also limited to four (4) visits per member per month. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-65.2 for exceptions to the four visit limit for children under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). Additional Preventive service exceptions include:

(A) Obstetrical care. A Rural Health Clinic (RHC) should have a written contract with its physician, certified nurse-midwife, advanced practice nurse, or physician assistant PA, APRN, or CNM that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician’s compensation for rural health and non-rural health clinic (other ambulatory) services, RHC and other ambulatory services.
   (i) If the clinic compensates the physician, certified nurse-midwife or advanced practice nurse PA, APRN, or CNM to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.
   (ii) If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, certified nurse-midwives, physician assistants, and advanced practice nurses PAs, APRNs and CNMs (refer to OAC 317:30-5-22).
   (iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

(B) Family planning services. Family planning services are available only to members with reproductive capability. Family planning visits do not count as one (1) of the four (4) RHC visits per month.

(2) Other ambulatory services. Services defined as "other ambulatory" services are not considered a part of an RHC visit and are therefore billable to the SoonerCare program by the RHC or provider of service on the appropriate claim form. These services are not considered a part of an RHC visit; therefore, these may be billed to the SoonerCare program by the RHC or service provider on the appropriate claim form. Other ambulatory services are subject to the same scope of coverage as other SoonerCare services billed to the program, i.e., limited adult services and some services for under 21 subject to same prior authorization process. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows:

   (A) Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors. There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)
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317:30-5-357. Coverage for children

Coverage for rural health clinic (RHC) services and other ambulatory services for children include the same services as for adults, in addition to the following: RHC services and other ambulatory services for children include the same services as for adults. Medical review will be required for additional visits for children. Additional services for children include:

1. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are covered for eligible members under twenty-one (21) years of age in accordance with Oklahoma Administrative Code (OAC) OAC 317:30-3-65. An EPSDT exam performed by an RHC must be billed on the appropriate claim form with the appropriate preventive medicine procedure code from the Current Procedural Terminology (CPT) manual. If an EPSDT screening is billed, an RHC encounter should not be billed on the same day. Refer to OAC 317:30-3-65 through 317:30-3-65.12.

2. Under EPSDT, coverage is allowed for visual screenings and eyeglasses to correct visual defects. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

3. An EPSDT screening is considered a comprehensive examination. A provider billing the Medicaid program for an EPSDT screening may not bill any other visits for that patient on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. Additional services such as tests, immunizations, etc., required at the time of screening may be billed independently from the screening.

4. The administration fee for immunizations should be billed if provided at the same time as a scheduled EPSDT examination.

5. Payment may be made directly to the RHC for the professional services of physician assistants performing EPSDT screenings within the certified RHC. The claim form must include the signature of the supervising physician.

317:30-5-361. Billing

(a) Encounters. Payment is made for one encounter per member per day. Medical review will be required for additional visits for children. Payment is also limited to four visits per member per month for adults. Rural health clinics must bill the combined fees of all "core" services provided during an encounter on the appropriate claim form. Claims must include reasonable and customary charges.

1. RHC. The appropriate revenue code is required. No HCPCS or CPT code is required.

2. Mental health. Mental health services must include a revenue code and a HCPCS code.

3. Obstetrical care. The appropriate revenue code and HCPCS code are required. The date the member is first seen is required. The primary pregnancy diagnosis code is also required. Secondary diagnosis codes are used to describe complications of pregnancy. Delivery must be billed by the independent practitioner who has a contract with the OHCA.

4. Family planning. Family planning encounters require a revenue code, HCPCS code, and a family planning diagnosis.

5. EPSDT screening. EPSDT screenings must be billed by the attending provider using the appropriate Preventative Medicine procedure code from the Current Procedural Terminology Manual (CPT).

(b) Services billed separately from encounters. Other ambulatory services and preventive services itemized separately from encounters must be billed using the appropriate revenue, HCPCS and/or CPT codes. Claims must include reasonable and customary charges.

1. Laboratory. The rural health clinic must be CLIA certified for specialized laboratory services performed. Laboratory services must be itemized separately using the appropriate CPT or HCPCS code.

2. Radiology. Radiology must be identified using the appropriate CPT or HCPCS code with the technical component modifier. Radiology services are paid at the technical component rate. The professional component is included in the encounter rate.

3. Immunizations. The administration fee for immunizations provided on the same day as the EPSDT exam is billed separately.

4. Contraceptives. Contraceptives are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPCS codes are required. The following are examples:

   A. DepoProvera 150 mg. (Medroxyprogesterone Acetate).
   B. Insertion and implantation of a subdermal contraceptive device.
   C. Removal, implantable contraceptive devices.
   D. Removal, with reinsertion, implantable contraceptive device.
   E. Insertion of intrauterine device (IUD).
   F. Removal of intrauterine device.
   G. ParaGard IUD.
   H. Progestasert IUD.

5. Eyeglasses. Eyeglasses prescribed by a licensed optometrist are billed using the appropriate revenue code and HCPCS code. Payment is limited to two eyeglasses per year. Any eyeglasses beyond this limit must be prior authorized and determined to be medically necessary.

(a) Encounters. Payment is made for one (1) encounter per member per day. Encounters with more than one (1) health
professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Medical review will be required for additional visits for children. Payment is also limited to four (4) visits per member per month for adults. RHCs must bill the combined fees of all "core" services provided during an encounter on the appropriate claim form. Claims must include reasonable and customary charges.

(1) **RHC.** The appropriate revenue code is required. No HCPCS or CPT code is required.
(2) **Mental health.** Mental health services must include a revenue code and a HCPCS code.
(3) **Obstetrical care.** The appropriate revenue code and HCPCS code are required. The date the member is first seen is required. The primary pregnancy diagnosis code is also required. Secondary diagnosis codes are used to describe complications of pregnancy. Delivery must be billed by the independent practitioner who has a contract with the OHCA.
(4) **Family planning.** Family planning encounters require a revenue code, HCPCS code, and a family planning diagnosis.
(5) **EPSDT screening.** EPSDT screenings must be billed by the attending provider using the appropriate Preventative Medicine procedure code from the CPT Manual. Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist for members under the age of twenty-one (21).
(6) **Dental.** Dental services for children must be billed on the appropriate dental claim form.

(A) **EPSDT dental screening.** An EPSDT dental screening includes oral examination, prophylaxis and fluoride treatment, charting of needed treatment, and, if necessary, x-rays (including two bite wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.
(B) **Dental encounter.** A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.
(7) **Visual analysis.** Visual analysis services for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Visual analysis services are billed using the appropriate revenue code and a HCPCS code. Payment is made directly to the RHC on an encounter basis for on-site optometric services by a licensed optometrist for members under the age of twenty-one (21).

(b) **Services billed separately from encounters.**

(1) Other ambulatory services and preventive services itemized separately from encounters must be billed using the appropriate revenue, HCPC and/or CPT codes. Claims must include reasonable and customary charges from the physical location where services were rendered/ performed.

(A) **Laboratory.** The RHC must be CLIA certified for specialized laboratory services performed. Laboratory services must be itemized separately using the appropriate CPT or HCPCS code.
(B) **Radiology.** Radiology must be identified using the appropriate CPT or HCPCS code with the technical component modifier. Radiology services are paid at the technical component rate. The professional component is included in the encounter rate.
(C) **Immunizations.** The administration fee for immunizations provided on the same day as the EPSDT exam is billed separately.
(D) **Contraceptives.** Contraceptives are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPCS codes are required.
(E) **Eyeglasses.** Eyeglasses prescribed by a licensed optometrist are billed using the appropriate revenue code and HCPCS code. Payment is limited to two eyeglasses per year. Any eyeglasses beyond this limit must be prior authorized and determined to be medically necessary.

(2) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the SoonerCare program by the provider rendering the service. Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.

**PART 75. FEDERALLY QUALIFIED HEALTH CENTERS**

317:30-5-659. **Definitions**

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

"APRN" means advanced practice registered nurse.
"C.F.R" means the U.S. Code of Federal Regulations.
"CLIA" means the Clinical Laboratory Improvement Amendments.
"CMS" means the Centers for Medicare and Medicaid Services.
"CNM" means certified nurse midwife.
"Core services" means outpatient services that may be covered when furnished to a patient at the Center or other location, including the patient's place of residence.
"CPT" means current procedural terminology.
"CSW" means clinical social worker.
"Encounter" or "visit" means a face-to-face contact between an approved health care professional as authorized in the FOHC pages of the Oklahoma Medicaid State Plan and an eligible SoonerCare member for the provision of defined services through a Health Center within a twenty-four (24) hour period ending at midnight, as documented in the patient's medical record.
Permanent Final Adoptions

"FFS" means the current OHCA's fee-for-service reimbursement rate.

"FQHC" means Federally Qualified Health Center.

"HHS" means the U.S. Department of Health and Human Services.

"HRSA" means the Health Resources and Services Administration.

"Licensed behavioral health professional (LBHP)" means any of the following practitioners:

(A) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(B) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the areas of practice listed in (i) through (vi).

(i) Psychology;

(ii) Social work (clinical specialty only);

(iii) Professional counselor;

(iv) Marriage and family therapist;

(v) Behavioral practitioner; or

(vi) Alcohol and drug counselor.

(C) An advanced practice registered nurse certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.

(D) A physician assistant who is licensed and in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

"OAC" means the Oklahoma Administrative Code.

"OHCA" means the Oklahoma Health Care Authority.

"Other ambulatory services" means other health services covered under the Oklahoma Medicaid State Plan other than core services.

"PA" means physician assistant.

"Physician" means:

(A) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;

(B) Within limitations as to the specific services furnished, a doctor of dentistry or dental, a doctor of optometry, or a doctor of podiatry.

"Physicians' services" means professional services that are performed by a physician at the Health Center (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the Center provides that he or she will be paid by the Health Center for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the Oklahoma Medicaid State Plan.

317:30-5-660. Eligible providers

(a) Federally Qualified Health Centers (FQHC) are entities or programs more commonly known as Community Health Centers, Migrant Health Centers, and Health Care for the Homeless Programs. The facilities in this Part are hereafter referred to as "Health Centers" or "Centers".

(b) For purposes of providing covered services under SoonerCare, Health Centers may qualify by one of the following methods:

(1) The entity receives a grant under Section 330 of the Public Health Service (PHS) Act (Public Law 104-229), receives funding from such grants under a contract with the recipient of such a grant and includes an outpatient health program or entity operated by a tribe or tribal organization under the Indian Self Determination Act (Public Law 93-638);

(2) The Health Resources and Services Administration (HRSA) within the PHS recommends, and the Centers for Medicare and Medicaid Services (CMS) determines that the entity meets the requirements for receiving such a grant and is designated a FQHC look-alike; or

(3) The Secretary of Health and Human Services (Secretary) determines that an entity may, for good cause, qualify through waiver of requirements. Such a waiver cannot exceed a period of two years.

(c) Any entity seeking to qualify as a FQHC should contact the U.S. Public Health Service.

(a) FQHCs are community-based health care providers that receive federal funds to provide primary care services in underserved areas. FQHCs may be Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Centers for Residents of Public Housing. The facilities in this Part may also be referred to as "Health Centers" or "Centers".

(b) To qualify as an FQHC SoonerCare provider, Health Centers must meet one (1) of the following requirements:

(1) Received a grant under Section 330 of the Public Health Service (PHS) Act or is funded by the same grant contract to the recipient;

(2) Based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, which qualifies the entity as an "FQHC look-alike";

(3) Treated by the Secretary of HHS as a comprehensive federally funded health center; or

(4) Operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self-Determination Act or as an urban Indian organization getting funds under Title V of the Indian Health Care Improvement Act.

(c) Any entity seeking to qualify as a FQHC should contact the U.S. Public Health Service.

317:30-5-660.1. Health Center multiple sites contracting

(a) Health Centers may contract as SoonerCare Traditional providers and as a PCP/CM under SoonerCare Choice (Refer to OAC 317:25-7-5).
317:30-5-660.2. Health Center professional staff

(a) Health Centers must either directly employ or contract the services of legally credentialed professional staff that are authorized within their scope of practice under state law to provide the services for which claims are submitted to OHCA or its designated agent. Health Centers must either directly employ or contract the services of professional staff who is licensed or certified and in good standing in the state in which services are provided. Services must be within the scope of the professional's license or certification for which claims are submitted to OHCA or its designated agent.

(b) Professional staff contracted or employed by the Health Center recognized by the OHCA for direct reimbursement are required to individually enroll with the OHCA and will be affiliated with the organization which contracts or employs them. Participating Health Centers are required to submit a list of names upon request of all practitioners working within the Center and a list of all individual OHCA provider numbers. Reimbursement for services rendered at or on behalf of the Health Center is made to the organization. Practitioners eligible for direct reimbursement for providing services to a clinic patient outside of the clinic may bill with their individual assigned number if they are not compensated under agreement by the Health Center.

(c) Other providers who are not eligible for direct reimbursement may be recognized by OHCA for the provision and payment of FQHC services to a health center as long as they are legally credentialed under state law and OHCA enrollment requirements licensed or certified in good standing and meet OHCA enrollment requirements.

317:30-5-660.5. Health Center service definitions

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

"Core Services" means outpatient services that may be covered when furnished to a patient at the Center or other location, including the patient's place of residence.

"Encounter or Visit" means a face-to-face contact between an approved health care professional as authorized in the FQHC state plan and an eligible SoonerCare member for the provision of defined services through a Health Center within a 24-hour period ending at midnight, as documented in the patient's medical record.

"Licensed Behavioral Health Professional (LBHP)" means licensed psychologists, licensed clinical social workers (LCSWs), licensed marital and family therapists (LMFTs), licensed professional counselors (LPCs), licensed behavioral practitioners (LBPs), and licensed alcohol and drug counselors (LADCs).

"Other ambulatory services" means other health services covered under the State plan other than core services.

"Physician" means:

(A) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service; or

(B) within limitations as to the specific services furnished, a doctor of dentistry or dental or oral surgery, a doctor of optometry, or a doctor of podiatry.

"Physicians’ services" means professional services that are performed by a physician at the Health Center (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the Center provides that he or she will be paid by the Health Center for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the State plan.

317:30-5-661. Coverage by category [REVOKED]

Health Center services are covered for SoonerCare adults and children as set forth in this Part, unless otherwise specified.

317:30-5-661.1. Health Center core services Coverage of core services

Health Center "core" services include:

(1) Physicians’ services and supplies incidental to a physician’s services;

(2) Services of advanced practice nurse (APNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;

(3) Services and supplies incidental to the services of APNs, certified nurse midwives, and PAs;

(4) Visiting nurse services to the homebound;

(5) Behavior health professional services as authorized under the FQHC State Plan pages and services and supplies incidental thereto;

(6) Preventive primary care services;

(7) Preventive primary dental services-Health Center services are covered for SoonerCare adults and children as set forth in this Part, unless otherwise specified.

(1) Services furnished by a physician, PA, APRN, CNM, CP, or CSW.

(2) Services and supplies incidental to services provided by a physician, PA, APRN, CNM, CP, or CSW are covered in accordance with 42 C.F.R §§405.2413 and 405.2415, if the service or supply is:
317:30-5-661. Services and supplies "incident to"

Health Center encounters [REVOKED]

(a) Services and supplies incident to the service of covered health center providers may be covered if the service or supply is:

(1) a type commonly furnished in physician offices;
(2) furnished under the direct supervision of a physician, PA, APRN, CNM, CP or CSW services; or
(3) furnished as an incidental, although integral, part of professional services furnished by a physician, advanced practice nurse, physician assistant, certified nurse midwife, or specialized advanced practice nurse;

(b) "Services and supplies incident to" include services such as minor surgery, reading x-rays, setting casts or simple fractures and other activities that involve evaluation or treatment of a patient's condition. They also include laboratory services performed by the Health Center, specimen collection for laboratory services furnished by an off-site CLIA certified laboratory and injectable drugs.

317:30-5-661.3. Visiting Nurse services [REVOKED]

Visiting Nurse services may be covered if the Health Center is located in an area in which the Secretary of Health and Human Services has determined that there is a shortage of home health agencies.

317:30-5-661.5. Health Center preventive primary care services

(a) Preventive primary care services, as described in 42 C.F.R § 405.2448, are those health services that:

(1) are furnished by or under the direct supervision of an APN, PA, CNMW, specialized advanced practice nurse practitioner, licensed psychologist, LCSW, a physician, PA, APRN, CNM, CP, CSW or other approved health care professional as authorized in the approved FQHC state plan;

(b) Preventive primary care services which may be paid for when provided by Health Centers include:

(1) medical social services;
(2) nutritional assessment and referral;
(3) preventive health education;
(4) children's eye and ear examinations;
(5) prenatal and post-partum care;
(6) perinatal services;
(7) well-child care, including periodic screening (refer to OAC 317:30-3-65);
(8) immunizations, including tetanus-diphtheria booster and influenza vaccine;
(9) voluntary family planning services;
(10) taking patient history;
(11) blood pressure measurement;
(12) weight;
(13) physical examination targeted to risk;
(14) visual acuity screening;
(15) hearing screening;
(16) cholesterol screening;
(17) stool testing for occult blood;
(18) dipstick urinalysis;
(19) assessment and initial counseling regarding risks;
(20) tuberculosis testing for high risk patients;
(21) clinical breast exam;
(22) referral for mammography; and
(23) thyroid function test; and
(24) dental services (specified procedure codes).

(c) Primary care services do not include:
(1) health education classes, or group education activities, including media productions and publications, group or mass information programs;
(2) eyeglasses, hearing aids or preventive dental services (except under EPSDT);
(3) screening mammography provided at a Health Center unless the Center meets the requirements as specified in OAC 317:30-5-900; and
(4) vaccines covered by the Vaccines for Children program (refer to OAC 317:30-5-14).

317:30-5-661.6. Health Center preventive and primary care exclusions [REVOKED]
Preventive primary care Health Center services do not include:
(1) health education classes, or group education activities, including media productions and publications, group or mass information programs;
(2) eyeglasses, hearing aids (except under EPSDT);
(3) screening mammography provided at a Health Center unless the Center meets the requirements as specified in OAC 317:30-5-900; and
(4) vaccines covered by the Vaccines for Children program (refer to OAC 317:30-5-14).

317:30-5-664.1. Provision of other health services outside of the Health Center core services
(a) If the Center chooses to provide other Oklahoma Medicaid State Plan covered health services which are not included in the Health Center core service definition in Oklahoma Administrative Code (OAC)OAC 317:30-5-661.1, the practitioners of those services are subject to the same program coverage limitations, enrollment, and billing procedures described by the Oklahoma Health Care Authority (OHCA). OHCA and these services (e.g., home health services) are not included in the PPS settlement methodology in OAC 317:30-5-664.12.
(b) Other medically necessary health services that will be reimbursed at the fee for service (FFS) rate include, but are not limited to:
(1) Dental services (refer to OAC 317:30-5-696) except for primary preventive dental services;
(2) Eyeglasses (refer to OAC 317:30-5-431, 317:30-5-432.1 and 317:30-5-451);
(3) Clinical lab tests performed in the Center lab (other than the specific laboratory tests set out for Health Centers' certification and covered as Health Center services);
(4) Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the Center physician is included as physician professional services);
(5) Durable medical equipment (refer to OAC 317:30-5-210);
(6) Transportation by ambulance (refer to OAC 317:30-5-335);
(7) Prescribed drugs (refer to OAC 317:30-5-70);
(8) Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;
(9) Specialized laboratory services furnished away from the clinic;
(10) Psychosocial rehabilitation services (refer to OAC 317:30-5-241.3);
(11) Behavioral health related case management services (refer to OAC 317:30-5-241.6); and
(12) Applied behavior analysis (ABA) (refer to OAC 317:30-3-65.12).
(13) Diabetes self-management training (DSMT) education and support (DSMES) services (refer to OAC 317:30-5-1080 through 317:30-5-1084).

317:30-5-664.3. Federally Qualified Health Center (FQHC) encounters
(a) FQHC encounters that are billed to the Oklahoma Health Care Authority (OHCA) must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by the authorized health care professional in the approved FQHC state plan pages within the scope of their licensure trigger a prospective payment system (PPS) encounter rate.
(b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a FQHC within a 24-hour twenty-four (24) hour period ending at midnight, as documented in the member's medical record.
(c) An FQHC may bill for one_ (1) medically necessary encounter per twenty-four (24) hour period when the appropriate modifier is applied. Medical review will be required for additional visits for children. For information about multiple encounters, refer to the approved FQHC state plan pages.
(d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:
(1) medical;
(2) diagnostic;
(3) dental, medical and behavioral health screenings;
(4) vision;
(5) physical therapy;
(6) Occupational Therapy;
(7) Podiatry;
(8) Behavioral Health;
(9) Speech;
(10) Hearing;
(11) Medically necessary FQHC encounters with a registered nurse or licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC 317:30-5-661.3); and
(12) Any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the FQHC's scope of services when medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements.

(e) Services and supplies incident to a physician's professional service are reimbursable within the encounter if the service or supply is:
   (1) of a type commonly furnished in physicians' offices;
   (2) of a type commonly rendered either without a charge or included in the health clinic's bill;
   (3) furnished as an incidental, although integral, part of a physician's professional services;
   (4) furnished under the direct, personal supervision of a physician; and
   (5) in the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic. Services and supplies incident to the services of a physician, PA, APRN, CNM, CP and CSW are reimbursable within the encounter, as described in 42 C.F.R § 405.2413 and OAC 317:30-5-661.1.

(f) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit.

317:30-5-664.7. Dental services provided by Health Centers

(a) Adults. The Health Center core service benefit to adults is intended to provide services requiring immediate treatment, relief of pain and/or extraction and is not intended to restore teeth as described in OAC 317:30-5-696. For scope of services for individuals eligible under other program categories refer to OAC 317:30-5-696. Core services are limited to treatment for conditions such as:
   (1) Acute infection;
   (2) Acute abscesses;
   (3) Severe tooth pain; and
   (4) Tooth re-implantation, when clinically appropriate.

(b) Children. Medically necessary dental services for children under twenty-one (21) are covered.

(c) Exclusions and Limitations. Other medically necessary dental services which are not considered core services may be billed by the Health Center utilizing the current SoonerCare fee schedule including but not limited to smoking and tobacco use cessation.

(1) Smoking and tobacco use cessation is a covered service for adults and children and is separately reimbursable. Refer to OAC 317:30-5-2.
(2) Refer to OAC 317:30-5-695 for other specific coverage, exclusions and prior authorization requirements.

(d) Claims. Health Centers must submit all claims for SoonerCare reimbursement for dental services on the American Dental Association (ADA) form.

(e) Other provisions. For additional coverage, medical necessity criteria, exclusions, billing, and prior authorization requirements, refer to OAC 317:30-5-695 through 317:30-5-705.

[OAR Docket #21-398; filed 6-14-21]

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

[OAR Docket #21-394]

RULEMAKING ACTION: PERMANENT final adoption

RULES:
Subchapter 5. Individual Providers and Specialties
Part 79. Dentists
317:30-5-696 [AMENDED]
317:30-5-698 [AMENDED]

(Reference APA WF # 20-34)

AUTHORITY: The Oklahoma Health Care Authority Act, Section 5007(C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY: December 22, 2020

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EFFECTIVE: September 1, 2021

SUPERSEDED EMERGENCY ACTIONS: n/a

INCORPORATIONS BY REFERENCE: n/a

GIST/ANALYSIS: The proposed revisions add “scaling in the presence of a generalized moderate or severe gingival inflammation” as a new procedure to dental policy. Additional revisions will specify that a caries risk assessment form must be documented when submitting a prior authorization for crowns. Further revisions will explain that written consent from a parent or court appointed legal guardian must be provided for any services that are rendered to a minor child. Finally, revisions will clarify billing language for administering nitrous oxide and involve cleanup of formatting and grammatical errors.

CONTACT PERSON: Sandra Pueba, Director of Federal and State Authorities, 405-522-7270, Sandra.Pueba@okhca.org.
PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 79. DENTISTS

317:30-5-696. Coverage by category
Payment is made for dental services as set forth in this Section.

(1) Adults.
(A) Dental coverage for adults is limited to:
(i) Medically necessary extractions, as defined in Oklahoma Administrative Code (OAC) 317:30-5-695. Tooth extraction must have medical need documented;
(ii) Limited oral examinations and medically necessary images, as defined in OAC 317:30-5-695, associated with the extraction or with a clinical presentation with reasonable expectation that an extraction will be needed;
(iii) Smoking and tobacco use cessation counseling; and
(iv) Medical and surgical services performed by a dentist or physician to the extent such services may be performed under State law when those services would be covered if performed by a physician.

(B) Payment is made for dental care for adults residing in private intermediate care facilities for individuals with intellectual disabilities (ICF/IID) and who have been approved for ICF/IID level of care, similar to the scope of services available to individuals under age twenty-one (21).

(C) Limited dental services are available for members who meet all medical criteria, but need dental clearance to obtain organ transplant approval. Providers must obtain prior authorization before delivery of dental service, with the exception of evaluation and extractions. All requests must be filed on the currently approved American Dental Association (ADA) form and must include diagnostic images, six-point periodontal charting, narratives and comprehensive treatment plans. The Oklahoma Health Care Authority (OHCA) will notify the provider of determination using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization request. The following dental services are available:

(i) Comprehensive oral evaluation;
(ii) Two (2) bitewing images;

(iii) Prophylaxis;
(iv) Fluoride application;
(v) Limited restorative procedures; and
(vi) Periodontal scaling/root planing.

(2) Home and community-based services (HCBS) waiver for the intellectually disabled. All providers participating in the HCBS must have a separate contract with the OHCA to provide services under the HCBS. Dental services are defined in each waiver and must be prior authorized.

(3) Children. The OHCA Dental Program provides the basic medically necessary treatment. For services rendered to a minor, the minor's parent or legal guardian must provide a signed, written consent prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. The services listed below are compensable for members under twenty-one (21) years of age without prior authorization. All other dental services must be prior authorized. Anesthesia services are covered for children in the same manner as adults. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.

(A) Comprehensive oral evaluation. This procedure should precede any images, and chart documentation must include image interpretations, carries risk assessment, six-point periodontal charting (as applicable), and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(B) Periodic oral evaluation. This procedure may be provided for a member of record once every six (6) months. An examination should precede any images, and chart documentation must include image interpretations, carries risk assessment, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(C) Limited oral evaluation. This procedure is only compensable to the same dentist or practice for two (2) visits prior to a comprehensive or periodic evaluation examination being completed.

(D) Images. To be SoonerCare compensable, images must be of diagnostic quality and medically necessary. A clinical examination must precede any images, and chart documentation must include member history, prior images, carries risk assessment, the six-point periodontal charting (as applicable), and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified images of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Periapical images must include at least three (3) millimeters beyond the apex of the tooth being imaged. Panoramic films and two (2) bitewings are considered full mouth
images. Full mouth images as noted above or traditional [minimum of twelve (12) periapical films and two (2) posterior bitewings] are allowable once in a three (3) year period and must be of diagnostic quality. Individually listed intraoral images by the same dentist/dental office are considered a complete series if the number of individual images equals or exceeds the traditional number for a complete series. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of exposure is not to rule out or evaluate caries. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three (3) years of the original set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the interproximal and occlusal surfaces to be eligible for this service. This service is available through eighteen (18) years of age and is compensable once every thirty-six (36) months if medical necessity is documented.

(F) **Interim caries arresting medicament application.** This service is available for primary and permanent teeth once every one hundred eighty-four (184) days for two (2) occurrences per tooth in a lifetime. The following criteria must be met for reimbursement:

(i) A member is documented to be unable to receive restorative services in the typical office environment within a reasonable amount of time;
(ii) A tooth that has been treated should not have any non-carious structure removed;
(iii) A tooth that has been treated should not receive any other definitive restorative care for three (3) months following an application;
(iv) Reimbursement for extraction of a tooth that has been treated will not be allowed for three (3) months following an application; and
(v) The specific teeth treated and number and location of lesions must be documented.

(G) **Dental prophylaxis.** This procedure is provided once every one hundred eighty-four (184) days along with topical application of fluoride.

(H) **Stainless steel crowns for primary teeth.** The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are allowed if:
   (I) The child is five (5) years of age or under;
   (II) Seventy percent (70%) or more of the root structure remains; or
   (III) The procedure is provided more than twelve (12) months prior to normal exfoliation.

(ii) Stainless steel crowns are treatment of choice for:
   (I) Primary teeth treated with pulpal therapy, if the above conditions exist;
   (II) Primary teeth where three (3) surfaces of extensive decay exist; or
   (III) Primary teeth where cuspal occlusion is lost due to decay or accident.

(iii) Preoperative periapical images and/or written documentation explaining the extent of decay must be available for review, if requested.
(iv) Placement of a stainless steel crown is allowed once for a minimum period of twenty-four (24) months. No other restoration on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(I) **Stainless steel crowns for permanent teeth.** The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are the treatment of choice for:
   (I) Posterior permanent teeth that have completed endodontic therapy if three (3) or more surfaces of tooth is destroyed;
   (II) Posterior permanent teeth that have three (3) or more surfaces of extensive decay; or
   (III) Where cuspal occlusion is lost due to decay prior to age sixteen (16) years.

(ii) Preoperative periapical images and/or written documentation explaining the extent of decay must be available for review, if requested.
(iii) Placement of a stainless steel crown excludes placement of any other type of crown for a period of twenty-four (24) months. No other restoration on that tooth is compensable during that period of time.

(J) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies and pulpal debridement are allowable once per lifetime. Pre- and post-operative periapical images must be available for review, if requested. Therapeutic pulpotomies and pulpal debridement is available for the following:

   (I) Primary molars having at least seventy percent (70%) or more of their root structure remaining or more than twelve (12) months prior to normal exfoliation;
   (II) Tooth numbers O and P before age five (5) years;
   (III) Tooth numbers E and F before six (6) years;
   (IV) Tooth numbers N and Q before five (5) years;
   (V) Tooth numbers D and G before five (5) years.

(ii) Therapeutic pulpotomies and pulpal debridement are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one (1) year or if seventy percent (70%) or more of root structure is remaining.
(K) **Endodontics.** Payment is made for the services provided in accordance with the following:

(i) This procedure is allowed when there are no other missing anterior teeth in the same arch requiring replacement.

(ii) The provider documents history of member’s improved oral hygiene and flossing ability in records.

(iii) Prior authorization is required for members who have a treatment plan requiring more than two (2) anterior and/or any posterior root canals.

(iv) Pre and post-operative periapical images must be available for review.

(v) Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA.

(vi) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for twenty-four (24) month post completion.

(vii) Endodontically treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.

(L) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six (6) months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

(I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than five (5) millimeters below the crest of the alveolar ridge.

(II) First primary molars are not allowed space maintenance if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal relationship.

(III) If there are missing posterior teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.

(IV) The teeth numbers shown on the claim should be those of the missing teeth.

(V) Post-operative bitewing images must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four (4) mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

(ii) **Lingu al arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used when permanent incisors are erupted and the second primary molar (K or T) is missing in the same arch.

(II) The requirements are the same as for band and loop space maintainer.

(III) Pre and post-operative images must be available.

(M) **Analgies.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four (4) occurrences per year and is not separately reimbursable, if provided on the same date by the same provider as IV sedation, non-intravenous conscious sedation, or general anesthesia. The medical need for this service must be documented in the member’s record.

(ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date by the same provider as analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation, or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members, uncontrollable members or justifiable medical or dental conditions. The report must detail the member’s condition. No services are reimbursable when provided primarily for the convenience of the member and/or the dentist, it must be medically necessary.

(N) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted calcium hydroxide or mineral trioxide aggregate (MTA) materials, not a cavity liner or chemical used for dentinal hypersensitivity. Indirect and direct pulp cap codes require specific narrative support addressing materials used, intent and reasons for use. Application of chemicals used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes is verified by post payment review.

(O) **Protective restorations.** This restoration includes removal of decay, if present, and is reimbursable for the same tooth on the same date of service with a direct or indirect pulp cap, if needed. Permanent restoration of the tooth is allowed after sixty (60) days unless the tooth becomes symptomatic and requires pain relieving treatment.

(P) **Smoking and tobacco use cessation counseling.** Smoking and tobacco use cessation counseling is covered when performed utilizing the five (5) intervention steps of asking the member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight (8) sessions are covered per year per individual who has documented tobacco use.
It is a covered service when provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, Oklahoma State Health Department (OSDH) and Federally Qualified Health Center (FQHC) nurses, and maternal/child health licensed clinical social workers with a Tobacco Treatment Specialist Certification (TTS-C). Chart documentation must include a separate note that addresses the 5A's, separate signature, and the member specific information addressed in the five (5) steps and the time spent by the practitioner performing the counseling. Anything under three (3) minutes is considered part of a routine visit.

(Q) Diagnostic casts and/or oral/facial images. Diagnostic casts and/or oral/facial images may be requested by OHCA or representatives of OHCA. If cast and/or images are received they will be considered supporting documentation and may be used to make a determination for authorization of services. Submitted documentation used to base a decision will not be returned. Providers will be reimbursed for either the study model or images.

(i) Documentation of photographic images must be kept in the client's medical record and medical necessity identified on the submitted electronic or paper claim.
(ii) Oral/facial photographic images are allowed under the following conditions:
   (I) When radiographic images do not adequately support the necessity for requested treatment.
   (II) When photo images better support medical necessity for the requested treatment rather than diagnostic models.
   (III) If a comprehensive orthodontic workup has not been performed.
(iii) For photographic images, the oral/facial portfolio must include a view of the complete lower arch, complete upper arch, and left and right maximum intercuspatation of teeth.
   (I) Maximum intercuspatation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.
   (II) Intercuspatation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.
(iv) Study models or photographic images not in compliance with the above described diagnostic guidelines will not be compensable. The provider may be allowed to resubmit new images that adhere to the diagnostic guidelines. If the provider does not provide appropriate documentation, the request for treatment will be denied.

317:30-5-698. Services requiring prior authorization
(a) Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis [See Oklahoma Administrative Code (OAC) 317:30-5-695(d)(2)]. Requests for dental services requiring prior authorization must be accompanied by sufficient documentation.
(b) Requests for prior authorization are filed on the currently approved American Dental Association (ADA) form. Prior authorized services must be billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.
(c) Prosthodontic services provided to members who have become ineligible mid-treatment are covered if the member was eligible for SoonerCare on the date the final impressions were made.
(d) Listed below are examples of services requiring prior authorization for members under twenty-one (21) and eligible intermediate care facilities for individuals with intellectual disabilities (ICF/IID) residents. Minimum required records to be submitted with each request are right and left mounted bitewings and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. Images must be of diagnostic quality. Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, and a completed current ADA form requesting all treatments requiring prior authorization. The images, digital media, photographs, or printouts must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request. If radiographs are not taken, the provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) Endodontics. Root canal therapy is not considered an emergency procedure unless due to trauma to an anterior tooth. The provider must document the member's oral hygiene and flossing ability in the member's records. Pulpal debridement may be performed for the relief of pain while waiting for the decision from the Oklahoma Health Care Authority (OHCA) on request for endodontics.

(A) Anterior endodontics. Prior authorization is required for members who have a treatment plan requiring more than two (2) anterior root canals. All rampant, active caries should be removed prior to requesting anterior endodontics. Payment is made for services provided in accordance with the following:
   (i) Permanent teeth only;
   (ii) Accepted ADA materials must be used;
   (iii) Pre and post-operative periapical images must be available for review;
   (iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within twenty-four (24) months post completion;
(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor; and
(vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown.

(B) **Posterior endodontics.** The guidelines for this procedure are as follows:

(i) The provider must document the member's oral hygiene and flossing ability in the member's records.
(ii) Teeth that require pre-fabricated post and cores to retain a restoration due to lack of natural tooth structure should not be treatment planned may not be approved for root canal therapy.
(iii) Pre and post-operative periapical images must be available for review.
(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within twenty-four (24) months post completion.
(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if there is a poor crown to root ratio or weakened root furcation area. Approval of second molars is contingent upon proof of medical necessity.
(vi) Only ADA accepted materials are acceptable under the OHCA policy.
(vii) Posterior endodontic procedure may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.
(viii) Endodontics will not be considered if:
(I) An opposing tooth has super erupted;
(II) Loss of tooth space is one third or greater;
(III) Opposing second molars are involved unless prior authorized;
(IV) The member has multiple teeth failing due to previous inadequate root canal therapy or follow-up; or
(V) All rampant, active caries must be removed prior to requesting posterior endodontics.
(ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. Core build-up code is only available for use if other restorative codes are not sufficient. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.

(2) **Crowns for permanent teeth.** Crowns are compensable for restoration of natural teeth for members who are sixteen (16) years of age or older and adults residing in private ICF/IID and who have been approved for ICF/IID level of care. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure:

(i) All rampant, active caries must be removed prior to requesting any type of crown;
(ii) The tooth must be decayed to such an extent to prevent proper cuspal or incisal function;
(iii) The clinical crown is fractured or destroyed by one-half or more; and
(iv) Endodontically treated teeth must have three (3) or more surfaces restored or lost due to carious activity to be considered for a crown.

(B) The conditions listed above in (A)(i) through (iv) should be clearly visible on the submitted images when a request is made for any type of crown.
(C) Routine build-up(s) for authorized crowns are included in the fee for the crown. Non authorized restorative codes may be used if available.
(D) A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, there is invasion of the biologic width, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed for molar or pre-molar teeth.
(E) Preformed post(s) and core build-up(s) are not routinely provided with crowns for endodontically treated teeth.
(F) The provider must document the member's oral hygiene and flossing ability in the member's records including improved oral hygiene for at least twelve (12) months. Chart documentation must include the OHCA caries risk assessment form.
(G) Provider is responsible for replacement or repair of all crowns if failure is caused by poor laboratory processes or procedure by provider for forty-eight (48) months post insertion.

(3) **Cast frame partial dentures.** This appliance is the treatment of choice for replacement of missing anterior permanent teeth or two (2) or more missing posterior teeth in the same arch for members sixteen (16) through twenty (20) years of age. Provider must indicate which teeth will be replaced. Members must have improved oral hygiene documented for at least twelve (12) months in the provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up for a period of two (2) years post insertion.

(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of three (3) or more missing teeth in the same arch for members twelve (12) through sixteen (16) years of age. Provider must indicate tooth numbers to be replaced. This appliance includes all necessary clasps and rests.

(5) **Occlusal guard.** Narrative of medical necessity must be sent with prior authorization. Model should not be made or sent unless requested.
(6) Fixed cast non-precious metal or porcelain/metal bridges. Only members seventeen (17) through twenty (20) years of age will be considered for this treatment. Destruction of healthy teeth to replace a single missing tooth is not considered medically necessary. Members must have excellent oral hygiene documented for at least eighteen (18) months in the requesting provider’s records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up until member loses eligibility.

(7) Periodontal scaling and root planing. Procedure is designed for the removal of calculus or tissue that is contaminated and may require anesthesia and some soft tissue removal. This procedure requires that each tooth have three (3) or more of the six point measurements five (5) to four (4) millimeters or greater, and have multiple areas of image supported bone loss, subgingival calculus and must involve two (2) or more teeth per quadrant for consideration. This procedure is not allowed in conjunction with any other periodontal surgery.

(8) Scaling in the presence of generalized moderate or severe gingival inflammation. Procedure is designed for removal of plaque, calculus and stain from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation, as indicated by generalized suprabony pockets and bleeding on probing, in the absence of periodontitis (bone loss). This procedure is only performed after a comprehensive evaluation has been completed and is not performed in conjunction with a prophylaxis.

[OAR Docket #21-394; filed 6-14-21]

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

[OAR Docket #21-388]

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]
317:30-5-953 [AMENDED]
(Reference APA WF # 20-24A)

AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board

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n/a

INCORPORATIONS BY REFERENCE:
n/a

GIST ANALYSIS:
The proposed revisions align waiver policy with the Oklahoma Health Care Authority’s overarching Electronic Visit Verification rules. Additional revisions will involve eliminating or updating outdated policy and correcting grammatical errors.

CONTACT PERSON:
Sandra Puebla, Director of Federal and State Authorities, 405-522-7270, Sandra.Puebla@okhca.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

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 State Plan Amendment and Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority (OHCA) Board.
(1) The rate for Nursing Facility (NF) respite is set equivalent to the rate for routine level of care NF services that require providers having equivalent qualifications;
(2) The rate for daily units for Adult Day Health is set equivalent to the rate established by the Oklahoma Department of Human Services (DHS/OKDHS) for equivalent services provided for the DHS/OKDHS Adult Day Service Program that requires providers have equivalent qualifications.
(3) The rate for units of home-delivered meals is set equivalent to the rate established by the DHS/OKDHS for the equivalent services provided for the DHS/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 that requires 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;
Consumer-Directed Personal Assistance Services and Supports (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 items listed in (A) B (C) of this paragraph.

(A) The Individual Budget Allocation (IBA) 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 Personal Care (PSA) and Personal Care Advanced Supportive/Restorative (APSA) service unit rates are calculated by the DHSOKDHS Aging Services (AS) during the CD-PASS service eligibility determination process. DHSOKDHS AS sets the PSA and APSA unit rates at a level that is not less than eighty percent (80%) and not more than ninety-five percent (95%) of the comparable Agency Personal Care (PSA) or Advanced Supportive/Restorative (APSA) PSA or APSA service rates. The allocation of portions of the PSA and/or APSA rates to cover salary, mandatory taxes, and optional benefits including Worker's Compensation insurance, when available, is determined individually for each member using the CD-PASS Individualized Budget Allocation (IBA) IBA 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. When 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 person-centered service plan to increase CD-PASS service units appropriate to meet additional member need. DHSOKDHS AS, upon favorable review, authorizes the amended person-centered service 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 Financial Management Service, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

Three (3) per diem reimbursement rate levels for the ADvantage assisted living services are set. Different rates per diem 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 Activities of Daily Living and Instrumental Activities of Daily Living (ADL/IADL) and health care needs. Rounding to the nearest cent, the lowest level Assisted Living Services per diem rate is set equivalent to 11.636 times the State Plan Agency Personal Care unit rate; the mid-level per diem rate is set equivalent to 15.702 times the State Plan Agency Personal Care unit rate; and the highest level Assisted Living Services per diem rate is set equivalent to 21.964 times the State Plan Agency Personal Care unit rate. The specific rate level appropriate to a particular member's service is determined by Uniform Comprehensive Assessment Tool, Part III (UCAT III) assessment by the member's Advantage case manager employed by a case management agency independent of the Assisted Living Services provider. ADvantage payment is not made for 24 hour twenty-four (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 health 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 twenty-four (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 ninety percent (90%) of the Supplemental Security Income (SSI) Federal Benefit Rate. When, per OAC Oklahoma Administrative Code (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.

The maximum total annual reimbursement for a member's hospice care within a 12-month period is limited to an amount equivalent to eighty-five percent (85%) of the Medicare Hospice Cap payment.

(b) The DHSOKDHS AS approved ADvantage person-centered service plan is the basis for the Medicaid Management Information Systems (MMIS) service prior authorization, specifying the:

(1) service; 
(2) service provider; 
(3) units authorized; and 
(4) begin and end dates of service authorization.

(c) Service time for personal care, case management services, for institution transitioning, nursing, skilled nursing, supportive/restorative assistance, and in-home respite, is documented solely through the use of the designated statewide Electronic Visit Verification System (EVV) previously known.
as Interactive Voice Response Authentication system, when
services are provided in the home. Providers are required to
use the EVV system after access to the system is made avail-
able by DHS/OKDHS. Refer to OAC 317:30-3-34(7) for
additional procedures for EVV system failure or EVV system
unavailability. The EVV system provides alternate backup
solutions when the automated system is unavailable. In the
event of EVV backup system failure, the provider documents
time in accordance with their agency backup plan. The
agency's backup procedures are permitted only when the EVV
system is unavailable.

[OAR Docket #21-388; filed 6-14-21]

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

[OAR Docket #21-389]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 5. Individual Providers and Specialties
Part 110. Indian Health Services, Tribal Programs, and Urban Indian Clinics (U/T/Us)
317:30-5-1094 [AMENDED]
(Reference APA WF # 20-25)

AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of
Oklahoma Statutes; the Oklahoma Health Care Authority Board
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N/A

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N/A

GIST/ANALYSIS:
The proposed revisions add coverage and reimbursement of Peer Recovery
Support Specialist (PRSS) services. The proposed revisions will also support
other policies in adding coverage and reimbursement of residential substance
use disorder (SUD) treatment services. Other revisions will reorganize policy
for clarity and correct grammatical errors.

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.,
SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE
DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS
AND SPECIALTIES
PART 110. INDIAN HEALTH SERVICES, TRIBAL PROGRAMS, AND URBAN INDIAN CLINICS(I/T/US)

317:30-5-1094. Behavioral health services provided at I/T/U

(a) Behavioral health services that are primary, preventive, and therapeutic and would be covered if provided in another setting may be provided by I/T/U providers. Services provided by an I/T/U (refer to OAC 317:30-5-241 for a description of services) must meet the same requirements as services provided by another provider. Services include:

1. Mental Health and/or Substance Use Assessment/Evaluation And Testing;
2. Service Plan Development;
3. Crisis Intervention Services;
4. Medication Training and Support;
5. Individual/Interactive Psychotherapy;
6. Group Psychotherapy; and
7. Family Psychotherapy.

(b) Behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified mental health and/or substance use disorder(s). Behavioral health services must be billed on an appropriate claim form using the appropriate procedure code and guidelines. The time indicated on the claim form must be the time actually spent with the member.

(c) In order to support access to mental health services, these services may be provided in settings outside of the I/T/U. Offsite services must take place in a confidential setting.

(d) The outpatient behavioral health services provider enrollment and reimbursement process may change the OHCA's policy with regard to reimbursement of practitioners. Licensed clinical social workers (LCSW), licensed mental and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), licensed alcohol and drug counselors (LADC), and licensure candidates are not eligible for direct reimbursement as practitioners. Their services are compensable only when billed by their employers and when provided in those clinical settings in which they are currently approved to render services. Licensure candidates must meet the requirements contained in OAC 317:30-5-240.3.

(e) For the provision of behavioral health related case management services, I/T/U providers must meet the requirements found at OAC 317:30-5-241.6, and be contracted as such. The provision of these services is considered to be outside of the I/T/U encounter. Contracted behavioral health case management providers are responsible for obtaining all necessary prior authorizations, if needed, and will be paid at the current fee-for-service rate.

(f) For the provision of psychosocial rehabilitation services, I/T/U facilities must meet the requirements found at OAC 317:30-5-241.3, and must contract as an outpatient behavioral health agency. The provision of these services is considered to be outside of the I/T/U encounter. Contracted psychosocial rehabilitation service providers are responsible for obtaining all necessary prior authorizations, if needed, and will be paid at the current fee-for-service rate.

(a) Inpatient behavioral health. Services are covered when provided in accordance with a documented individualized service plan developed to treat the identified behavioral health needs. Inpatient psychiatric service providers must meet the requirements and applicable limitations, restrictions, or prior authorization requirements set forth in Oklahoma Administrative Code (OAC) 317:30-5-95 through 317:30-5-97.

1. The provision of inpatient psychiatric services by Indian Health Services (IHS) facilities are reimbursed at the OMB inpatient encounter rate. Inpatient psychiatric services provided by non-IHS facilities are reimbursed at the established per diem or DRG rate.

2. For the provision of residential substance use disorder (SUD) treatment services, I/T/U facilities must be contracted as residential SUD service providers and meet the requirements found at OAC 317:30-5-95.43 through 317:30-5-95.49. Residential SUD treatment services will be reimbursed at the OMB outpatient encounter rate.

(b) Outpatient behavioral health. Services are covered when provided in accordance with a documented individualized service plan developed to treat the identified mental health needs and/or SUD. Outpatient behavioral health services are reimbursed at the I/T/U outpatient encounter rate unless otherwise noted in the section.

1. A full description of services may be found at OAC 317:30-5-241 and 317:30-5-241.5(d), 317:30-5-241.7. Services may include, but are not limited to:

A. Mental health and/or substance use assessment/evaluation and testing;
B. Service plan development;
C. Crisis intervention services;
D. Medication training and support;
E. Individual/interactive psychotherapy;
F. Group psychotherapy;
G. Family psychotherapy;
H. Medication-assisted treatment (MAT) services and/or medication; and
I. Peer recovery support specialist (PRSS) services.

2. In order to support access to behavioral health services, these services may be provided in settings outside of the I/T/U. Offsite services must take place in a confidential setting.

3. For the provision of behavioral health related case management services, I/T/U facilities must be fully contracted with the Oklahoma Health Care Authority (OHCA) as an outpatient behavioral health agency. The provision of these services is considered to be outside of the I/T/U encounter and will be paid at the current FFS rate. Contracted behavioral health case management providers must comply with the requirements found at OAC 317:30-5-241.6 and are responsible for obtaining all necessary prior authorizations, if needed.

4. For the provision of psychosocial rehabilitation services, I/T/U facilities must be fully contracted with the OHCA as an outpatient behavioral health agency. The
Part 6. Inpatient Psychiatric and Substance Use Disorder Services

317:30-5-95.24 [AMENDED]

Gubernatorial approval:
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38 Ok Reg 442

Docket number:
20-1094

(Reference APA WF # 20-27)

INTEGRATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
The proposed revisions update the specialty Acute II and the specialty Psychiatric Residential Treatment Facility (PRTF) staffing ratio from one (1) staff: three (3) members to one (1) staff: four (4) members. Revisions will also clarify inpatient psychiatric admission criteria for members under twenty-one (21) accessing specialty facilities. The proposed revisions will help support access to specialty providers for children with specialized treatment needs who are most in need of in-state specialty services.

CONTACT PERSON:
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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC AND SUBSTANCE USE DISORDER SERVICES

317:30-5-95.24. Prior authorization of inpatient psychiatric services for individuals under twenty-one (21)

(a) All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by the OHCA or its designated agent. All inpatient Acute, Acute II, and PRTF services will be prior authorized for an approved length of stay. Admission requirements for services must be provided in accordance with 42 C.F.R. Part 441 and 456. Additional information will be required for SoonerCare-compensable approval on enhanced treatment units or in special population programs.

(b) Unit staffing ratios shall always meet the requirements in OAC 317:30-5-95.24 (c), (d), and (h) and (i). The facility cannot use staff that is also on duty in other units of the facility in order to meet the unit staffing ratios. Patients shall be grouped for accommodation by gender, age, and treatment needs. At a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each population. A unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. A unit that does not allow clear line of sight due to the presence of walls or doors is considered a separate unit. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.
(c) In Acute and Acute II settings, at least one (1) registered nurse (RN) must be on duty per unit at all times, with additional RNs to meet program needs. RNs must adhere to Oklahoma State Department of Health (OSDH) policy at OAC 310:667-15-3 and 310:667-33-2(a)(3).

(d) Acute, non-specialty Acute II, and non-specialty PRTF programs require a staffing ratio of one (1) staff: six (6) patients during routine waking hours and one (1) staff: eight (8) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by an RN for management of behaviors and medical complications. For PRTF programs, at a minimum, a supervising RN must be available by phone and on-site within one (1) hour. If the supervising RN is off-site, then an RN or licensed practical nurse (LPN) must be on-site to adhere to a twenty-four (24) hour nursing care coverage ratio of one (1) staff: thirty (30) patients during routine waking hours and one (1) staff: forty (40) patients during time residents are asleep.

(e) Specialty treatment at Acute II or PRTF is a longer-term treatment that requires a higher staff-to-member ratio because of the need for constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one (1) time a week.

(f) An Acute II or PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit.

(g) A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the members and must meet active treatment requirements found at OAC 317:30-5-95.34.

(h) Criteria for classification as a specialty Acute II or PRTF will require a staffing ratio of one (1) staff: three (3) four (4) patients at a minimum during routine waking hours and one (1) staff: six (6) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by an RN for management of behaviors and medical complications. The specialty Acute II or PRTF will be a secure unit, due to the complexity of needs and safety considerations. Admissions will be restricted to members who meet the medical necessity criteria for the respective level of care and also meet at least two (2) or more of the following:

1. Have failed at other levels of care or have not been accepted by other non-specialty levels of care;
2. Have behavioral, emotional, and cognitive problems requiring secure treatment that includes one (1) staff: one (1) patient, one (1) staff: two (2) patients, or one (1) staff: three (3) patients staffing due to the member being a danger to themselves and others, for impairments in socialization problems, communication problems, and restriction, repetitive, and stereotyped behaviors. These symptoms must be severe and intrusive enough that management and treatment in a less restrictive environment places the member and others in danger, but do not meet acute medical necessity criteria. These symptoms must be exhibited across multiple environments and must include at least two (2) or more of the following:
   1. Marked impairments in the use of multiple nonverbal behaviors such as eye to eye gaze, facial expression, body postures, and gestures to regulate social interaction;
   2. Inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly;
   3. Failure to develop peer relationships appropriate to developmental level;
   4. Lack of spontaneously seeking to share enjoyment, interest, or achievements with other people;
   5. Lack of social or emotional reciprocity;
   6. Lack of attachment to caretakers;
   7. Require a higher level of assistance with activities of daily living requiring multiple verbal cues at least fifty (50) percent of the time to complete tasks;
   8. Delay, or total lack of, the development of spoken language which is not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime;
   9. Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others;
   10. Stereotyped and repetitive use of language or idiosyncratic language;
   11. Lack of varied, spontaneous make-belong play or social imitative play appropriate to developmental level;
   12. Encompassing preoccupation with one (1) or more stereotyped and restricted pattern and interest that is abnormal in intensity of focus;
   13. Inflexible adherence to specific, nonfunctional routines or rituals;
   14. Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body movements); and/or
   15. Persistent occupation with parts of objects;
3. Member is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment, and/or
4. Has full scale IQ below forty (40) (profound intellectual disability). Admissions and authorization for continued stay for a specialty Acute II will be restricted to members who meet the medical necessity criteria at OAC 317:30-5-95.29 and OAC 317:30-5-95.30 for the respective level of care and meet the additional criteria found in the Behavioral Health Services Medical Necessity Criteria Manual, available on OHCA's website, www.okhma.org.

(i) Criteria for classification as a specialty PRTF will require a staffing ratio of one (1) staff: four (4) patients at a minimum during routine waking hours and one (1) staff: six (6) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by an RN for management of behaviors and medical complications. The specialty PRTF will
be a secure unit, due to the complexity of needs and safety considerations. Admissions and authorization for continued stay in a specialty PRTF will be restricted to members who meet the medical necessity criteria at OAC 317:30-5-95.29 and OAC 317:30-5-95.30 for the respective level of care and meet the additional criteria found in the Behavioral Health Services Medical Necessity Criteria Manual, available on OHCA’s website, www.okhca.org.

(j) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.

(k) The OHCA, or its designated agent, will prior authorize all services for an approved length of stay based on the medical necessity criteria described in OAC 317:30-5-95.25 through 317:30-5-95.30.

(l) For out-of-state placement policy, refer to OAC 317:30-3-89 through 317:30-3-92. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in active treatment, including discharge and reintegration planning. Out-of-state facilities are responsible for insuring appropriate medical care, as needed under SoonerCare provisions, as part of the per-diem rate.

(1) Reimbursement for inpatient psychiatric services in all psychiatric units of general hospitals, psychiatric hospitals, and PRTFs are limited to the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.30. The approved length of stay applies to both facility and physician services.

[OAR Docket #21-391; filed 6-14-21]

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

[OAR Docket #21-410]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 3. Coverage and Exclusions
317:35-3-2 [REVOKED]
(Reference APA WF # 20-36B)

AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007(C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
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Approved June 11, 2021 by HJR 1046

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SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
The proposed revisions remove duplicate policy regarding lodging, meals, and SoonerRide non-emergency transportation. The policies regarding these services are already outlined in the Oklahoma Health Care Authority’s Chapter 30.

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., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 3. COVERAGE AND EXCLUSIONS

317:35-3-2. SoonerCare transportation and subsistence [REVOKED]

(a) The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible SoonerCare members who are in need of SoonerCare medical services in accordance with 42 CFR 431.53. The agency contracts with a broker to provide statewide curb-to-curb coverage for non-emergency transportation under the SoonerRide program. The broker provides the most appropriate and least costly mode of transportation necessary to meet the individual needs of SoonerCare members. As the Medicaid Agency, OHCA is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. The agency contracts directly with ambulance and air providers for all other transportation needs for eligible members not provided by SoonerRide. SoonerRide excludes those individuals who are categorized as:

(1) Qualified Medicare Beneficiaries (QMB) when SoonerCare pays only the Medicare premium, deductible, and co-pay;
(2) Specified Low Income Medicare Beneficiaries (SLMB) only;
(3) Qualifying Individuals 1; (4) individuals who are in an institution for mental disease (IMD);
(5) inpatient;
(6) institutionalized;
(7) Home and Community-Based Waiver members with the exception of the In-home Supports Waiver for
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Children, the ADvantage Waiver, the Living Choice demonstration, and the Medically Fragile Waiver.

(b) Members seeking medically necessary non-emergency transportation will be required to contact the SoonerRide reservation center. Contact will be made via a toll-free phone number which is answered Monday through Saturday, 8 a.m. to 6 p.m. Whenever possible, the member is required to notify SoonerRide at least 72 hours prior to the appointment. The member is asked to furnish the SoonerRide reservation center their SoonerCare member number, home address, the time and date of the medical appointment, the address and phone number of the medical provider, and any physical/mental limitations which will impact the type of transportation needed. SoonerRide makes arrangements for the most appropriate, least costly transportation. SoonerRide verifies appointments when appropriate. If the member disagrees with the transportation arranged or denied by SoonerRide, an appeal must be filed with OHCA according to OAC 317:2-1-2. The appropriateness of transportation may be appealed only to the extent that the transportation does not meet the medical needs of the member. Dissatisfaction with the use of public transportation, shared rides, type of vehicle, etc., is not appropriate grounds for appeal. The Oklahoma Health Care Authority’s decision is final.

(1) Authorization for transportation by private vehicle or bus. Transportation by private vehicle or bus is administered through the broker when it is necessary for an eligible member to receive medical services.

(2) Authorization for transportation by taxi. Taxi service may be authorized at the discretion of the broker.

(3) Transportation by ambulance (ground, air ambulance or helicopter). Transportation by ambulance is compensable for individuals eligible for SoonerCare benefits when other available transportation does not meet the medical needs of the individual. Payment is made for ambulance transportation to and/or from a medical facility for medical care compensable under SoonerCare.

(4) Transportation by airplane. When an individual’s medical condition is such that transportation out-of-state by a commercial airline is required, approval for airfare must be secured by telephoning the OHCA who will make the necessary flight arrangements.

(5) Subsistence (lodging and meals). Payment for lodging and/or meals assistance for an eligible member and/or an approved medical escort is provided only when medically necessary in connection with transportation to and from SoonerCare compensable services. The member and/or medical escort must make a reasonable effort to secure lodging at a hospital or non-profit organization. The Oklahoma Health Care Authority (OHCA) has discretion and final authority to approve or deny any lodging and/or meal services.

(A) Lodging and/or meals are reimbursable when prior approved. Payment for lodging and/or meals is limited to a period of up to 24 hours prior to the start of the member’s medical services and up to 24 hours after the services end. Lodging is approved for the member and/or one approved medical escort. The following factors may be considered by OHCA when approving reimbursement for a member and/or one medical escort:

(i) travel is to obtain specialty care; and
(ii) the trip cannot be completed during SoonerRide operating hours;
(iii) the trip is 100 miles or more from the member’s residence, as listed in the OHCA system, to the medical facility and/or
(iv) the member’s medical treatment requires an overnight stay, or the condition of the member discourages traveling.

(B) When a member is not required to have a PCP or when a PCP referral is not required to obtain a SoonerCare covered service, a member may go to any provider they choose but SoonerCare will not reimburse for transportation, lodging, or meals if the distance is beyond what is considered the nearest appropriate facility.

(C) Meals will be reimbursed if lodging criteria is met, and duration of trip is or exceeds 18 hours.

(D) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required.

(E) During inpatient or outpatient medical stays, lodging and/or meals services are reimbursed for a period of up to 14 days without prior approval; stays exceeding the 14 day period must be prior approved. A member may not receive reimbursement for lodging and/or meals service for days the member is an inpatient in a hospital or medical facility.

(F) For eligible members in the Neonatal Intensive Care Unit (NICU) a minimum visitation of 6 hours per day for the medical escort is required for reimbursement of lodging and/or meals services. Non-emergency transportation services for medically necessary visitation may be provided for eligible medical escorts.

(G) Lodging must be with a SoonerCare contracted Room and Board provider, when available, before direct reimbursement to a member and/or medical escort can be approved. If the lodging provider provides meals the member and/or medical escort is not eligible for separate reimbursement and may not seek assistance for meals obtained outside of the contracted Room and Board provider facility. If lodging and/or meal assistance with contracted Room and Board providers is not available, the member and/or medical escort may request reimbursement assistance by submitting the appropriate travel reimbursement forms. The travel reimbursement forms may be obtained by contacting SoonerCare Care Management Division. Any lodging and/or meal expenses claimed on the travel reimbursement forms must be documented with the required receipts and medical records to document the lodging and/or meals criteria have been met. Reimbursement will not exceed established state per diem amounts. The OHCA has
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discretion and the final authority to approve or deny lodging and/or meals reimbursement.

(6) Escort assistance required. Payment for transportation and lodging and/or meals of one medical escort may be approved if the service is required. If the Oklahoma Department of Human Services (OKDHS) removes a child from his/her home, a court must appoint a temporary guardian. During this time the temporary guardian is eligible for escort related lodging and/or meals services. It is the responsibility of the OHCA to determine this necessity. The decision should be based on the following circumstances:

(A) when the individual's health or disability does not permit traveling alone, and

(B) when the individual seeking medical services is a minor child.

[OAR Docket #21-410; filed 6-14-21]

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

[OAR Docket #21-409]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 5. Eligibility and Countable Income
Part 5. Countable Income and Resources
317:35-5-41.9 [AMENDED]
(Reference APA WF # 20-31)

AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; The Achieving a Better Life Experience (ABLE) Act of 2014 (Public Law 113-295), Section 103

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n/a

GIST/ANALYSIS:
The proposed revisions further define rules regarding State Treasurer's Achieving a Better Life Experience (ABLE) accounts by specifying that if a contribution is made to a SoonerCare member's STABLE account, contributions will be evaluated in accordance with OHCA long-term care eligibility rules. STABLE accounts are tax-favored savings accounts for individuals with disabilities.

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., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-41.9. Exclusions from resources
(a) The following are excluded resources. In order for payments and benefits listed in paragraph (b) and (c) to be excluded from resources, such funds must be segregated and not commingled with other countable resources so that the excludable funds are identifiable.

(b) Resources excluded by the Social Security Act, in accordance with section 416.1210 of Title 20 of the Code of Federal Regulations (C.F.R.), unless otherwise noted:

(1) The home that is the principal place of residence, as described at Oklahoma Administrative Code (OAC) 317:35-5-41.1;

(2) Household goods and personal effects, as described at OAC 317:35-5-41(a)(5);

(3) One automobile, as described at OAC 317:35-5-41.3;

(4) Property essential to self-support:
(A) Property of a trade or business which is essential to the means of self-support, as described at OAC 317:35-5-41.12(c);

(B) Nonbusiness property used to produce goods or services essential to self-support, as described at OAC 317:35-5-41.12(c);

(C) Nonbusiness income producing property, as described at OAC 317:35-5-41.12(c);

(5) Resources of a blind or disabled individual which are necessary to fulfill an approved plan for achieving self-support;

(6) Stock in regional or village corporations held by natives of Alaska during the twenty-year (20-year) period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act;

(7) Life insurance policies, as described at OAC 317:35-5-41.2(b);

(8) Restricted allotted Indian lands;

(9) Disaster relief assistance provided under Federal law or by state or local government;

(10) Burial spaces, as described at OAC 317:35-5-41.2(c);
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(11) Burial funds, as described at OAC 317:35-5-41.2(d);
(12) Irrevocable burial contracts as described at OAC 317:35-5-41.2(e);
(13) Supplemental Security Income (SSI) and Social Security retroactive payments for nine (9) months following the month of receipt;
(14) Housing assistance paid pursuant to:
   (A) The United States Housing Act of 1937;
   (B) The National Housing Act;
   (C) Section 101 of the Housing and Urban Development Act of 1965;
   (D) Title V of the Housing Act of 1949;
   (E) Section 202(h) of the Housing Act of 1959;
(15) Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit for nine (9) months following the month of receipt;
(16) Payments received as compensation for expenses incurred or losses suffered as a result of a crime;
(17) Relocation assistance for nine (9) months beginning with the month following the month of receipt. The assistance must be provided by a State or local government that is comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 that is subject to the treatment required by Section 216 of that Act;
(18) Money in a dedicated account for SSI-eligible individuals under age eighteen (18) that is required by 20 C.F.R. § 416.640(e);
(19) Gifts to children under age eighteen (18) with life-threatening conditions from an organization described at 26 United States Code (U.S.C.) § 501(c)(3) that is exempt from taxation under 26 United States Code (U.S.C.) § 501(a);
(20) Restitution of Social Security, SSI, or a Special Benefit for World War II Veterans made because of misuse by a representative payee, for nine (9) months following the month of receipt;
(21) Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses, for nine (9) months beginning the month after the month of receipt;
(22) Payment of a refundable child tax credit for nine (9) months following the month of receipt;
(23) Any annuity paid by a State to a person (or his or her spouse) based on the State's determination that the person is:
   (A) A veteran (as defined in 38 U.S.C. § 101); and
   (B) Blind, disabled, or aged;
(24) The principal and income of trusts complying with OAC 317:35-5-41.6(6). See also 42 U.S.C. § 1396p(d)(4);
(25) Workers' Compensation Medicare Set Aside Arrangements (WCMSAs) which allocate a portion of the workers' compensation settlement for future medical expenses; and/or
(26) For individuals with an Oklahoma Long-Term Care Partnership Program approved policy, resources equal to the amount of benefits paid on the insured's behalf by the long-term care insurer. Said disregard is made at the time of application for long-term care services provided by SoonerCare. The Oklahoma Insurance Department approves policies as Long-term Care Partnership Program policies.
(c) Resources excluded by federal laws other than the Social Security Act, in accordance with 20 C.F.R. § 416.1236, unless otherwise noted:
(1) An Achieving a Better Life Experience (ABLE) account is regulated by the Internal Revenue Service as a tax-advantaged account that protects resources from being counted toward the resource limit of public benefits programs (including Medicaid) if used according to the federal regulations. Funds and interest held in an Achieving a Better Life Experience (ABLE) account, pursuant to 26 U.S.C. § 529A:
   (A) A contribution to an ABLE account by another individual is neither income nor a resource to the individual with the ABLE account, unless such contribution exceeds the annual federal gift tax exclusion established by 26 U.S.C. § 2503(b), in which case, any contribution in excess of the annual federal gift tax exclusion is a countable resource and income in the month deposited. If the individual who made the contribution later requests Medicaid for long-term care services, the contribution shall be evaluated in accordance with OAC 317:35-5-41.8.
   (B) A distribution from an ABLE account that is retained after the month of receipt is neither income nor a resource to the individual in any month when spent on a qualified disability expense (QDE).
   (C) A QDE is any expense related to the blindness or disability of the individual and made for the benefit of the individual. QDE's include but are not limited to:
      (i) Education;
      (ii) Housing;
      (iii) Transportation;
      (iv) Employment training and support;
      (v) Assistive technology;
      (vi) Health;
      (vii) Prevention and wellness;
      (viii) Financial management and administrative services;
      (ix) Legal fees;
      (x) Expenses for ABLE account oversight and monitoring;
      (xi) Funeral and burial; and
      (xii) Basic living expenses.
   (D) A distribution, or portion of a distribution, from an ABLE account that is retained after the month of receipt, and used for a non-QDE in the next or subsequent month, is a countable resource to the individual in the month in which the funds were spent. Any unspent portion of the distribution the individual continues to retain is not a countable resource.
   (E) A distribution, or portion of a distribution, from an ABLE account that is received and used for a non-QDE in the same month, is considered unearned
income to the individual in the month of receipt. Any unspent portion of the distribution the individual retains after the month of receipt is not a countable resource.

(F) The responsibility of an Oklahoma Medicaid administrator is to ask the ABLE account beneficiary or Authorized Legal Representative (ALR) if the account has been used only in accordance with ABLE regulations and, if so, to exclude the balance of the ABLE account from the determination of countable resources.

(G) The testimony of the ABLE account beneficiary or ALR is all that is required in the determination of appropriate use of the ABLE account.

(2) Payments made under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (84 Stat. 1902, 42 U.S.C. ‘4636);

(3) Payments made to Native Americans as listed in paragraphs (b) and (c) of section IV of the Appendix to Subpart K of Part 416 of C.F.R. Title 20;

(4) Indian judgment funds held in trust by the Secretary of the Interior or distributed per capita pursuant to a plan prepared by the Secretary of the Interior and not disapproved by a joint resolution of the Congress under Public Law 93-134, as amended by Public Law (Pub. L.) 97-458 (25 U.S.C. § 1407). Indian judgment funds include interest and investment income accrued while the funds are so held in trust. This exclusion extends to initial purchases made with Indian judgment funds, but will not apply to proceeds from sales or conversions of initial purchases or to subsequent purchases;

(5) Supplemental Nutrition Assistance Program benefits;


(8) Any grant or loan to any undergraduate student for educational purposes made or insured under any program administered by the Commissioner of Education as provided by section 507 of the Higher Education Amendments of 1968, Pub.L. 90-575 (82 Stat. 1063);


(10) Compensation provided to volunteers by the Corporation for National and Community Service (CNCS), unless determined by the CNCS to constitute the minimum wage in effect under the Fair Labor Standards Act of 1938 (29 U.S.C. §§ 201 et seq.) or applicable State law, pursuant to 42 U.S.C. § 5044(f)(1). Programs include:

(A) AmeriCorps;

(B) Special and demonstration volunteer programs;

(C) University year for ACTION;

(D) Retired senior volunteer program;

(E) Foster grandparents program; and

(F) Senior companion program;

(11) Distributions received by an individual Alaska Native or descendant of an Alaska Native from an Alaska Native Regional and Village Corporation pursuant to the Alaska Native Claims Settlement Act, as follows: cash, including cash dividends on stock received from a Native Corporation, is disregarded to the extent that it does not, in the aggregate, exceed two-thousand ($2,000) per individual each year [the $2,000 limit is applied separately each year, and cash distributions up to $2,000 which an individual received in a prior year and retained into subsequent years will not be counted as resources in those years]; stock, including stock issued or distributed by a Native Corporation as a dividend or distribution on stock; a partnership interest; land or an interest in land, including land or an interest in land received from a Native Corporation as a dividend or distribution on stock; and an interest in a settlement trust. This exclusion is pursuant to the exclusion under section 15 of the Alaska Native Claims Settlement Act Amendments of 1987, Pub.L. 100-241 [43 U.S.C. § 1626(e)], effective February 3, 1988;

(12) Value of Federally donated foods distributed pursuant to section 32 of Pub.L. 74B320 or section 416 of the Agriculture Act of 1949 [7 C.F.R. § 250.6(e)(9) as authorized by 5 U.S.C. § 301];

(13) All funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to a member of that tribe under Pub.L. 98-64;


(15) Student financial assistance for attendance costs received from a program funded in whole or in part under Title IV of the Higher Education Act of 1965, as amended, or under Bureau of Indian Affairs (BIA) Student assistance programs if it is made available for tuition and fees normally assessed a student carrying the same academic workload, as determined by the institution, including costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study; and an allowance for books, supplies, transportation, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution, under section 14(27) of Pub.L. 100-50, the Higher Education Technical Amendments Act of 1987 (20 U.S.C. § 1087uu) or under BIA student assistance programs. This includes, but is not limited to:

(A) Pell grants;

(B) Student services incentives;

(C) Academic achievement incentive scholarships;

(D) Byrd scholars;

(E) Federal supplemental education opportunity grants;

(F) Federal educational loans (federal PLUS loans, Perkins loans, Stafford loans, Ford loans, etc.);
(G) Upward Bound;
(H) GEAR UP (Gaining Early Awareness and Readiness for Undergraduate Programs);
(I) State educational assistance programs funded by the leveraging educational assistance programs; and
(J) Work-study programs;
(16) Amounts paid as restitution to certain individuals of Japanese ancestry and Aleuts under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act, sections 105(f) and 206(d) of Pub.L. 100-383 (50 U.S.C. app. 1989 b and c);
(17) Payments made on or after January 1, 1989, 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.) under Pub.L. 101-201 (103 Stat. 1795) and section 10405 of Pub.L. 101-239 (103 Stat. 2489);
(19) Payments made to individuals because of their status as victims of Nazi persecution excluded pursuant to section 1(a) of the Victims of Nazi Persecution Act of 1994, Pub.L. 103-286 (108 Stat. 1450);
(20) Any matching funds and interest earned on matching funds from a demonstration project authorized by Pub.L. 105-285 that are retained in an Individual Development Account, pursuant to section 415 of Pub.L. 105-285 (112 Stat. 2771);
(22) Payments made to individuals who were captured and interned by the Democratic Republic of Vietnam as a result of participation in certain military operations, pursuant to section 606 of Pub.L. 105-78 and section 657 of Pub.L. 104-201 (110 Stat. 2584);
(23) Payments made to certain Vietnam veteran's children with spina bifida, pursuant to section 421 of Pub.L. 104-204 [38 U.S.C. § 1805(d)];
(24) Payments made to the children of women Vietnam veterans who suffer from certain birth defects, pursuant to section 401 of Pub.L. 106-419, [38 U.S.C. § 1833(c)];
(25) Assistance provided for flood mitigation activities under section 1324 of the National Flood Insurance Act of 1968, pursuant to section 1 of Public Law 109-64 (119 Stat. 1997, 42 U.S.C. § 4031); and/or

[OAR Docket #21-409; filed 6-14-21]
SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-7. Determining categorical relationship to the children and parent and caretaker relative groups

(a) Categorical relationship. All individuals under age nineteen (19) are automatically related to the children's group and further determination is not required. Adults age nineteen (19) or older are related to the parent and caretaker relative group 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) 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 SoonerCare and a parent is absent from the home, the parent or caretaker relative must agree to cooperate with OCSS. However, federal regulations provide for a waiver of this requirement when cooperation with OCSS is not in the best interest of the child. OCSS is responsible for making the good cause determination. If the parent or caretaker relative is claiming good cause, he/she cannot be certified for SoonerCare in the parent and caretaker relative group unless OCSS has determined good cause exists. There is no requirement of cooperation with OCSS for child(ren) or pregnant women to receive SoonerCare. However, cooperation with OCSS is not required in the following instances:

1. OCSS made a good cause determination that cooperation is not in the best interest of the child;
2. The child is eligible for health care services through the Indian Health Service and the child support case was or would have been opened because of a Medicaid referral based solely on health care services provided through an Indian Health Program, in accordance with Section 533.152 of Title of the Code of Federal Regulations; or
3. The SoonerCare application is only for child(ren) and/or pregnant women.

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-44. Child/spousal support

The Omnibus Budget Reconciliation Act of 1987 requires the Oklahoma Department of Human Services (OKDHS) to provide Child Support Services to certain families receiving SoonerCare benefits through the Oklahoma Child Support Services Division (OCSS). The families are required to cooperate in assignment of medical support rights, except as specified in Oklahoma Administrative Code (OAC) 317:35-5-7(b). In accordance with Section 433.152 of Title 42 of the Code of Federal Regulations, the Oklahoma Health Care Authority (OHCA) may not refer a case for medical support enforcement when the Medicaid referral is based solely upon health care services provided through an Indian Health Program [as defined at 25 United States Code § 1603(12)], including through the Purchased/Referred Care program, to a child who is eligible for health care services from the Indian Health Services. These families will not be required to cooperate with the 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 the children's, the blind or the disabled groups 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 Children and Family Services Division (CFSD). The rules in OAC 317:10 are used, with the following exceptions:

1. In the event the family already has an existing child support case, the only action required is a memo to the appropriate OCSS district office notifying them of the certification.
2. Prior to October 1, 2013, child/spousal support is always counted as income less any applicable income disregard. This income inclusion applies whether it is redirected to the OCSS or retained by the member. Effective October 1, 2013, see rules regarding financial eligibility for the individual's eligibility group to determine whether child or spousal support is counted as income.
3. Children who are in custody of OKDHS may be exempt from referral to OCSS. Should the pursuit of the OCSS services be determined to be detrimental to the OKDHS CFSD service plan, an exemption may be approved.

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

[OAR Docket #21-402]
AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board; The Advancing Chronic Care, Extenders, and Social Services Act (ACCESS Act) which was included in Public Law No. 115-123 Section 53103; and 42 U.S.C. Section 1396a(e)(14)(K)

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
November 24, 2020

COMMENT PERIOD:
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SUPERSEDED EMERGENCY ACTIONS:
Superseded rules:
Subchapter 6. SoonerCare for Pregnant Women and Families with Children
Part 6. Countable Income for MAGI
317:35-6-51 [AMENDED]
317:35-6-55 [NEW]
Subchapter 10. Other Eligibility Factors for Families with Children and Pregnant Women
Part 5. Income
317:35-10-26 [AMENDED]

Gubernatorial approval:
May 14, 2020

Register publication:
37 Ok Reg 763

Docket number:
20-415

(Reference APA WF # 20-03)

INCORPORATIONS BY REFERENCE:

n/a

GIST/ANALYSIS:
The proposed revisions will bring the agency into compliance with the Advancing Chronic Care, Extenders and Social Services Act, referred to as the ACCESS Act and included in Public Law No. 115-123 Section 53103. The ACCESS Act changed the way qualified lottery winnings or qualified gambling winnings of $80,000 and above, which are paid out in a single payout option, are treated when determining MAGI-based income eligibility. Previous federal regulations and OHCA rules required that all lump sum income, including lottery and gambling winnings, be counted as income only in the month received. Winnings will still be counted as income against the SoonerCare household in the month received; however, winnings of $80,000 and above which are paid out in a single payout option will be counted in multiple months and in equal monthly installments against the individual household member receiving the winnings. Lottery winnings that are paid out in installments over a period of time will be treated as recurring income. The formula for counting winnings of $80,000 and above is set forth in the new OHCA policy.

CONTACT PERSON:
Sandra Puebla, Director of Federal and State Authorities, 405-522-7270, Sandra.Puebla@okhca.org

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 6. COUNTABLE INCOME FOR MAGI

317:35-6-51. Exceptions to Internal Revenue Code rules
(a) The following sources of income are excluded from household income for SoonerCare eligibility under MAGI: Modified Adjusted Gross Income (MAGI), regardless of whether they are included in MAGI in Section 36B of the Internal Revenue Code:

(1) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses; and

(2) The following types of American Indian / Alaska Native income:

(A) Distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior;

(B) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:

(i) Rights of ownership or possession in any lands described in Paragraph (a)(2)(A) of this section; or

(ii) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(C) Distributions resulting from real property ownership interests related to natural resources and improvements:

(i) Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or

(ii) Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

(D) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom;

(E) Student financial assistance provided under the Bureau of Indian Affairs education programs; and

(F) Distributions from Alaska Native Corporations and Settlement Trusts.

(b) Amounts received as a lump sum are counted as income only in the month received (see also OAC Oklahoma Administrative Code (OAC) 317:35-10-26), with the exception of certain lottery or gambling winnings as specified in OAC 317:35-6-55. If a lump sum amount is received from an income source that is not counted in MAGI according to section 36B(d)(2)(B) of the Internal Revenue Code or the exceptions listed in this section, the amount is not counted.
317:35-6-55.  Treatment of qualified lottery or qualified gambling winnings

(a)  Definitions. The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) "Qualified lottery winnings" means winnings from a sweepstakes, lottery, or pool described in paragraph three (3) of Section 4402 of the Internal Revenue Code of 1986 or a lottery operated by a multistate or multi-jurisdictional lottery association paid out in a single payout and not in installments over a period of time.

(2) "Qualified gambling winnings" means monetary winnings from gambling, as defined by Section (§) 1955(b)(4) of Title 18 of the United States Code (U.S.C.).

(3) "Undue hardship" means circumstances resulting from a loss or denial of SoonerCare eligibility that would deprive an individual of medical care, such that the individual's health or life would be endangered, or that would deprive the individual or his or her financially dependent family members of food, clothing, shelter, or other necessities of life.

(b) Income determinations. In accordance with 42 U.S.C. § 1396a(e)(14)(K), qualified lottery and gambling winnings shall be considered as income in determining the financial eligibility of individuals whose eligibility is determined based on the application of Modified Adjusted Gross Income (MAGI), as follows:

(1) Winnings less than $80,000 are counted in the month received.

(2) Winnings greater than or equal to $80,000, but less than $90,000, are counted as income over two (2) months, with an equal amount counted in each month.

(3) Winnings greater than or equal to $90,000, but less than $100,000, are counted as income over three (3) months, with an equal amount counted in each month.

(4) Winnings greater than or equal to $100,000 are counted as income over three (3) months, with one (1) additional month for every increment of $10,000 in winnings received over $100,000, with an equal amount counted in each month; and

(5) The maximum period of time over which winnings may be counted is one hundred and twenty (120) months, which would apply to winnings greater than or equal to $1,260,000.

(c) Treatment of household members. Qualified lottery and gambling winnings shall be counted as household income for all household members in the month of receipt; however, the requirement to count qualified lottery and gambling winnings in household income over multiple months applies only to the individual receiving the winnings.

(d) Undue hardship. An individual who loses or is denied eligibility due to qualified lottery or gambling winnings may timely file a member appeal, in accordance with Oklahoma Administrative Code 317:2-1-2. If, as part of that appeal, the individual proves by a preponderance of the evidence that loss or denial of eligibility would result in undue hardship, eligibility shall be restored or approved, provided all other conditions of eligibility have been met.

(e) Notice. SoonerCare members or applicants who are determined financially ineligible due to the counting of lottery or gambling winnings will receive a notice of the date on which the lottery or gambling winnings will no longer be counted for eligibility purposes. The notice will also inform the member or applicant of the undue hardship exemption and of their opportunity to enroll in a Qualified Health Plan on the Federally Facilitated Exchange.

[OAR Docket #21-402; filed 6-14-21]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
[OAR Docket #21-401]

RULEMAKING ACTION: PERMANENT final adoption

RULES:

Subchapter 6. SoonerCare for Pregnant Women and Families with Children Part 7. Certification, Redetermination and Notification

317:35-6-60 [AMENDED]
317:35-6-60.2 [NEW]

(Reference APA WF # 20-02)

AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board; 42 C.F.R. Section 435.915; and SoonerCare 1115 Waiver 11-W-00048/6

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Subchapter 6. SoonerCare for Pregnant Women and Families with Children Part 7. Certification, Redetermination and Notification

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317:35-6-60.2 [NEW]

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May 14, 2020

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37 Ok Reg 767

Docket number:

20-414

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INCORPORATIONS BY REFERENCE:

n/a

GIST/ANALYSIS:
The proposed revisions will allow for a retroactive period of eligibility for pregnant women and children. Revisions provide that, in addition to certifying an applicant for coverage from the date of certification forward, the applicant may also be certified for coverage for a retroactive period of three
months directly prior to the date of application. Revisions will also specify the requirements that must be met to be eligible for retroactive coverage.

CONTACT PERSON:
Sandra Puebla, Director of Federal and State Authorities, 405-522-7270, Sandra.Puebla@okhca.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-60. Certification for SoonerCare for pregnant women and families with children

An individual determined eligible for SoonerCare may be certified for a medical service provided on or after the date of certification. The period of certification may not be for a retroactive period unless otherwise prior approved by OHCA. The individual who is categorically needy and related to pregnancy-related services retains eligibility for the period covering prenatal, delivery and postpartum periods without regard to eligibility for other household members in the case. Eligibility during the postpartum period does not apply to women receiving pregnancy-related coverage under Title XXI.

(a) General rules of certification.

(1) An individual determined eligible for SoonerCare may be certified for a prospective period of coverage on or after the date of certification.

(2) In accordance with 42 Code of Federal Regulations (C.F.R.) § 435.915 and Oklahoma Administrative Code (OAC) 317:35-6-60.2, an individual may also be determined eligible and certified for a retroactive period of coverage during the three (3) month period directly prior to the date of application. This only applies if the individual received covered medical services at any time during that period, and would have been eligible for SoonerCare at the time he or she received the services, regardless of whether the individual is alive when application for Medicaid is made. An individual may be eligible for the retroactive period even though ineligible for the prospective period.

(3) The individual who is categorically needy and related to pregnancy-related services retains eligibility for the period covering prenatal, delivery, and postpartum periods without regard to eligibility for other household members in the case. Eligibility during the postpartum period does not apply to women receiving pregnancy-related coverage under Title XXI.

(4c) 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.

(2c) Certification of non-cash assistance individuals related to the children and parent and caretaker relative groups.

The certification period for the individual related to the children or parent and caretaker relative groups is twelve (12) months. The certification period can be less than twelve (12) months if the individual:

(A) is certified as eligible in a money payment case during the 12-month-twelve-month (12-month) period;

(B) is certified for long-term care during the 12-month-twelve-month (12-month) period;

(C) becomes ineligible for SoonerCare after the initial month; or

(D) becomes financially ineligible.

(4d) Certification of individuals related to pregnancy-related services.

The certification period for the individual related to pregnancy-related services will cover the prenatal, delivery and postpartum periods. The postpartum period is defined as the two (2) months following the month the pregnancy ends. Financial eligibility is based on the income received in the first month of the certification period. No consideration is given to changes in income after certification.

(4e) Certification of newborn child deemed eligible.

(A) Every newborn child is deemed eligible on the date of birth for SoonerCare when the child is born to a woman who is eligible for and enrolled in pregnancy-related services as categorically needy. The newborn child is deemed eligible through the last day of the month the newborn child attains the age of one (1) 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 (1). 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 SoonerCare as long as he/she continues to live in Oklahoma. In accordance with 42 C.F.R. § 435.117, no other conditions of eligibility are applicable, including social security number enumeration, 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 the Oklahoma Child Support Services (OCSS) division at ODH/SDHS. The referral enables child support services to be initiated.

(3) When a categorically needy newborn child is deemed eligible for SoonerCare, he/she remains eligible through the end of the month that the newborn child reaches age one (1). 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:

(iA) loses Oklahoma residence; or

(iB) expires.

(4) A newborn child cannot be deemed eligible when the mother's only coverage was presumptive eligibility, and continued eligibility was not established.

317:35-6-60.2 Retroactive eligibility

(a) Retroactive eligibility, as outlined in this section, shall be available to pregnant women and/or members under the age of nineteen (19). For retroactive eligibility rules related to other SoonerCare population groups, refer to Oklahoma Administrative Code (OAC) 317:35-7-60(b).
(b) In addition to the period of eligibility specified in Oklahoma Administrative Code (OAC) 317:35-6-60, an applicant, or individuals within the applicant's household, shall be eligible for SoonerCare benefits up to three (3) months prior to the date of application if all of the following requirements are met:

(1) The individual for whom retroactive coverage is being requested would have been eligible for SoonerCare coverage if an application for SoonerCare had been made during the retroactive month.

(A) The individual does not have to be eligible for the month of application to be found eligible for one (1) of the three (3) retroactive months.

(B) The eligibility factors (e.g. income, residency, household composition, etc.) are evaluated separately for each retroactive month for which retroactive eligibility is being requested.

(2) The applicant completes the retroactive eligibility application form and provides, within six (6) months of the date the services were provided, documentation for verification purposes as requested by SoonerCare.

(3) The individual applying for retroactive coverage states that the individual for whom retroactive coverage is being requested received reimbursable SoonerCare services which were provided by a SoonerCare-contracted provider during the retroactive month.

(4) An applicant cannot be approved for retroactive coverage for a month in which his or her application was previously denied.

(c) Per 42 Code of Federal Regulations (CFR) § 435.915(b), if an applicant is determined to be eligible for retroactive coverage at any time during the requested retroactive month, then coverage will begin on the first (1st) day of the month and be effective for the entire month.

(d) If the applicant is applying for SoonerCare benefits due to pregnancy, then the applicant must have been pregnant during the requested retroactive month.

(e) Regardless of retroactive eligibility being granted, the requirement for the claim to be filed timely, per OAC 317:30-3-11, is still in effect.

(f) Retroactive coverage for SoonerCare health services received during a retroactive month will be secondary to any third-party which has primary responsibility for payment. If the individual eligible for retroactive coverage has already paid for the health services, the provider may refund the payment and bill SoonerCare in accordance with the timely filing requirements in OAC 317:30-3-11.

(g) Retroactive coverage for SoonerCare reimbursable health services that require prior authorization shall not be denied solely because of a failure to secure prior authorization. Medical necessity, however, must be established before reimbursement can be made.

(h) Denials of requests for retroactive eligibility may be appealed in accordance with OAC 317:2-1-2(d)(1)(F).

[OAR Docket #21-401; filed 6-14-21]

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

[OAR Docket #21-408]
revisions will involve eliminating or updating outdated policy and correcting grammatical errors.

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., SECTIONS 250.3(S) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

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 Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Questions regarding billing procedures that cannot be resolved through a study of the manual are referred to the Oklahoma Health Care Authority (OHCA).

(b) The Oklahoma Department of Human Services (DHS)OKDHS Aging Services (AS) approved ADvantage service plan is the basis for the Medicaid Management Information Systems (MMIS) service prior authorization, specifying the:

1. Service: Service;
2. Service provider;
3. Units authorized; and
4. Begin-End dates of service authorization.

(c) As part of ADvantage quality assurance, provider audits are used to evaluate if paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims not supported by service plan authorization and documentation of service provision are turned over to the OHCA Clinical Provider Audits Unit for follow-up investigation.

(d) All contracted providers for ADvantage Waiver services must submit billing to the State Medicaid agency, OHCA. Soonercare using the appropriate designated software, or web-based solution to submit for all claims transactions. When the designated system is unavailable, contracted providers submit billing directly to OHCA.

(e) Service time of personal care, case management, case management for transitioning, nursing, advanced supportive/restorative assistance, in-home respite, consumer-directed personal assistance services and supports (CD PASS), personal services assistance, and advanced personal services assistance is documented solely through the designated statewide Electronic Visit Verification System (EVV) when provided in the home. Providers are required to use the EVV system. The EVV system provides alternate backup solutions when the automated system is unavailable. In the event of EVV system failure, the provider documents time in accordance with internal policy and procedures. This documentation suffices to account for in-home and office services delivered. Provider agency backup procedures are only permitted when the EVV system is unavailable. Refer to OAC 317:30-3-34(7) for additional procedures for EVV system failure or EVV system unavailability.

(f) The provider must document the amount of time spent for each service, per Oklahoma Administrative Code (OAC) 317:30-5-763. For service codes that specify a time segment in their description, such as fifteen (15) minutes, each timed segment equals one (1) unit. Only time spent fulfilling the service for which the provider is authorized, per OAC 317:30-5-763 is authorized for time-based services. Providers do not bill for a unit of time when not more than one-half of a timed unit is performed, such as, when a unit is defined as fifteen (15) minutes, providers do not bill for services performed for less than eight (8) minutes. The rounding rules utilized by the EVV and web-based billing system to calculate the billable unit-amount of care, services provided for duration of:

1. Less than eight minutes (8 minutes) eight (8) minutes cannot be rounded up and do not constitute a billable fifteen minute (15 minute) fifteen (15) minute unit; and
2. Eight (8) to fifteen (15) minutes are rounded up and do constitute a billable fifteen minute (15 minute) fifteen (15) minute unit.

(g) Providers required to use EVV must do so in compliance with OAC 317:30-3-4.1, Uniform Electronic Transaction Act (UETA). Providers must ensure:

1. an established process is in place to deactivate an employee’s access to EVV or designated system records upon termination of employment of the designated employee;
2. safeguards are in place to ensure improper access or use of EVV or designated system is prohibited and sanctions will be applied for improper use or access by staff;
3. that staff providing or delivering in-home personal care services must use the EVV system for checking in and checking out when providing services;
4. staff delivering personal care services is trained in the use of the EVV system;
5. a record of services delivered is maintained;
6. that staff confirms in writing that they will use the system as they are trained or directed;
7. that staff will access the system using their assigned personal identification number (PIN) for in-home service delivery;
8. staff accessing EVV or other designated systems for billing, properly use the authentication features of the system to properly document work and confirm work that is submitted for billing for services that were rendered;
9. procedures as outlined in the UETA pertaining to electronic signatures, will be applied at such time when use of the electronic signatures is approved and applicable for necessary transaction;
10. the EVV or other designated system is responsible for retention of all records that are associated with and
Permanent Final Adoptions

generated for the purpose of claims and billing submitted for payment of services rendered;
(11) that they produce and enforce a security policy that outlines who has access to their data and what transactions employees are permitted to complete as outlined; and
(12) when using EVV or other designated system for billing and claims submissions, each new invoice or claim, must include the following information in (i) through (vi).
The:
(A) type of service performed;
(B) individual receiving the services;
(C) date of the service;
(D) location of service delivery;
(E) individual providing the service; and
(F) time the service begins and ends.

[OAR Docket #21-408; filed 6-14-21]

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

[OAR Docket #21-406]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 18. Programs of All-Inclusive Care for the Elderly (PACE)
317:35-18-5 [AMENDED]
317:35-18-7 [AMENDED]
(Reference APA WF # 20-22)

AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; 42 C.F.R. Section 460.122

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Approved June 11, 2021 by HJR 1046

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June 11, 2021

EFFECTIVE:
September 1, 2021

SUPERSEDED EMERGENCY ACTIONS:
Not applicable

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
The proposed revisions update policy regarding enrollment denials for Programs of All-Inclusive Care for the Elderly (PACE) to reflect current business practices. Additional policy changes will add language to clarify and establish OHCA’s role in reviewing justifications for expedited appeals from PACE organizations. These proposed rule changes will align policy with Section 460.122 of Title 42 of the Code of the Federal Regulations.

CONTACT PERSON:
Sandra Puebla, Director of Federal and State Authorities, 405-522-7270, Sandra.Puebla@okhca.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 18. PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

317:35-18-5. Eligibility criteria
(a) To be eligible for participation in Programs of All-Inclusive Care for the Elderly (PACE), the applicant must:
(1) be age fifty-five (55) years or older;
(2) live in a PACE service area;
(3) be determined by the state to meet nursing facility level of care; and
(4) be determined by the PACE interdisciplinary team (IDT) as able to be safely served in the community at the time of enrollment. If the PACE provider denies enrollment because the IDT determines that the applicant cannot be served safely in the community, the PACE provider must:
(A) notify the applicant in writing of the reason for the denial;
(B) refer the applicant to alternative services as appropriate;
(C) maintain supporting documentation for the denial and notify the Centers for Medicare and Medicaid Services and the Oklahoma Health Care Authority (OHCA) of the denial and make the supporting documentation available for review; and
(D) advise the applicant orally and in writing of the grievance and appeals process.

(b) To be eligible for SoonerCare capitated payments, the individual must:
(1) meet categorical relationship for the aged, blind, or disabled [refer to Oklahoma Administrative Code (OAC) 317:35-5-4];
(2) be eligible for Title XIX services if institutionalized as determined by the Oklahoma Department of Human Services (DHSS/OKDHS)
(3) be eligible for SoonerCare State Plan services;
(4) meet the same financial eligibility criteria as set forth for the SoonerCare ADvantage program per OAC 317:35-17-10 and 317:30-17-11; and
(5) meet appropriate medical eligibility criteria.

(c) The nurse designee makes the medical determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT) Part I, Part III, and other available medical information.
(1) When PACE services are requested:
(A) The PACE nurse or OHSOKDH nurse is responsible for completing the UCAT assessment.
(B) The PACE intake staff is responsible for aiding the PACE enrollee in contacting OHSOKDH to initiate
the financial eligibility application process.

(2) The nurse completes the UCAT, Part III visit with
the PACE enrollee, in the participant's home, within ten
(10) days of receipt of the referral for PACE services.

(3) The nurse sends the UCAT, Part III to the designated
OHCA nurse staff member for review and level of care
determination.

(4) A new medical level of care determination may be
required when a member requests any of the following
changes in service programs:
(A) From PACE to ADvantage;
(B) From PACE to State Plan Personal Care Services;
(C) From Nursing Facility to PACE;
(D) From ADvantage to PACE if previous
UCAT was completed more than six (6) months prior
to member requesting PACE enrollment; or
(E) From PACE site to PACE site.

(d) To obtain and maintain eligibility, the individual must
agree to accept the PACE providers and its contractors as
the individual's only service provider. The individual may be held
financially liable for services received without prior authorization
except for emergency medical care.

317:35-18-7. Programs of All-Inclusive for the Elderly
(PACE) organization's Appeals process
(a) Internal appeals:
(1) Any individual who is denied program services is
entitled to an appeal through the provider.
(2) If the individual also chooses to file an external ap-
peal, the provider must assist the individual in filing an ex-
ternal appeal.

(b) External appeals may be filed through the OHCA legal
division and follow the process outlined in Oklahoma Admin-
stative Code (OAC) 317:2-1-2.
(c) Expedited appeals process (refer to 42 CFR § 460.122).
(1) A PACE organization must have an expedited ap-
peals process for situations in which the participant be-
lieves that his or her life, health, or ability to regain or
maintain maximum function could be seriously jeopard-
dized, absent provision of the service in dispute.
(2) Except as provided in paragraph (c)(3) of this sec-
tion, the PACE organization must respond to the appeal
as expeditiously as the participant's health condition re-
quires, but no later than seventy-two (72) hours after it
receives the appeal.
(3) The PACE organization may extend the sev-
enty-two (72) hour timeframe by up to fourteen (14)
calendar days for either of the following reasons:
(A) The participant requests the extension; or
(B) The organization justifies to the State admin-
istering agency (OHCA) the need for additional in-
formation and how the delay is in the interest of the
participant.

(4) Supporting documentation must be submitted to
(OHCA) once it has been determined that they will be
unable to respond to the appeal within the seventy-two
(72) hour timeframe.

[OAR Docket #21-406; filed 6-14-21]

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

[OAR Docket #21-403]
Permanent Final Adoptions

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED
FINALLY ADOPTED AS SET FORTH IN 75 O.S.,
SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE
DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 18. PROGRAMS OF
ALL-INCLUSIVE CARE FOR THE ELDERLY
(PACE)

317:35-18-6. PACE program benefits
(a) The PACE program offers a comprehensive benefit plan.
A provider agency must provide a participant all the services
listed in 42 C.F.R. 440.92 Section (8) of Title 42 of the
Code of Federal Regulations (C.F.R.) that are approved by the
IDD-interdisciplinary team (IDT). The PACE benefit package
for all participants, regardless of the source of payment, must
include but is not limited to the following:
(1) All SoonerCare-covered services, as specified in
the State's approved SoonerCare plan-Medicaid State
Plan;
(2) Interdisciplinary assessment[DT] and treatment
planning;
(3) Primary care, including physician and nursing
services;
(4) Social work services;
(5) Restorative therapies, including physical therapy,
occupational therapy, and speech-language pathology
services;
(6) Personal care and supportive services;
(7) Nutritional counseling;
(8) Recreational therapy;
(9) Transportation;
(10) Meals;
(11) Medical specialty services including, but not
limited to the following:
(A) Anesthesiology;
(B) Audiology;
(C) Cardiology;
(D) Dentistry;
(E) Dermatology;
(F) Gastroenterology;
(G) Gynecology;
(H) Internal medicine;
(I) Nephrology;
(J) Neurosurgery;
(K) Oncology;
(L) Ophthalmology;
(M) Oral surgery;
(N) Orthopedic surgery;
(O) Otortinolaryngology;
(P) Plastic surgery;
(Q) Pharmacy consulting services;
(R) Podiatry;
(S) Psychiatry;
(T) Pulmonary disease;
(U) Radiology;
(V) Rheumatology;
(W) General surgery;
(X) Thoracic and vascular surgery; and
(Y) Urology.
(12) Laboratory tests, x-rays, and other diagnostic
procedures;
(13) Drugs and biologicals;
(14) Prosthetics, orthotics, durable medical equip-
ment, medical supplies, equipment, and appliances,
corrective vision devices, such as eyeglasses and lenses,
hearing aids, dentures, and repair and maintenance of
these items;
(15) Acute inpatient care, including the following:
(A) Ambulance;
(B) Emergency room care and treatment room ser-
dices;
(C) Semi-private room and board;
(D) General medical and nursing services;
(E) Medical surgical/intensive care/coronal care
units;
(F) Laboratory tests, x-rays, and other diagnostic
procedures;
(G) Drugs and biologicals;
(H) Blood and blood derivatives;
(I) Surgical care, including the use of anesthesia;
(J) Use of oxygen;
(K) Physical, occupational, respiratory therapies,
and speech-language pathology services; and
(L) Social services.
(16) Nursing facility (NF) care, including:
(A) Semi-private room and board;
(B) Physician and skilled nursing services;
(C) Custodial care;
(D) Personal care and assistance;
(E) Drugs and biologicals;
(F) Physical, occupational, recreational therapies,
and speech-language pathology, if necessary;
(G) Social services; and
(H) Medical supplies, equipment, and appliances.
(17) Other services determined necessary by the in-
terdisciplinary team[DT] to improve and maintain the
participant's overall health status.
(b) The following services are excluded from coverage
under PACE:
(1) Any service that is not authorized by the interdisci-
plinary team[DT], even if it is a required service, unless it is
an emergency service.
(2) In an inpatient facility, private room and private
duty nursing (PDN) services (unless medically neces-
sary), and non-medical items for personal convenience
such as telephone charges and radio or television rental
(unless specifically authorized by the interdisciplinary
team[DT] as part of the participant's plan of care).
COMMENT PERIOD: January 19, 2021 through February 18, 2021
PUBLIC HEARING: February 23, 2021
ADOPTION: March 17, 2021
SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE: March 18, 2021
LEGISLATIVE APPROVAL: Approved June 11, 2021 by HJR 1046
FINAL ADOPTION: June 11, 2021
EFFECTIVE: September 1, 2021
SUPERSeded EMERGENCY ACTIONS: Not applicable
INCORPORATIONS BY REFERENCE: n/a

GIST/ANALYSIS: The proposed revisions change the timeframe from ninety (90) days to one (1) calendar year for which a required physical health examination and medical evaluation can be completed when an individual is applying for the DDS Home and Community-Based Services waiver. These revisions improve the process of certifying cases for HCBS waivers by making it more efficient. DDS may also require a current medical evaluation when a significant change of condition, disability, or physical health status is noted. Additionally, revisions will add language defining remote services that can be provided in the member’s home, family home, or employment site. Remote services are created to promote the independence of a member who receives DDS services through remote services. Revisions will also address the new agency companion household criteria and new agency champion provider requirements, as well as, modify the procedures for the DDS home profile process. Agency companion providers may not simultaneously serve more than three members through any combination of companion or respite services. Further, revisions will establish new criteria on how the member is to obtain assistive technology devices and clarify instructions to staff whom are providing Stabilization Services authorized through remote supports. The requirement to add Assistive Technology devices must be prescribed by a physician with a SoonerCare contract. The proposed revisions increase the designated amount than an area resource development staff can approve or deny for AT from $2500 up to $5000. Finally, revisions will also increase the amount the state office AT programs manager can approve for AT from $2500 to $5000 or more.

CONTACT PERSON: Sandra Puebla, Director of Federal and State Authorities, 405-522-7270, Sandra.Puebla@okhca.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS

317:40-1-1. Home and Community-Based Services (HCBS) Waivers for persons with intellectual disabilities or certain persons with related conditions

(a) Applicability. This Section applies to services funded through Medicaid HCBS Waivers per Oklahoma Administrative Code (OAC) 317:35-9-5 and Section 1915(c) of the Social Security Act. Specific Waivers are the In-Home Supports Waiver (IHSW) for Adults, IHSW for Children, Community Waiver, and Homeward Bound Waiver.
(b) **Program provisions.** Each individual requesting services provided through an HCBS Waiver and his or her family or guardian, are responsible for:

1. **accessing** Accessing with the Oklahoma Department of Human Services (DHS) (OKDHS) staff assistance, all benefits available under Oklahoma's Medicaid State Plan or other payment sources prior to accessing funding for those same services under an HCBS Waiver program;

2. **cooperating** Cooperating in the determination of medical and financial eligibility including prompt reporting of changes in income or resources;

3. **choosing** Choosing between services provided through an HCBS Waiver or institutional care; and

4. **reporting** Reporting any changes in address or other contact information to DHS (OKDHS) within thirty (30) calendar days.

(c) **Waiver eligibility.** To be eligible for Waiver services, an applicant must meet the criteria established in (1) of this Subsection and the criteria for one (1) of the Waivers established in (1) through (8) of this Subsection.

1. **HCBS Waiver services.** Services provided through an HCBS Waiver are available to Oklahoma residents meeting SoonerCare (Medicaid) eligibility requirements established by law, regulatory authority, and policy within funding available through State or Federal resources. To be eligible and receive services funded through any of the Waivers listed in (a) of this Section, an applicant must meet conditions per OAC 317:35-9.5. The applicant:

   (A) must be determined financially eligible for SoonerCare, per OAC 317:35-9.68;

   (B) may not simultaneously be enrolled in any other Medicaid Waiver program or receiving services in an institution including a hospital, rehabilitation facility, mental health facility, nursing facility, or residential care home per Section 63 of the Oklahoma Statutes (O.S.) 63:1-820, or Intermediate Care facility for individuals with intellectual disabilities (ICF/IID);

   (C) may not be receiving Developmental Disabilities Services (DDS) state-funded services, such as the Family Support Assistance Payment, Respite Voucher Program, sheltered workshop services, community integrated employment services, or assisted living without Waiver supports, per OAC 340:100-5.22.2; and

   (D) must also meet other Waiver-specific eligibility criteria.

2. **In-Home Supports Waivers (IHSW).** To be eligible for services funded through the IHSW, an applicant must:

   (A) meet all criteria listed in (c) of this Section; and

   (B) be determined by the Social Security Administration (SSA) to have a disability and a diagnosis of intellectual disability; or

   (C) be determined to have a disability and a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU); and

   (D) be three (3) years of age or older; and

   (E) be determined by the OHCA LOCEU to meet the ICF/IID Institutional Level of Care requirements per OAC 317:30-5.122; and

   (F) reside in:

   (i) the home of a family member or friend; A family member's or friend's home;

   (ii) His or her own home;

   (iii) An OKDHS Child Welfare Services (CWS) foster home; or

   (iv) A CWS group home; and

   (vii) have critical support needs that can be met through a combination of non-paid, non-Waiver, and SoonerCare (Medicaid) resources available to the individual; and HCBS Waiver resources within the annual per capita Waiver limit, agreed on between the State of Oklahoma and the Centers for Medicare and Medicaid Services (CMS).

3. **Community Waiver.** To be eligible for services funded through the Community Waiver, the applicant must:

   (A) meet all criteria listed in (c) of this Section;

   (B) be determined by the SSA to have a disability and a diagnosis of intellectual disability; or

   (C) have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition by DDS and be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

   (D) be determined to have a disability and a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or the OHCA LOCEU; and

   (E) be three (3) years of age or older; and

   (F) be determined by the OHCA LOCEU, to meet ICF/IID Institutional Level of Care requirements per OAC 317:30-5.122; and

   (G) have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the DDS director or designee.

4. **Homeward Bound Waiver.** To be eligible for services funded through the Homeward Bound Waiver, the applicant must:

   (A) be certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in Homeward Bound et al. v. The Hissom Memorial Center, Case No. 85-C-437-E; and

   (B) meet all criteria for HCBS Waiver services listed in (c) of this Section; and
(C) be determined by SSA to have a disability and a diagnosis of intellectual disability; or

(D) have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition per OAC 317:35-9-45 as determined by DDS, and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(E) have a disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA/LOCEU; and

(F) meet Institutional Level of Care requirements per OAC 317:30-5-122, as determined by the OHCA LOCEU.

(5) **Evaluations and information.** Applicants desiring services through any of the Waivers listed in (a) of this section participates in diagnostic evaluations and provides information necessary to determine HCBS Waiver services eligibility, including:

(A) a psychological evaluation, by a licensed psychologist that includes:

   (i) a full-scale, functional and/or adaptive assessment; and

   (ii) a statement of age of onset of the disability; and

   (iii) intelligence testing that yields a full-scale, intelligence quotient.

   (I) Intelligence testing results obtained at sixteen (16) years of age and older are considered valid of the current status, provided they are compatible with current behavior. Intelligence testing results obtained between 2 to 16 years of age are considered current for four (4) years when the full-scale intelligence quotient is less than 40; forty (40) and for two (2) years when the intelligence quotient is forty (40) or above.

   (II) DDS may require a current psychological evaluation when a significant change of condition, disability, or psychological status is noted;

(B) a social service summary, current within twelve (12) months of the requested approval date that includes a developmental history; and

(C) a medical evaluation, current within the calendar year of the requested approval date; and

(D) completed Form LTC-300, ICF/IID Level of Care Assessment; and

(E) proof of disability per SSA guidelines. When a disability determination is not made by SSA, OHCA LOCEU may make a disability determination using SSA guidelines.

(6) **Eligibility determination.** OHCA reviews the diagnostic reports listed in (2) of this subsection and makes an eligibility determination for DDS HCBS Waivers.

(7) **State's alternative disposition plan.** For individuals who are determined to have an intellectual disability or a related condition by DDS per the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, DDS reviews the diagnostic and eligibility reports listed in (2) of this subsection and, on behalf of OHCA, makes a determination of eligibility for DDS HCBS Waiver services and ICF/IID level of care.

(8) **Member's choice.** A determination of need for ICF/IID Institutional Level of Care does not limit the opportunities of the person receiving services to participate in community services. Individuals are assured of the opportunity to exercise informed choice in the selection of services.

(d) **Request list.** When state DDS resources are unavailable to add individuals to services funded through an HCBS Waiver, persons are placed on a statewide Request for Waiver Services List.

(1) The Request for Waiver Services List is maintained in chronological order, based on the date of receipt of a written request for services on Form 06MP001E, Request for Developmental Disabilities Services. The applicant must submit the required documentation per Form 06MP001E, Request for Developmental Disabilities Services for initial consideration of potential eligibility. Active United States Armed Forces personnel, who have a pending HCBS Waiver application in another state for an immediate family member, may be placed on the list with the date they applied in the other state. The person's name is added to the list when he or she provides proof of application date from the other state.

(2) The Request for Waiver Services List for persons requesting services provided through an HCBS Waiver is administered by DDS uniformly throughout the state.

(3) An individual applicant is removed from the Request for Waiver Services List when he or she:

   (A) is found to be ineligible for services;

   (B) cannot be located by DDS/OKDHS;

   (C) does not provide information or fails to respond;

   (D) is not an Oklahoma resident at the requested Waiver approval date; or

   (E) declines an offer of Waiver services.

(4) An applicant removed from the Request for Waiver Services List, because he or she could not be located, may submit a written request to be reinstated to the list. The applicant is returned to the same chronological place on the Request for Waiver Services List, provided he or she was on the list prior to January 1, 2015.

(e) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, DDS ensures action regarding a request for services occurs within forty-five (45) calendar days. When action is not taken within the required forty-five (45) calendar days, the applicant may seek resolution per OAC 340:2-5-61.
Permanent Final Adoptions

(1) Applicants are allowed sixty (60) calendar days to provide information requested by DDS to determine eligibility for services.

(2) When requested information is not provided within sixty (60) calendar days, the applicant is notified that the request was denied, and he or she is removed from the Request for Waiver Services List.

(f) Admission protocol. Initiation of services funded through an HCBS Waiver occurs in chronological order from the Request for Waiver Services List per (d) of this Section based on the date of DDS receipt of a completed request for services, as a result of the informed choice of the person requesting services or the individual acting on the member's behalf, and upon determination of eligibility, per (c) of this Section. Exceptions to the chronological requirement may be made when:

(1) An emergency situation exists in which the health or safety of the person needing services or of others is endangered and there is no other resolution to the emergency. An emergency exists when:

(A) the person is unable to care for himself or herself; and:
   (i) the person's caretaker, per 42A O.S. § 10-103; 43A O.S. § 10-103;
   (II) is hospitalized;
   (II) moved into a nursing facility;
   (III) is permanently incapacitated; or
   (IV) died;

(ii) there is no caretaker to provide needed care to the individual; or

(iii) an eligible person is living at a homeless shelter or on the street;

(B) DHSS finds the person needs protective services due to ongoing physical, sexual, or emotional abuse or neglect in his or her present living situation, resulting in serious jeopardy to the person's health or safety;

(C) the behavior or condition of the person needing services is such that others in the home are at risk of being seriously harmed by the person. For example, when the person is routinely physically assaultive to the caretaker or others living in the home and sufficient supervision cannot be provided to ensure the safety of those in the home or community; or

(D) the person's medical, psychiatric, or behavioral challenges are such that the person is seriously injuring or harming himself or herself, or is in imminent danger of doing so;

(2) The Legislature appropriated special funds with which to serve a specific group or a specific class of individuals, per HCBS Waiver provisions;

(3) Waiver services may be required for people who transition to the community from a public ICF/IID or children in DHSS custody receiving services from DHSS. Under some circumstances Waiver services related to accessibility may be authorized in advance of transition, but may not be billed until the day the member leaves the ICF/IID and enters the Waiver; or

(4) individuals subject to the provisions of Public Law 100-203 residing in nursing facilities for at least 30-continuous months prior to January 1, 1989, and are determined by Preadmission Screening and Resident Review (PASRR) evaluation conducted per Title 42 Section 483.100 of the Federal Code of Regulations to have an intellectual disability or a related condition, who are covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, and choose to receive services funded through the Community or Homeward Bound Waiver.

(g) Movement between DDS HCBS Waiver programs. A person's movement from services funded through one DDS-administered HCBS Waiver to services funded through another DDS-administered HCBS Waiver is explained in this subsection.

(1) When a member receiving services funded through the IHSW for children becomes eighteen (18) years of age, services through the IHSW for adults becomes effective.

(2) Change to services funded through the Community Waiver from services funded through the IHSW occurs only when:

(A) a member has critical health and safety support needs that cannot be met by IHSW services, non-Waiver services, or other resources as determined by the DDS director or designee; and

(B) funding is available per OAC 317:35-9-5.

(3) Change to services funded through the IHSW from services funded through the Community Waiver may only occur when a member's history of annual service utilization was within the IHSW per capita allowance.

(4) When a member served through the Community Waiver has support needs that can be met within the per capita Waiver allowance of the applicable IHSW and through a combination of non-Waiver resources, the individual may choose to receive services through the IHSW.

(h) Continued eligibility for HCBS Waiver services. Eligibility for members receiving services provided through the HCBS Waiver is re-determined by the OHCA LOCEU when a significant change of condition, disability, or psychological status is noted.

(1) DDS may require a new psychological evaluation and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status is noted.

(2) Annual review of eligibility requires a medical evaluation that is current within one year of the requested approval date. The medical evaluation must be submitted by the member or the individual acting on his or her behalf.
30 calendar days prior to the Plan of Care expiration.
(i) **HCBS Waiver services case closure.** Services provided through an HCBS Waiver are terminated, when:
   (1) a family member or the individual acting on the member's behalf chooses to no longer receive Waiver services;
   (2) a family member is incarcerated;
   (3) a family member is financially ineligible to receive Waiver services;
   (4) a family member is determined by SSA to no longer have a disability qualifying the individual for services under these Waivers;
   (5) a family member is determined by the OHCA LOCEU to no longer be eligible;
   (6) a family member moves out of state or the custodial parent or guardian of a member who is a minor moves out of state;
   (7) a family member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for more than 30 consecutive calendar days;
   (8) the guardian of a member who is a minor or adjudicated adult fails to cooperate during the annual review process, per OAC 340:100-5-50 through 340:100-5-58;
   (9) the guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of DHS policy, the OKDHS rule or service delivery in a manner that places the health or welfare of the member at risk, after efforts to remedy the situation through Adult Protective Services or Child Protective Services were not effective;
   (10) the member is determined to no longer be SoonerCare eligible;
   (11) there is sufficient evidence the member or the individual acting on the member's behalf engaged in fraud or misrepresentation, failed to use resources as agreed on in the Individual Plan, or knowingly misused public funds associated with these services;
   (12) the member or the individual acting on the member's behalf, either cannot be located, did not respond, or did not allow case management to complete plan development or monitoring activities as required, per OAC 340:100-3-27, and the member or the individual acting on the member's behalf:
      (A) does not respond to the notice of intent to terminate; or
      (B) the response prohibits the case manager from being able to complete plan development or monitoring activities as required, per OAC 340:100-3-27;
   (13) the member or the individual acting on the member’s behalf fails to cooperate with the case manager to implement a Fair Hearing decision;
   (14) it is determined services provided through an HCBS Waiver are no longer necessary to meet the member's needs and professional documentation provides assurance the member's health, safety, and welfare can be maintained without Waiver supports;
   (15) the member or the individual acting on the member's behalf fails to cooperate with service delivery;
   (16) a family member, the individual acting on the member's behalf, other individual in the member's household, or persons who routinely visit, pose a threat of harm or injury to provider staff or official DHS/OKDHS representatives; or
   (17) a family member no longer receives a minimum of one (1) Waiver service per month and DDS is unable to monitor the member on a monthly basis.

(j) **Reinstatement of services.** Waiver services are reinstated when:
   (1) the situation resulting in case closure of a Hissom class member is resolved;
   (2) a family member is incarcerated for 90 calendar days or less;
   (3) a family member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for 90 calendar days or less; or
   (4) a family member's SoonerCare eligibility is re-established within 90 calendar days of the SoonerCare ineligibility date.

317:40-1-4. **Remote support (RS)**
(a) **General Information.** RS services are intended to promote a member's independence. RS services are provided in the member's home, family home, or employment site to reduce reliance on in person support while ensuring the member’s health and safety. RS services are included in the member's Individual Plan (Plan) and arrangements for this service are made through the case manager.
   (1) RS services are:
      (A) Based on the member's needs as documented and supported by the Plan and Person-Centered Assessment;
      (B) The least-restrictive option and the member's preferred method to meet an assessed need;
      (C) Provided when all adult members of the household; his or her guardians, when applicable; and Personal Support Team (Team) agree to the provision of RS services as documented in the Plan; and
      (D) Reviewed by the Team after sixty (60) calendar days of initial installation to determine continued appropriateness of services.
   (2) RS services are not a system to provide surveillance or for staff convenience.
(b) **Service description.** RS is monitoring of an adult member; allowing for live, two-way communication with him or her in his or her residence or employment site, by monitoring staff using one or more of the systems in one (1) through eight (8) that are:
   (1) Live-video feed;
   (2) Live-audio feed;
   (3) Motion-sensing monitoring;
   (4) Radio-frequency identification;
   (5) Web-based monitoring;
   (6) Personal Emergency Response System (PERS);
(7) Global positioning system (GPS) monitoring devices; or
(8) Any other device approved by the Developmental Disabilities Services (DDS) director or designee.

c) General provider requirements. RS service providers must have a valid Oklahoma Health Care Authority (OHCA) SoonerCare (Medicaid) provider agreement to provide agency-based RS services to Oklahoma Human Services (OKDHS) DDS Home-and-Community Based Services (HCBS) Waiver members. Requests for applications to provide RS are made to and approved by OKDHS DDS state office.

(1) An RS assessment is completed:
   (A) Annually;
   (B) Prior to RS implementation; and
   (C) As required by ongoing progress and needs assessments.

(2) Each member is required to identify at least two emergency response staff. The member’s emergency response staff are documented in his or her Plan.

(3) RS observation sites are not located in a member’s residence.

(4) The use of camera or video equipment in the member’s bedroom or other private area is prohibited.

(5) RS services are provided in real time by awake staff at a monitoring base using the appropriate connection, not by a recording. While RS is provided the RS staff does not have duties other than remote supports.

(6) RS equipment used in the member’s residence includes a visual indicator to the member that the system is on and operating.

(7) RS provider agencies must immediately notify in writing, the member’s residential provider agency, vocational provider agency, assigned DDS case manager, or guardian of activity in the household, who could potentially compromise the member’s health or safety.

(8) Emergency response provider agency staff records are maintained, per Oklahoma Administrative Code (OAC) 340:100-3-40.

(9) RS provider records are maintained for seven (7) calendar years or until any pending litigation involving the service recipient is completed, whichever occurs last and include at a minimum:
   (A) The member’s name;
   (B) The staff’s name who delivered the service;
   (C) Service dates;
   (D) Service begin and end times;
   (E) Provider’s location;
   (F) Description of services provided or observation note;
   (G) Method of contact with member; and
   (H) The member’s current photograph.

(10) RS providers must have:
   (A) Safeguards in place including, but not limited to:
       (i) A battery or generator to insure continued coverage during an electrical outage at the member’s home and monitoring facility;
permanent final adoptions

(A) May not have any assigned duties other than oversight and support of members at the time they are assigned as response staff;
(B) Receive all trainings required, per OAC 340:100-3-38.1, for members in residential settings; OAC 340:100-3-38.2 for members in employment settings; or OAC 340:100-3-38.3, for members in non-residential settings per the Plan prior to providing support;
(C) Provide a response on site at the member's residence or employment site within twenty (20) minutes when contacted by RS staff unless a shorter timeframe is indicated in the member’s Plan;
(D) Have an on-call back-up person who responds when the primary response staff engaged at another home or employment site is unable to respond within the specified time frame;
(E) Provide written or verbal acknowledgement of a request for assistance from the RS staff;
(F) Complete and document emergency drills with the member quarterly when services are provided in the member's home;
(G) Implement the Plan as written and document each time they are contacted to respond, including the nature of the intervention and the duration;
(H) Complete incident reports, per OAC 340:100-3-34; and
(I) Are eighteen (18) years of age and older.

(2) Natural emergency response persons:
(A) Are unpaid family members or other interested parties who agree to become, and are approved as, an emergency response person by the member's Team;
(B) Are available to respond in the case of an emergency within twenty (20) minutes from the time they are contacted by RS staff, unless a shorter response time is indicated in the Plan;
(C) Have an on-call back-up person who responds when the primary response staff is unable to respond within the specified time frame;
(D) Provide written or verbal acknowledgement of a request for assistance from the remote support staff; and
(E) Are eighteen (18) years of age and older.

(f) Service limitations. RS is limited to twenty-four (24) hours per day. RS is not provided simultaneously with HTS services; homemaker services; agency companion services; group home services; specialized foster care, respite, intensive personal supports services, group job coaching, or where foster care is provided to children. RS can be provided in conjunction with daily living supports, individual job coaching, employment stabilization services, and center and community based services.

(1) Services not covered include, but are not limited to:
(A) Direct care staff monitoring;
(B) Services to persons under the age of eighteen (18); or
(C) Services provided in any setting other than the member’s primary residence or employment site.

(2) RS services are shared among OKDHS/DDS Waiver members of the same household in a residential setting. RS provider agencies may only bill for one (1) member of a household at a time. Only one (1) remote support provider per household.

(g) RS Discontinuation. The member and his or her Team determine when it is appropriate to discontinue RS services. When RS services are terminated, the RS provider agency coordinates termination of service with the member’s residential provider agency or vocational provider agency and Team to ensure a safe transition. When a member requests the termination of RS services while RS is being provided, the RS staff:
(1) Notifies the provider to request an emergency response staff;
(2) Leaves the system operating until the emergency response staff arrives; and
(3) Turns off the system once relieved by the emergency response staff.

SUBCHAPTER 5. MEMBER SERVICES

PART 1. AGENCY COMPANION SERVICES

317:40-5.3. Agency companion services (ACS)
(a) Agency companion services (ACS) are:
(1) provided by agencies that have a provider agreement with the Oklahoma Health Care Authority (OHCA);
(2) provided by the provider agency or contract agencies and provide a shared living arrangement developed to meet the member’s specific needs of care to the member at the member’s home.

(b) An agency companion:
(1) must have an approved home profile, per OAC 317:40-5-3, and contract with a provider agency approved by DDS;
(2) may provide companion services for one (1) member. Exceptions to serve as companion for two (2) members.

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members may be approved by the DDS director or designee. Exceptions for up to two (2) members 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 (2) members.

Exceptions for additional members may be granted when the DDS director or designee determines an emergency situation exists and there is no other resolution, and the companion demonstrates the skill and ability required to serve as a companion.

(3) Household: Household is limited to one (1) individual companion provider. Exceptions for two (2) individual companion providers in a household who each provide companion services to different members may be approved by the DDS director or designee.

(4) may not provide companion services to more than two (2) members at any time;

(5) Household: Household may not simultaneously serve more than three (3) 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) The companion may have employment when:

(i) personal support team (Team) documents and addresses all related concerns in the member's Plan;

(ii) Employment is approved in advance by the DDS area manager or designee; and

[iii] Employment is approved in advance by the DDS area residential services program manager;

[iv] Companion's Companion's employment does not require on-call duties and occurs during the day the member is engaged in outside activities such as school, employment or other routine scheduled meaningful activities; and

[v] 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.

(B) If, after receiving approval for employment, authorized DDS staff determines the employment interferes with the care, training, or supervision needed by the member, the companion must terminate, within thirty (30) calendar days:

(i) his or her employment; or

(ii) his or her contract as an agency companion.

(C) Homemaker, habilitation training specialist, and respite services are not provided for the companion to maintain other employment.

(c) Each member may receive up to sixty (60) calendar days per year of therapeutic leave without reduction in the agency companion's payment.

1. Therapeutic leave:

(A) is a SoonerCare (Medicaid) payment made to the contract provider to enable the member to retain services; and

(B) is claimed when the:

(i) member does not receive ACS for twenty-four (24) consecutive hours due to:

(a) A visit with family or friends without the companion;

(b) vacation without the companion; or

(c) hospitalization, regardless of whether the companion is present; or

(ii) companion uses authorized respite time;

(C) is limited to no more than fourteen (14) consecutive, calendar days per event, not to exceed sixty (60) days per Program of Care (POC) year; and

(D) cannot be carried over from one (1) POC year to the next.

(2) The therapeutic leave daily rate is the same amount as the ACS per diem rate except for the per diem rate that is paid at the enhanced agency companion per diem rate.

(3) The provider agency pays the agency companion the payment he or she would earn if the member were not on therapeutic leave.

(d) The companion may receive a combination of hourly or daily respite per POC year equal to seven hundred and twenty (720) hours.

(e) Habilitation Training Specialist (HTS) services:

(1) may be approved by the DDS director or designee when providing ACS with additional support represents the most cost-effective placement for the member when there is an ongoing pattern of not:

(A) sleeping at night; or

(B) working or attending employment, educational, or day services;

(2) may be approved when a time-limited situation exists in which the companion provider is unable to provide ACS, and the provision of HTS will maintain the placement or provide needed stability for the member, and must be reduced when the situation changes;

(3) must be reviewed annually or more frequently as needed, which includes a change in agencies or individual companion providers; and

(4) must be documented by the Team and the Team must continue efforts to resolve the need for HTS.

(f) The contractor model does not include funding for the provider agency for the provision of benefits to the companion.

(g) The agency receives a daily rate based on the member's level of support. Levels of support for the member and corresponding payment are:

1. determined by authorized DDS staff per levels described in (A) through (D); and

2. re-evaluated when the member has a change in agency companion providers that includes a change in agencies or individual companion providers.
(A) **Intermittent level of support.** Intermittent level of support is authorized when the member requires minimal physical assistance with basic daily living skills, such as bathing, dressing, and eating;

(i) requires requires minimal physical assistance with basic daily living skills, such as bathing, dressing, and eating;

(ii) may May be able to spend short periods of time unsupervised inside and outside the home; and

(iii) requires requires assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities.

(B) **Close level of support.** Close level of support is authorized when the member requires the level of assistance outlined in (g)(2)(A) and at least two (2) of the following:

(i) regular Requires frequent and sometimes constant physical assistance and support to complete daily living skills, such as bathing, dressing, eating, and toileting;

(ii) extensive Extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities; and/or

(iii) assistance Assistance with health, medication, or behavior interventions 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 requires the level of assistance outlined in (g)(2)(B) and at least one (1) of the following:

(i) is Is totally dependent on others for:

(I) completion Completion of daily living skills, such as bathing, dressing, eating, and toileting; and

(II) medication Medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, and arranging transportation or other activities;

(ii) demonstrates Demonstrates ongoing complex medical issues requiring specialized training courses, per OAC 340:100-5-26; or

(iii) has Has behavioral issues that requires a protective intervention plan protocol (PIP) with a restrictive or intrusive procedure, per OAC 340:100-1.2. The PIP must:

(I) be Be approved by the Statewide Human Rights Behavior Review Committee (SBRC), (SHRBRC), per OAC 340:100-3-14; or

(II) be reviewed by the Human Rights Committee (HRC), per OAC 340:100-3-6, or

(iii) has Have received expedited approval, per OAC 340:100-5-57;

(iv) Meets the requirements of (g)(2)(C)(i) through (iv); and 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.

(D) **Pervasive level of support.** Pervasive level of support requires the level of assistance outlined in (g)(2)(C), and is authorized when the member:

(i) requires 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 By a licensed professional counselor (LPC) or professional with a minimum of Masters of Social Work (MSW) degree; and

(II) As As ongoing support and training to the companion, offering best practice approaches in dealing with specific members; and

(iii) Close Close as part of the ACS and not billed as a separate service. Waiver services may be authorized for the development of a PIP, per OAC 340:100-5-57; and

(ii) Does Does not have an available personal support system. The need for this service level:

(I) must Must be identified by the grand staffing committee, per OAC 340:75-8-40; and

(II) requires Requires the provider to market, recruit, screen, and train potential companions for the member identified.

(h) Authorization for payment of Agency Companion Services is contingent upon receipt of:

(1) the The applicant's approval letter authorizing ACS for the identified member;

(2) An An approved relief and emergency back-up plan addressing a back-up location and provider;

(3) the The Plan;

(4) the The POC; and

(5) the The date the member moved is scheduled to move to the companion's home. When a member transitions from a DDS placement funded by a interagency the incoming provider may request eight (8) hours of HTS for the first day of service.

(i) The Plan reflects the amount of room and board the member pays to the companion. The provider must use the room and board reimbursement payment to meet the member's needs. Items purchased with the room and board reimbursement payment include housing and food.

(j) If the amount exceeds $500, the additional amount must be:

(1) agreed upon by the member and, when applicable, legal guardian;

(2) recommended by the Team; and

(3) approved by the DDS area manager or designee. The room and board payment may include all but
one-hundred and fifty dollars ($150) per month of the service recipient's income, up to a maximum of ninety (90) percent of the current minimum Supplemental Security Income (SSI) payment for a single individual.

317:40-5-5. Agency Companion Services

(a) Companions are required to meet all applicable standards outlined in this subchapter and competency-based training per Oklahoma Administrative Code (OAC) 340:100-3-38. The provider agency ensures all companions meet the criteria in this Section.

(b) Failure to follow any rules or standards, failure to promote the independence of the member, or failure to follow recommendation(s) of the personal support team (Team) results in problem resolution, per OAC 340:100-3-27, for the companion, and when warranted, revocation of approval of the companion.

(c) The companion:

1. Ensures no other adult or child is cared for in the home on a regular or part-time basis, including other Oklahoma Department of Human Services (DHS) OKDHS) placements, family members, or friends without prior written authorization from the Developmental Disabilities Services - Division (DDS) area residential programs manager or designated state office residential services programs manager.

2. Meets the requirements of OAC 317:40-5-103. Neither the companion nor the provider agency may claim transportation reimbursement for vacation travel.

3. Transports or arranges transportation for the member to and from school, employment programs, recreational activities, medical appointments, and therapy appointments.

4. Delivers services in a manner that contributes to the member's enhanced independence, self-sufficiency, community inclusion, and well-being.

5. Participates as a member of the member's Team and assists in the development of the member's Individual Plan (Plan) for service provision.

6. Develops, implements, evaluates, and revises the training strategies corresponding to the relevant outcomes for which the companion is responsible, as identified in the Plan. The companion may request assistance from the case manager or program coordinator.

7. Delivers services at appropriate times as directed in the Plan.

8. Does not deliver services that duplicate the services mandated to be provided by the public school district pursuant to the Individuals with Disabilities Education Act (IDEA).

9. Is sensitive to and assists the member in participating in the member's chosen religious faith. No member is expected to attend any religious service against his or her wishes.

10. Participates in, and supports visitation and contact with the member's natural family, guardian, and friends, when visitation is desired by the member.

11. Obtains permission from the member's legal guardian, a guardian is assigned, and notifies the family, the provider agency program coordination staff, and the case manager prior to:

   A) traveling out of state; Traveling out-of-state;

   B) overnight visits; or

   C) involvement of the member in any publicity.

12. Serves as the member's health care coordinator, per OAC 340:100-5-26;

13. Ensures the monthly room and board contribution received from the member is used toward the cost of operating the household;

14. Assists the member in accessing entitlement programs for which the member may be eligible and maintains records required for the member's ongoing eligibility;

15. Works closely with the provider agency program coordination staff and the DDS case manager, to ensure all aspects of the member's program are implemented to the satisfaction of the member, the member's family or legal guardian, when appropriate, and the member's Team;

16. Assists the member to achieve the member's maximum level of independence;

17. Submits in a timely manner, to the provider agency program coordination staff all necessary information regarding the member;

18. Ensures the member's confidentiality is maintained per OAC 340:100-3-2;

19. Supports the member in forming and maintaining friendships with neighbors, co-workers, and peers, including people who do not have disabilities;

20. Implements training and provides supports that enable the member to actively join in community life;

21. Does not serve as representative payee for the member without a written exception from the DDS area residential services programs manager or designated state office residential services program manager.

(A) The written exception and approved DDS home profile are retained in the member's home record.

(B) When serving as payee, the companion complies with OAC 340:100-3-4 requirements;

22. Ensures the member’s funds are properly safeguarded;

23. Obtains prior approval from the member’s representative payee when making a purchase of over $50 fifty dollars ($50) with the member’s funds;

24. Allows provider agency and DDS staff to make announced and unannounced visits to the home;

25. Develops an Evacuation Plan, using DHS (OKDHS) Form 06AC200E, Evacuation/Escape Plan, for the home and conducts training with the member;
(26) Conducts fire and weather drills at least quarterly and documents the fire and weather drills using OKDHS Form 06AC021E, Fire and Weather Drill Record;
(27) develops and maintains a personal possession inventory for personal possessions and adaptive equipment, using OKDHS Form 06AC022E, Personal Possession Inventory;
(28) supports the member's employment program by:
   (A) assisting the member to wear appropriate work attire; and
   (B) contacting the member's employer as outlined by the Team and in the Plan;
(29) is responsible for the cost of the member's meals and entertainment during recreational and leisure activities. Activities must be affordable to the member. Concerns about affordability are presented to the Team for resolution;
(30) for adults, reports suspected maltreatment including abuse, verbal abuse, sexual abuse, neglect, financial neglect, and/or exploitation of a vulnerable adult per Section 10-104 of Title 43A of the Oklahoma Statutes, to the DHS/OKDHS Office of Client Advocacy (OCA);
(31) for children, reports abuse, neglect, sexual abuse, or sexual exploitation per Section 1-2-101 of Title 10A of the Oklahoma Statutes to the Child Abuse and Neglect Hotline at 1-800-522-3511;
(32) follows all applicable rules promulgated by the Oklahoma Health Care Authority and DDS, including:
   (A) OAC 340:100-3-40;
   (B) OAC 340:100-5-50 through 100-5-58;
   (C) OAC 340:100-5-26;
   (D) OAC 340:100-5-34;
   (E) OAC 340:100-5-32;
   (F) OAC 340:100-5-22.1;
   (G) OAC 340:100-5-27;
   (H) OAC 340:100-3-38; and
   (I) OAC 340:100-3-34;
   (A) OAC 340:100-3-27;
   (B) OAC 340:100-3-34;
   (C) OAC 340:100-3-38;
   (D) OAC 340:100-3-40;
   (E) OAC 340:100-5-22.1;
   (F) OAC 340:100-5-26;
   (G) OAC 340:100-5-32;
   (H) OAC 340:100-5-33; and
   (I) OAC 340:100-5-50 through 100-5-58.
(33) is neither the member's spouse, nor when the member is a minor child, the member's parent. A family member serving as companion must meet all requirements listed in this Subchapter; and
(34) is not the Chief Executive Officer of a provider agency.

PART 3. GUIDELINES TO STAFF

317:40-5-40. Home profile process 1 & 2
(a) Applicability. This Section establishes procedures for the Developmental Disabilities Services (DDS) home profile process. A home profile is required for:
   (1) agency companion services (ACS);
   (2) specialized foster care (SFC) services;
   (3) respite services delivered in the provider's home;
   (4) approving services in a home shared by a non-relative provider and a member; and
   (5) any other situation that requires a home profile.
(b) Pre-screening. Designated (DDS) DDS staff provides the applicant with program orientation and completes pre-screening information that includes, but inactivities to include, but are not limited to:
   (1) facts description, and guiding principles of the Home and Community-Based Services (HCBS) program;
   (2) An explanation of:
      (A) the home profile process;
      (B) basic provider qualifications;
      (C) health safety, and environmental issues; and
      (D) training required per Oklahoma Administrative Code (OAC) 340:100-3-38;
   (3) the Oklahoma Department of Human Services (DHS) Form 06AC012E, Specialized Foster Care/Agency Companion Services Information Sheet; Gathering relevant information about the family, including household members, addresses, and contact information, and motivation to provide services; and
   (4) explanation an explanation of a background investigation conducted on the applicant and any adult or child living in the applicant's home.
      (A) Background investigations are conducted at the time of application and include, but are not limited to:
         (i) An Oklahoma State Bureau of Investigation (OSBI) name and criminal records history search, including the Oklahoma Department of Public Safety (DPS), Sex Offender Registry and Mary Rippy Violent Offender Registry; and Nurse Aide and Non-technical Services Worker Registry;
         (ii) Federal Bureau of Investigation (FBI) national criminal history search, based on the fingerprints of the applicant and any adult members of the household; except when an exception is necessary as outlined below.
            (I) When fingerprints are low quality (as determined by OSBI, FBI, or both), make it impossible for the national crime information databases to provide results, a name-based search (state, national, or both) may be authorized.
            (II) When the DDS State Office residential staff request an exception from an individual, who has a severe physical condition precluding the individual from being fingerprinted,
of any involvement as a party in a court action; (iv) search of all DHS/DHSKDHSS records, including Child Welfare Services records, and the Community Services Worker Registry, and Restricted Registry; (v) a search of all applicable out-of-state child abuse and neglect registries for any applicant or adult household member who has not lived in Oklahoma continuously for the past five (5) years. A home is not approved without the results of the out-of-state—maintained—child abuse and neglect registry checks, when a registry is maintained in the applicable state, for all adult household members living in the home. When a child abuse and neglect registry is not maintained in the applicable state, a request for information is made to the applicable state; and (vi) a search of Juvenile Justice Information System (JOLTS) records for any child older than thirteen (13) years of age in the applicant’s household.

(B) An application is denied when the applicant or any person residing in the applicant’s home: (i) has has a criminal conviction of or pled guilty to: (I) physical assault, battery, or a drug-related offense in the five-year period preceding the application date; (II) child abuse or neglect; (III) domestic abuse; (IV) a crime against a child, including, but not limited to, child pornography; (V) a crime involving violence, including, but not limited to, rape, sexual assault, or homicide, including manslaughter, excluding physical assault and battery; or (ii) does not meet OAC 340:100-3-39 requirements;

(5) DHS Form 06AC015E, Agency Companion/Specialized Foster Care Employment Record;

(6) DHS Form 06AC016E, DDS Reference Information Waiver;

(7) DHS Form 06AC029E, Employer Reference Letter; and

(8) DHS Form 06AC013E, Pre-Screening for Specialized Foster Care/Agency Companion Services.

c Home profile process. When the applicant meets the requirements of the prescreening, the initial home profile process described in (1) through (8) of this subsection is initiated. (1) The applicant completes the required forms and returns them to the DDS address provided. Required forms include DHS forms providing required information for the completion of the home profile. (A) 06AC008E, Specialized Foster Care/Agency Companion Services Application; (B) 06AC009E, Financial Assessment; (C) 06AC011E, Family Health History; (D) 06AC018E, Self Study Questionnaire; (E) 06AC019E, Child’s Questionnaire; (F) 06AC010E, Medical Examination Report, when Form 06AC011E indicates conditions that may interfere with the provision of services; (G) 06AC017E, Insurance Information; and (H) 06AC020E, Evacuation/Escape Plan.

(2) When an incomplete form or other information is returned to DDS, designated DDS staff sends a letter to the provider or provider agency identifying information needed to complete the required forms. The home profile is not completed until all required information is provided to DDS.

(3) Designated DDS staff completes the home profile when all required forms are completed and provided to DDS.

(4) For each reference provided by the applicant, designated DDS staff completes DHS Form 06AC055E, Reference Letter, documents the results of each completed reference check.

(5) Designated DDS staff, through interviews, visits, and phone calls, gathers information required to complete DHS Form 06AC047E, Home Profile Notes the home profile.

(6) DHS Form 06AC069E, Review of Policies and Areas of Responsibilities, is dated and signed by the DDS staff review policies and areas of responsibilities with the applicant and acknowledgment is made in writing by the applicant and designated DDS staff.

(7) The DDS area residential services program manager sends to the applicant: (A) a provider approval letter confirming the applicant is approved to serve as a provider; or (B) a denial letter stating the application and home profile are denied.

(8) DDS staff records the dates of completion of each part of the home profile process.

d Home standards. In order to qualify and remain in compliance, the applicant’s or provider’s home must meet the provisions in (1) through (11) of this subsection.

(1) General conditions. (A) The home, buildings, and furnishings must be comfortable, clean, and in good repair and the grounds must be maintained. There must be no accumulation of garbage, debris, or rubbish or offensive odors.

(B) The home must: (i) be accessible to school, employment, church, day programming, recreational activities, health facilities, and other community resources as needed; (ii) have adequate heating, cooling and plumbing; and (iii) provide space for the member’s personal possessions and privacy;
(iv) **allow** adequate space for the recreational and social needs of the occupants.

(C) Provisions for the member’s safety must be present, including:

(i) **guards** and rails on stairways;

(ii) **wheelchair** wheelchair ramps;

(iii) widened doorways;

(iv) **grab bars**;

(v) **adequate lighting**;

(vi) **anti-scarf** Anti-scarf devices; and

(vii) **heat** and air conditioning equipment guarded and installed in accordance with manufacturer requirements. Home modifications and equipment may be provided through HCBS Waivers operated by DDS.

(D) Providers must not permit members to access or use swimming or other pools, hot tubs, saunas, ponds, or spas on the premises without supervision. Swimming pools, hot tubs, saunas, ponds, or spas must be equipped with sufficient safety barriers or devices designed to prevent accidental injury or unsupervised access.

(E) The household must be covered by homeowner’s or renter’s insurance including personal liability insurance.

(2) **Sanitation.**

(A) Sanitary facilities must be adequate and safe, including toilet and bathing facilities, water supply, and garbage and sewer disposal.

(B) When a septic tank or other non-municipal sewage disposal system is used, it must be in good working order.

(C) Garbage and refuse must be stored in readily cleanable containers, pending weekly removal.

(D) Sanitation for household pets and other domestic animals must be adequate to prevent health hazards.

(i) Proof of rabies or other vaccinations as required by a licensed veterinarian for household pets must be maintained on the premises.

(ii) Pets not confined in enclosures must be under control and not present a danger to members or guests.

(E) There must be adequate control of insects and rodents, including screens used for ventilation in good repair on doors and windows.

(F) Universal precautions for infection control must be followed in care to the member. Hands and other skin surfaces must be washed immediately and thoroughly when contaminated with blood or other body fluids.

(G) Laundry equipment, if in the home, must be located in a safe, well-ventilated, and clean area, with the dryer vented to the outside.

(3) **Bathrooms.** A bathroom must:

(A) **provide** for individual privacy and have a finished interior;

(B) be clean and free of objectionable odors; and

(C) have a bathtub or shower, flush toilet, and sink in good repair, and hot and cold water in sufficient supply to meet the member’s hygiene needs.

(i) A sink must be located near each toilet.

(ii) A toilet and sink must be provided on each floor where rooms of members who are non-ambulatory or with limited mobility are located.

(iii) There must be at least one **(1)** toilet, one **(1)** sink, and one **(1)** bathtub or shower for every six **(6)** household occupants, including the provider and family.

(4) **Bedrooms.** A bedroom must:

(A) have been constructed as such when the home was built or remodeled under permit;

(B) be provided for each member.

(i) Exception to allow members to share a bedroom may be made by DDS area residential program manager, when DDS determines sharing a bedroom is in the best interest of the member.

   Minor members must not share bedrooms with adults.

(ii) A member must not share a bedroom with more than one **(1)** other person;

(iii) Minor members must not share bedrooms with adults.

(C) have a minimum of **80** (80) square feet of usable floor space for each member or **120** (one-hundred and twenty) square feet for two **(2)** members and **two** **(2)** means of egress. The provider, family members, or other occupants of the home must not sleep in areas designated as common use living areas, nor share bedrooms with members;

(D) be finished with walls or partitions of standard construction that go from floor to ceiling;

(E) be adequately ventilated, heated, cooled, and lighted;

(F) include an individual bed for each member consisting of a frame, box spring, and mattress at least **36** (36) inches wide, unless a specialized bed is required to meet identified needs. Cots, rollaways, couches, futons, and folding beds must not be used for members.

(i) Each bed must have clean bedding in good condition consisting of a mattress pad, bedspread, **two** **(2)** sheets, pillow, pillowcase, and blankets adequate for the weather.

(ii) Sheets and pillowcases must be laundered at least weekly or more often if necessary.

(iii) Waterproof mattress covers must be used for members who are incontinent;

(G) have sufficient space for each member’s clothing and personal effects, including hygiene and grooming supplies.

(i) Members must be allowed to keep and use reasonable amounts of personal belongings and have private, secure storage space.

(ii) The provider assists the member in furnishing and decorating the member’s bedroom.
(iii) Window coverings must be in good condition and allow privacy for members;
(H) be on ground level for members with impaired mobility or who are non-ambulatory; and
(I) be in close enough proximity to the provider to alert the provider to nighttime needs or emergencies, or be equipped with a call bell or intercom an alert system.

(5) Food.
(A) Adequate storage must be available to maintain food at the proper temperature, including a properly working refrigerator. Food storage must be such that food is protected from dirt and contamination and maintained at proper temperatures to prevent spoilage. 
(B) Utensils, dishes, glassware, and food supplies must not be stored in bedrooms, bathrooms, or living areas.
(C) Utensils, dishes, and glassware must be washed and stored to prevent contamination.
(D) Food storage and preparation areas and equipment must be clean, free of offensive odors, and in good repair.

(6) Phone.
(A) A working phone must be provided in the home that is available and accessible for the member's use for incoming and outgoing calls.
(B) Phone numbers to the home and providers must be kept current and provided to DDS and, when applicable, the provider agency.

(7) Safety.
(A) Buildings must meet all applicable state building, mechanical, and housing codes.
(B) Heating, in accordance with manufacturer's specifications, and electrical equipment, including wood stoves, must be installed in accordance with all applicable fire and life safety codes. Such equipment must be used and maintained properly and in good repair.
(i) Protective glass screens or metal mesh curtains attached at top and bottom are required on fireplaces.
(ii) Unvented portable oil, gas, or kerosene heaters are prohibited.
(C) Extension cord wiring must not be used in place of permanent wiring.
(D) Hardware for all exit and interior doors must have an obvious method of operation that cannot be locked against egress.

(8) Emergencies.
(A) Working smoke detectors must be provided in each bedroom, adjacent hallways, and in two (2) story homes at the top of each stairway. Alarms must be equipped with a device that warns of low battery condition, when battery operated.
(B) At least one (1) working fire extinguisher must be in a readily accessible location.

(C) A working flashlight must be available for emergency lighting on each floor of the home.
(D) The provider:
(i) maintain Maintains a working carbon monoxide detector in the home;
(ii) maintain Maintains a written evacuation plan for the home and conducts training for evacuation with the member;
(iii) conducts Conducts fire drills quarterly and severe weather drills twice per year;
(iv) makes Makes fire and severe weather drill documentation available for review by DDS;
(v) has Has a written back-up plan for temporary housing in the event of an emergency; and
(vi) is responsible to re-establish a residence, if the home becomes uninhabitable.
(E) A first aid kit must be available in the home.
(F) The address of the home must be clearly visible from the street.

(9) Special hazards.
(A) Firearms and other dangerous weapons must be stored in a locked permanent enclosure. Ammunition must be stored in a separate locked location. Providers are prohibited from assisting members to obtain, possess, or use dangerous or deadly weapons, per OAC 340:100-5-22.1.
(B) Flammable and combustible liquids and hazardous materials must be safely and properly stored in original, properly labeled containers.
(C) Cleaning supplies, medical sharps containers, poisons, and insecticides must be properly stored in original, properly labeled containers in a safe area away from food, food preparation areas, dining areas, and medications.
(D) Illegal substances are not permitted on the premises.

(10) Vehicles.
(A) All vehicles used to transport members must meet local and state requirements for accessibility and safe transit, licensing, inspection, insurance, and capacity.
(B) Drivers of vehicles must have valid and appropriate driver licenses.

(11) Medication. Medication for the member is stored, per OAC 340:100-5-32.

(e) Evaluating the applicant and home. The initial home profile evaluation includes, but is not limited to:
(1) evaluating Evaluating the applicant's:
(A) interest Interest and motivation;
(B) life Life skills;
(C) children Children;
(D) methods Methods of behavior support and discipline;
(E) marital Marital status, background, and household composition;
(F) income Income and money management; and
(G) teamwork Teamwork and supervision, back-up plan, and use of relief; and
(2) **assessment Assessment** and recommendation. DDS staff:

(A) evaluates Evaluates the ability of the applicant to provide services;
(B) assesses Assesses the overall compatibility of the applicant and the service recipient, ensuring the lifestyles and personalities of each are compatible for the shared living arrangement. The applicant must:
   (i) express Express a long term commitment to the service member unless the applicant will only be providing respite services;
   (ii) demonstrate Demonstrate the skills to meet the individual needs of the member;
   (iii) express Express an understanding of the commitment required as a provider of services;
   (iv) express Express an understanding of the impact the arrangement will have on personal and family life;
   (v) demonstrate Demonstrate the ability to establish and maintain positive relationships, especially during stressful situations; and
   (vi) demonstrate Demonstrate the ability to work collaboratively and cooperatively with others in a team process;
(C) approves Approves only applicants who can fulfill the expectations of the role of service provider;
(D) when When the applicant does not meet standards, per OAC 317:40-5-40, ensures the final recommendation includes:
   (i) a A basis for the denial decision; and
   (ii) an An effective date for determining the applicant does not meet standards. Reasons for denying a request to be a provider may include, but are not limited to:
   (I) a A lack of stable, adequate income to meet the applicant's own or total family needs or poor management of the available income;
   (II) a A physical facility that is inadequate to accommodate the addition of a member to the home or presents health or safety concerns;
   (III) the The age, health, or any other condition of the applicant that impedes the applicant's ability to provide appropriate care for a member;
   (IV) relationships Relationships in the applicant's household that are unstable and unsatisfactory;
   (V) the The mental health of the applicant or other family or household member that impedes the applicant's ability to provide appropriate care for a member;
   (VI) references References who are guarded or have reservations in recommending the applicant;
   (VII) the The applicant failed to complete the application, required training, or verifications in a timely manner as requested or provided incomplete, inconsistent, or untruthful information;
   (VIII) the The home is determined unsuitable for the member requiring placement;
   (IX) confirmed Confirmed abuse, neglect, or exploitation of any person;
   (X) breach Breach of confidentiality;
   (XI) involvement Involvement of the applicant or provider involvement in criminal activity or criminal activity in the home;
   (XII) failure Failures to complete training, per OAC 340:100-3-38;
   (XIII) failure Failures of the home to meet standards per subsection (d) of this Section; and
   (XIV) failure Failures to follow applicable DHSOKDHS or Oklahoma Health Care Authority (OHCA) rules (OHCA) rules:
(E) notifies Notifies the applicant in writing of the final approval or denial of the home profile;
(F) when When an application is canceled or withdrawn prior to completion of the home profile, completes a final written assessment that includes the:
   (i) reason Reason the application was canceled or withdrawn; and
   (ii) DDS staff's impression of the applicant based on information obtained; and
   (iii) effective Effective date of cancellation or withdrawal. Written notice is sent to the applicant to confirm cancellation or withdrawal of the application, and a copy is included in local and State Office records.

(f) **Frequency of evaluation.** Home profile evaluations are completed for initial approval or denial of an applicant. After an initial approval, a home profile review is conducted annually and as needed for compliance and continued approval. DDS area residential services staff conduct at least biannual home visits to specialized foster care providers. The annual home profile review is a comprehensive review of the living arrangement, the provider's continued ability to meet standards, the needs of the member and the home to ensure ongoing compliance with home standards. A home profile review is conducted when a provider notifies DDS of his or her intent to move to a new residence. DDS staff assesses the home to ensure the new home meets home standards and is suitable to meet the member's needs. The annual home profile review:

(1) includes Includes information specifically related to the provider's home and is documented on DHS Form 06AC024E, Annual Review, as an annual review;
(2) includes form 06AC010E Medical Examination Report, includes a medical examination report completed a minimum of every three (3) years following the initial approval, unless medical circumstances warrant more frequent completion;
(3) includes Includes information from the DDS case manager, the provider of agency companion or SFC services, the Child Welfare specialist, Adult Protective Services, and Office of Client Advocacy staff, and the provider agency program coordinator when applicable.
(4) includes includes information from the service member indicating satisfaction with service and a desire to continue the arrangement;
(5) addresses includes areas of service where improvement is needed;
(6) includes includes areas of service where progress was noted or were of significant benefit to the member;
(7) ensures Ensures background investigation, per OAC 317:40-5-40(b), is repeated every year, except for the OSBI and FBI national criminal history search;
(8) ensures Ensures the FBI national criminal history search, per OAC 317:40-5-40(b)(4)(A)(ii) is repeated every five (5) years;
(9) includes Ensures written notification to providers and agencies, when applicable, of the continued approval of the provider.
(10) includes includes written notification to providers and agencies, when the provider or agency fails to comply with the home standards, per OAC 317:40-5-40 including deadlines for correction of the identified standards, and includes copies of DHS Forms 06AC0201E and, when applicable, 06AC0101E, in local and State Office records.

(g) Reasons a home profile review may be denied include, but are not limited to:

(1) Lack of stable, adequate income to meet the provider's own or total family needs or poor management of available income;
(2) A physical facility that is inadequate to accommodate the addition of a member to the home or presents health or safety concerns;
(3) The age, health, or any other condition of the provider that impedes the provider's ability to provide appropriate care for a member;
(4) Relationships in the provider's household that are unstable and unsatisfactory;
(5) The mental health of the provider or other family or household member impedes the provider's ability to provide appropriate care for a member;
(6) The provider fails to complete required training, or verifications in a timely manner as requested or provides incomplete, inconsistent, or untruthful information;
(7) The home is determined unsuitable for the member;
(8) Failure of the provider to complete tasks related to problem resolution, as agreed, per OAC 340:100-3-27;
(9) Failure of the provider to complete a plan of action, as agreed, per OAC 317:40-5-63;
(10) confirmed Confirmed abuse, neglect, or exploitation of any person;
(11) breach Breach of confidentiality;
(12) involvement Involvement of the applicant or provider involvement in the criminal activity or criminal activity in the home;
(13) Failure Failure to provide for the care and well-being of the service member;
(14) Failure or continued failure to implement the individual Plan, per OAC 340:100-5-50 through 100-5-58;
(15) Failure Failure to complete and maintain training, per OAC 340:100-3-38;
(16) Failure Failure to report changes in the household;
(17) Failure Failure to meet standards of the home per subsection (d) of this Section;
(18) Failure or continued failure to follow applicable DHS:OKDHS or OHCA rules;
(19) decline Decline of the provider's health to the point he or she can no longer meet the needs of the service member;
(20) employment Employment by the provider without prior approval of the DDS area programs manager for residential services; or
(21) domestic domestic disputes that cause emotional distress to the member.

(h) Termination of placement. When an existing placement is terminated for any reason:

(1) The Team meets to develop an orderly transition plan; and
(2) DDS staff ensures the property of the member and state is removed promptly and appropriately by the member or his or her designee.

PART 9. SERVICE PROVISIONS

317:40-5-100. Assistive technology (AT) devices and services
(a) Applicability. This Section applies to AT services and devices authorized by the Oklahoma Department of Human Services (DHS:OKDHS), Developmental Disabilities Services (DDS) through Home and Community Based Services (HCBS) Waivers.

(b) General information.

(1) AT devices include the purchase, rental, customization, maintenance, and repair of devices, controls, and appliances. AT devices include:
(A) visual Visual alarms;
(B) communication Telecommunication devices (TDDS);
(C) telephone Telephone amplifying devices;
(D) other Devices for the protection of health and safety of members who are deaf or hard of hearing;
(E) tape Tape recorders;
(F) talking Talking calculators;
(G) specialized Specialized lamps;
(H) magnifiers Magnifiers;
(I) braille Braille writers;
(J) braille Braille paper;
(K) talking Talking computerized devices;
(L) other Devices for the protection of health and safety of members who are blind or visually impaired;
(M) augmentative Augmentative and alternative communication devices including language board and electronic communication devices;
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(N) Competence-based cause and effect systems, such as switches;

(O) Mobility and positioning devices including:
   (i) Wheelchairs;
   (ii) Travel chairs;
   (iii) Walkers;
   (iv) Positioning systems;
   (v) Ramps;
   (vi) Seating systems;
   (vii) Stands;
   (viii) Lifts;
   (ix) Bathing equipment;
   (x) Specialty beds and positioning devices;
   (xi) Specialized chairs;

(P) Orthotic and prosthetic devices, including:
   (i) Braces;
   (ii) Prescribed modified shoes;
   (iii) Splints;

(Q) Environmental controls or devices;

(R) Items necessary for life support, and devices necessary for the proper functioning of such items, including durable and non-durable medical equipment not available through SoonerCare—Medicaid;

(S) Devices to protect the member's health and safety—can include, but are not limited to:
   (i) Motion sensors;
   (ii) Smoke and carbon monoxide alarms;
   (iii) Bed and/or chair sensors;
   (iv) Door and window sensors;
   (v) Pressure sensors in mats on the floor;
   (vi) Stove guards or oven shut off systems;
   (vii) Live web-based remote supports;
   (viii) Cameras;
   (ix) Automated medication dispenser systems;
   (x) Software to operate accessories included for environmental control;
   (xi) Software applications;
   (xii) Personal Emergency Response Systems (PERS) or Mobile;
   (xiii) Global positioning system (GPS) monitoring devices;
   (xiv) Radio frequency identification;
   (xv) Computers and tablets;
   (xvi) Any other device approved by the Developmental and Disabilities Services (DDS) director or designee;

(2) AT services include:
   (A) Sign language interpreter services for members who are deaf;
   (B) Reader services;
   (C) Auxiliary aids;
   (D) Training the member and provider in the use and maintenance of equipment and auxiliary aids;
   (E) Repair of AT devices;
   (F) Evaluation of the member's AT needs.

(3) AT devices and services must be included in the member's Individual Plan (IP), prescribed by a physician with a SoonerCare (Medicaid) contract, and arrangements for this HCBS service must be made through the member's case manager.

(4) AT devices are provided by vendors with a Durable Medical Equipment (DME) contract with the Oklahoma Health Care Authority (OHCA).

(5) AT devices and services are authorized in accordance with requirements of The Oklahoma Central Purchasing Act, other applicable statutory provisions, Oklahoma Administrative Code OAC 580:15 and DHS approved OKDHS approved purchasing procedures.

(6) AT services are provided by an appropriate professional services provider with a current HCBS contract with OHCA and current, unrestricted licensure and certification with their professional board, when applicable.

(7) AT devices or services may be authorized when the device or service:
   (A) has no utility apart from the needs of the person receiving services;
   (B) is not otherwise available through SoonerCare—Medicaid and an AT retrieval program, the Oklahoma Department of Rehabilitative Services, or any other third party or known community resource;
   (C) has no less expensive equivalent that meets the member's needs;
   (D) is not solely for family or staff convenience or preference;
   (E) is based on the assessment and Personal Support Team consideration of the member's unique needs;
   (F) is of direct medical or remedial benefit to the member;
   (G) enables the member to maintain, increase, or improve functional capabilities;
   (H) is supported by objective documentation included in a professional assessment, except as specified in OAC 317:40-5-100;
   (I) is within the scope of assistive technology
   (J) is the most appropriate and cost effective bid, if applicable;
   (K) exceeds a cost of $50-seventy-five dollars ($75) AT devices or services with a cost of $50-seventy-five dollars ($75) or less, are not authorized through DDS HCBS Waivers.

(8) The homeowner must sign a written agreement for any AT equipment that attaches to the home or property.

(e) Assessments. Assessments for AT devices or services are performed by a licensed professional service provider and reviewed by other providers whose services may be affected by
the type of device selected. A licensed, professional service provider must:

1. Determine if the member's identified outcome can be accomplished through the creative use of other resources, such as:
   - household items or toys;
   - equipment loan programs;
   - low technology devices or other less intrusive options; or
   - similar, more cost-effective device;

2. Recommend the most appropriate AT based on the member's:
   - present and future needs, especially for members with degenerative conditions;
   - history of use of similar AT, and his or her current ability to use the device currently and for at least the foreseeable future no less than 5 years;
   - outcomes;

3. Complete an assessment, including a decision making review and device trial that provides supporting documentation for purchase, rental, customization, or fabrication of an AT device. Supporting documentation must include:
   - a review of the device considered;
   - availability of the device rental with discussion of advantages and disadvantages;
   - how frequently, and in what situations the device will be used in daily activities and routines;
   - the features and specifications of the device necessary for the member, including rationale for why other alternatives are not available to meet the member's needs;

4. Upon DDS staff's request, provide a current, unedited videotape or picture or photograph of the member using the device, including the recorded trial time frames of the trials recorded, upon request by DDS staff.

5. Authorization of repairs, replacement of parts. Repairs to AT devices, or replacement of device parts, AT device repairs or parts replacements, do not require a professional assessment or recommendation. DDS area office resource development staff with assistive technology experience may authorize repairs and replacement of parts for previously recommended assistive technology AT.

6. Retrievals of assistive technology devices. AT device retrieval. When devices are no longer needed by a member, no longer needed an AT device, DDS OKDHS DDS staff may retrieve the device.

7. Team decision-making process. The member's Team reviews the licensed professional's assessment and decision-making review. The Team ensures the recommended AT:
   - is needed by the member to achieve a specific, identified functional outcome.

8. Functions, and in what situations the activity is meaningful to the member, occurs on a frequent basis, and would require assistance from others, if the member could not perform the activity independently, such as self-care, assistance with eating, or transfers.

9. Functional outcomes must be reasonable and necessary given a member's age, diagnosis, and abilities;

10. Allows the member receiving services to:
   - improve or maintain health and safety;
   - participate in community life;
   - express choices; or
   - participate in vocational training or employment;

11. Will be used frequently or in a variety of situations;

12. Will easily fit into the member's lifestyle and work place;

13. Is specific to the member's unique needs; and

14. Is not authorized solely for family or staff convenience.

(g) Requirements and standards for AT devices and service providers.

1. Providers guarantee devices, work, and materials for one (1) calendar year, and supply necessary follow-up evaluation to ensure optimum usability.

2. Providers ensure a licensed occupational therapist, physical therapist, speech therapist, or rehabilitation engineer evaluates the need for AT, and individually customizes AT devices as needed.

(h) Services not covered through AT devices and services.

1. Trampolines;
2. Hot tubs;
3. Bean bag chairs;
4. Recliners with lift capabilities;
5. Computers, except as adapted for individual needs as a primary means of oral communication approved, per OAC 317:40-5-100;
6. Massage tables;
7. Educational games and toys;
8. Generators.

(i) Approval or denial of AT.

1. DDS approval, conditional approval for pre-determined trial use, or denial of the purchase, rental, or lease of the AT is determined, per OAC 317:40-5-100.

   (A) The licensed professional's assessment and decision making review;
   (B) A copy of the Plan of Care (POC);
   (C) Documentation of the current Team consensus, including consideration of issues per OAC 317:40-5-100; and
   (D) Additional documentation to support the need for the AT device or service.
(2) The designated area---office AT-experienced resource development staff, with AT experience, approves or denies the AT request when the device costs less than $2,500-$5,000.

(3) The State Office programs manager for AT approves or denies the AT request when the device has a cost of $2,500-$5,000 or more.

(4) Authorization for purchase or a written denial is provided within 10 business days of receipt of a complete request;
   (A) If the AT is approved, a letter of authorization is issued;
   (B) If additional documentation is required by the area office AT-experienced resource development staff, with AT experience, to authorize the recommended AT, the request packet is returned to the case manager for completion;
   (C) When necessary, the case manager contacts the licensed professional to request the additional documentation;
   (D) The authorization of a $2,500 an AT device of $5,000 or more AT is completed per (2) of this subsection, except that, in the area office AT-experienced resource development staff with AT experience:
      (i) solicits three bids for the AT; Solicits three
      (3) AT bids;
      (ii) submits the AT request, bids, and other relevant information to the DDS State Office DDS AT programs manager or designee within five (5) business days of receipt of the required bids; and
      (iii) the State Office DDS AT programs manager or designee issues a letter of authorization, a written denial, or a request for additional information within five (5) business days of receipt of all required AT documentation for the AT.

(i) Approval of vehicle Vehicle approval adaptations. Vehicle adaptations are assessed and approved, per OAC 317:40-5-100. In addition, the requirements in (1) through (3) of this subsection must be met.
   (1) The vehicle to be adapted must be owned or in the process of being purchased by the member receiving services or his or her family, in order to be adapted.
   (2) The AT request must include a certified mechanic's statement that the vehicle and adaptations are mechanically sound.
   (3) Vehicle adaptations are limited to one vehicle in a 10 calendar year period per member. Authorization for more than one vehicle adaptation in a 10 year period must be approved by the DDS division administrator or designee.

(k) Denial AT denial. Procedures for denial of an AT device or service are described in (1) through (3) of this subsection.
   (1) The person denying the AT request provides a written denial to the case manager citing the reason for denial, per OAC 317:40-5-100.

(2) The case manager sends DHS FORM OAKDS Form 06MP004E, the Notice of Action, to the member and his or her family or guardian.

(3) Denial of AT service AT service denials may be appealed through the DHS OAKDS hearing process, per OAC 340:2-5.

(l) Return of an AT device returns. When, during a trial use period or rental of a device, the therapist or Team including the licensed professional when available, who recommended the AT, and when available, determines the device is not appropriate, the licensed professional sends a brief report describing the reason(s) for the change of device recommendation to the DDS case manager. The DDS case manager forwards the report to the designated area office resource development staff, who arranges for the return of the equipment return to the vendor or manufacturer.

(m) Rental of AT devices AT device rental. AT devices are rented when the licensed professional or area office AT-experienced resource development staff, with AT experience determines rental of the device is more cost effective than purchasing the device or the licensed professional recommends a trial period to determine if the device meets the member's needs.
   (1) The rental period begins on the date the manufacturer or vendor delivers the equipment to the member, unless otherwise stated in advance by the manufacturer or vendor.
   (2) Area office AT-experienced resource development staff, with AT experience monitor use of equipment during the rental agreement for:
      (A) cost effectiveness of the rental time frames; Rental time frame cost effectiveness;
      (B) conditions of renewal; and Renewal conditions;
      (C) the Team's, including the licensed professional's re-evaluation of the device, per OAC 317:40-5-100.

(3) Rental costs are applied toward the purchase price of the device whenever such when the option is available from the manufacturer or vendor.

(4) When a device is rented for a trial use trial-use period, the Team including the licensed professional, decides within 90 calendar ninety (90) calendar days whether the device:
      (A) the equipment meets the member's needs; and
      (B) to purchase the equipment or return it should be purchased or returned.

(n) Assistive Technology Committee AT committee. The AT committee reviews equipment requests when deemed necessary by the DHS OAKDS DDS State Office AT programs manager for AT.
   (1) The AT committee is comprised of:
      (A) DDS professional staff members of the appropriate therapy;
      (B) DDS AT State Office AT programs manager;
      (C) the DDS area manager, field administrator or designee; and
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(D) an AT expert, not employed by DHS.OKDHS.

(2) The AT committee performs a paper review, providing technical guidance, oversight, and consultation.

(3) The AT committee may endorse or recommend denial of a device or service, based on criteria provided in this Section. Any endorsement or denial includes a written rationale for the decision and, when necessary, an alternative solution, directed to the case manager within twenty (20) business days of the receipt of the request. Requests reviewed by the AT committee result in suspension of time frames specified, per OAC 317:40-5-100.

PART 11. OTHER COMMUNITY RESIDENTIAL SUPPORTS

317:40-5-152. Group home services for persons with an intellectual disability or certain persons with related conditions

(a) General Information. Group homes provide a congregate living arrangement offering up to twenty-four (24) hours per day supervision, supportive assistance, and training in daily living skills to persons who are eligible and eighteen (18) years of age or older. Upon approval of the Oklahoma Department of Human Services (DHS) Developmental Disabilities Services (DDS) director or designee, persons younger than eighteen (18) years of age 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 DHSOKDHS per 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 only be approved by the DDS director or designee:

(A) for a resident of a group home to resolve a temporary emergency when no other resolution exists; or

(B) for a resident of a community living group home when the resident's needs are so extensive that additional supports are needed for identified specific activities; and

(C) weekly average of fifty-six (56) hours of direct contact staff must be provided to the resident before HTS services may be approved.

(b) Minimum provider qualifications. Approved providers must have a current contract with the Oklahoma Health Care Authority (OHCA) to provide DDS Home and Community-Based Services (HCBS) for persons with an intellectual disability or related conditions.

(1) Group home providers must have a completed and approved application to provide DDS group home services.

(2) Group home staff must:

(A) complete the DHSOKDHS DDS-sanctioned training curriculum, per OAC 340:100-3-38; and

(B) fulfill requirements for pre-employment screening, per OAC Oklahoma Administrative Code (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 daily attendance form provided by DDS; and

(C) ensure program coordination staff (PCS) meet staff qualifications and supervise, guide, and oversee all aspects of group home services, per OAC 340:100-5-22.3 and 340:100-6, as applicable.

(d) Coverage limitations. Group home services are provided up to thirty-six hundred and sixty-six (366) days per year.

(e) Types of group home services. Three (3) types of group home services are provided through HCBS Waivers.

(1) Traditional group homes. Traditional group homes serve no more than twelve (12) members, per OAC 340:100-6.

(2) Community living homes. Community living homes serve no more than twelve (12) members.

(A) Members who receive community living home services:

(i) have needs that cannot be met in a less structured setting; and

(ii) require regular, frequent, and sometimes constant assistance and support to complete daily living skills, such as bathing, dressing, eating, and toileting; or

(iii) require supervision and training in appropriate social and interactive skills, due to ongoing behavioral issues to remain included in the community.
(B) Services offered in a community living home include:
   (i) 24-hour 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 when the member has had a change in health status or behavior and meets the requirements to receive community living home services. Requests to receive community living home services are sent to the DDS Community Services Residential Unit.

(3) Alternative group homes. Alternative group homes serve no more than four (4) members who have evidence of behavioral or emotional challenges in addition to an intellectual disability 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 DDS Community Services Unit director or designee that alternative group home services are appropriate.

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

317:40-7-11. Stabilization Services

Stabilization Services are ongoing support services needed to maintain a member in an integrated competitive employment site. Stabilization Services are provided for up to two (2) years per job. Stabilization Services continue until the next Plan of Care following the end of two (2) years of Stabilization Services.

(1) Stabilization Services are provided when the job coach intervention time required at the job site is 20 per cent (20%) or less of the member’s total work hours for four (4) consecutive weeks or when the member moved from Department of Rehabilitation Services (DRS) services.

   (A) If, after the member moves to Stabilization Services the Team determines that support is needed above 20 percent (20%) for longer than two (2) weeks, the Team may revise the member’s Plan of Care to reflect the need for Job Coaching Services.
   (B) A member receiving services from DRS moves to services funded by DSS upon completion of the Job Stabilization milestone. The employment provider agency submits the request for transfer of funding during the Job Stabilization milestone as described in the DRS Supported Employment contract.

   (2) Stabilization Services must:

   (A) identify the supports needed, including development of natural supports;
   (B) specify, in a measurable manner, the services to be provided.

(3) Reimbursement for Stabilization Services is based upon the number of hours the member is employed at a rate of minimum wage or above.

(4) If the member needs job coach services after the expiration of Stabilization Services, Employment Training Specialist Services may be authorized for the hours necessary to provide direct support to the member or consultation to the employer as described in outcomes and methods in the Individual Plan. Stabilization Services may be authorized through remote supports per a Health Insurance Portability and Accountability Act (HIPAA) compliant technology, when the Team has an approved remote supports risk assessment.

(5) If the member needs job coach services after the expiration of Stabilization Services, Employment Training Specialist Services may be authorized for the hours necessary to provide direct support to the member or consultation to the employer as described in outcomes and methods in the Individual Plan.

[OAR Docket #21-407; filed 6-14-21]

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

[OAR Docket #21-411]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 5. Member Services
317:40-5-104 [AMENDED] (Reference APA WF # 20-06C)

AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board; Section 6407 of the Affordable Care Act; Section 504 of the Medicare Access and CHIP Reauthorization Act of 2015; CMS-2348-F Final Rule; Public Law 114-10; 42 Code of Federal Regulations (C.F.R.) Section 440.70; and 42 C.F.R. Section 440.120

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INCORPORATIONS BY REFERENCE:
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GIST/ANALYSIS:
The proposed revisions will comply with the Home Health final rule in
which the DME and supplies benefit was revised from an optional benefit to
a mandatory benefit and was made subject to the scope of the home health
benefit. Durable medical equipment was changed to medical supplies,
equipment and appliances to match language in federal regulation.
CONTACT PERSON:
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Sandra.Puebla@okhca.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN,
THE FOLLOWING RULES ARE CONSIDERED
FINALLY ADOPTED AS SET FORTH IN 75 O.S.,
SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE
DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 5. MEMBER SERVICES

PART 9. SERVICE PROVISIONS

317:40-5-104. Specialized medical supplies
(a) Applicability. The rules in this section apply to specialized medical supplies, equipment, and appliances provided through Home and Community Based Services (HCBS) Waivers and community-based waiver services (HCBS) operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDS-DDS).

(b) General information. Specialized medical supplies, equipment, and appliances include supplies and services that may be provided in the plan of care that enable the member to increase his or her ability to perform activities of daily living. Specialized medical supplies, equipment, and appliances include the purchase of ancillary or additional supplies not available through SoonerCare.

(c) Limited coverage. Items available in limited quantities through specialized medical supplies, equipment, and appliances include:

(1) Incontinence wipes, three-hundred (300) wipes per month;

(2) Thirty-six hundred (3,600) individual non-sterile gloves, as approved by the Teamper plan year;

(3) Sixty (60) disposable underpads, 60 pads per month; and

(4) Specialized medical supplies, equipment, and appliances meet the criteria for service necessity given in OAC 340:100-3-33.1, per Oklahoma Administrative Code (OAC) 340:100-3-33.1.

(5) All items must meet applicable standards of manufacture, design, and installation.

Specialized medical supplies, equipment, and appliance providers must hold a current SoonerCare Durable Medical Equipment (DME) and/or Medical Supplies Provider Agreement with the Oklahoma Health Care Authority, and be registered to do business in Oklahoma or in 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.

(6) Items that can be purchased as specialized medical supplies, equipment, and appliances include:

(A) incontinence supplies, as described in subsection (b) of this Section;

(B) nutritional supplements; and

(C) supplies for respirator or ventilator care;

(D) decubitis care supplies;

(E) supplies for catheterization; and

(F) supplies needed for health conditions.

(7) Specialized medical supplies, equipment, and appliances must be:

(A) necessary to address a medical condition;

(B) of direct medical or remedial benefit to the 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.
(4) Incontinence briefs, 180 briefs per month. One-hundred eighty (180) disposable incontinence briefs per month. (Adult disposable incontinence briefs are purchased only in accordance with the implementation of elimination guidelines developed by the Team);

(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 member has a medical condition that precludes implementation of elimination guidelines, such as atomic bladder, neurogenic bladder, or following a surgical procedure.

(5) One-hundred fifty (150) disposable incontinence underwear/pull-ons per month. (Adult disposable incontinence underwear/pull-ons are purchased only in accordance with the implementation of elimination guidelines developed by the Team);

(6) Any combination of disposable incontinence briefs and disposable incontinence underwear/pull-ons that do not exceed one-hundred fifty (150) per month; and

(7) One-hundred fifty (150) disposable liner/shield/guard/pads per month.

(d) Exceptions. Exceptions to the requirements of this Section are explained in this subsection.

(1) When a member's Team determines that the member needs medical supplies that:

(A) are not available through SoonerCare and for which no Health Care Procedure Code exists, the case manager documents pertinent information regarding the member's medical supply need to the Specialized Medical Supplies programs manager responsible for Specialized Medical Supplies. The document 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(c) of this Section, the case manager documents the need in the Individual Plan for review and approval per OAC 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 medical supplies, equipment, and appliances exception does not exceed one (1) plan of care year.

[OAR Docket #21-411; filed 6-14-21]


Permanent Final Adoptions

FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

317:40-7-7. Job coaching services
(a) Job coaching services:
   (1) Are pre-planned, documented activities related to the member's identified employment outcomes that include training at the work site and support by provider agency staff who have completed DDSD Developmental Disabilities Services (DDS) sanctioned training, per 317:40-7-15(b); and
   (2) promote the member's capacity to secure and maintain integrated employment at a job of the member's choice paying at or more than minimum wage, or working to achieve minimum wage;
   (3) provide active participation in paid work. Efforts are made in cooperation with employers to adapt normal work environments to fit the needs of members through the maintenance of an active relationship with the business;
   (4) are available for individual and group placements.

   (A) Individual placement is:
      (i) one (1) member receiving job coaching services who:
         (I) works in an integrated job setting;
         (II) is paid at or more than minimum wage;
         (III) does not receive services from a job coach who is simultaneously responsible for continuous job coaching for a group;
         (IV) is employed by a community employer or provider agency; and
         (V) has a job description that is specific to the member's work and;
      (ii) authorized when on-site supports by a certified job coach are provided more than 20% of the member's compensable work time. Job coaching services rate continues until a member reaches 20% or less job coach intervention for four (4) consecutive weeks, at which time stabilization services begin and;
      (iii) Authorized through remote supports per Health Insurance Portability and Accountability Act (HIPAA) compliant technology, when the Personal Support Team (Team) has an approved remote supports risk assessment.

   (B) Group placement is two to eight members receiving continuous support in an integrated work site who may earn less than minimum wage:
      (i) Two (2) to three (3) members receiving continuous support in an integrated work site who are paid at, or more than, minimum wage; or
      (ii) Up to four (4) to five (5) members receiving continuous support in an integrated work site, who may earn less than minimum wage.

   (5) are based on the amount of time for which the member is compensated by the employer, except per OAC 317:40-7-11.

(b) For members in individual placements, the Personal Support Team (Team) Team:
   (1) evaluates the need for job coaching services at least annually; and
   (2) documents a plan for fading job coaching services as the member's independence increases.

(c) When the member receives commensurate compensation, employment goals include, but are not limited to, increasing:
   (1) productivity;
   (2) work quality;
   (3) independence;
   (4) minimum wage opportunities; and
   (5) competitive work opportunities.

317:40-7-15. Service requirements for employment services through Home and Community-Based Services (HCBS) Waivers
(a) The Oklahoma Department of Human Services (DHS) Developmental Disabilities Services (DDS) case manager, the member, the member's family or, when applicable, the member's legal guardian, and the member's provider develop a preliminary plan of services including the:
   (1) site and amount of the services offered;
   (2) types of services to be delivered; and
   (3) expected outcomes.

(b) To promote community integration and inclusion, employment services are delivered in non-residential sites.
   (1) Employment services through HCBS waivers cannot be reimbursed when those services occur in the residence or property of the member or provider-paid staff, including garages and sheds, whether or not the garage or shed is attached to the home or not.
   (2) No exceptions to Oklahoma Administrative Code (OAC) 317:40-7-15(b) are authorized except when a home-based business is established and supported through the Oklahoma Department of Rehabilitation Services (OKDRS) (DRS). Once OKDRS stabilization services end, DDS stabilization services are then utilized.

(c) The service provider is required to notify the DDS case manager in writing when the member:
   (1) is placed in a new job;
(2) loses his or her job. A personal support team (Team) meeting must be held when the member loses the job;
(3) experiences significant changes in the community-based or employment schedule; or
(4) is involved in critical and non-critical incidents per OAC 340:100-3-34.

(d) The provider submits a DHS Provider Progress Report, per OAC 340:100-5-52, for each member receiving services.
(e) The cost of a member's employment services, excluding transportation and state-funded services per OAC 340:100-17-30, cannot exceed $27,000 limits set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule, per Plan of Care (POC) year.
(f) Each member receiving HCBS is supported in opportunities to seek employment and work in competitive integrated settings. When the member is not employed in a competitive integrated job, the Team identifies outcomes and/or action steps, or both, to create opportunities that move the member toward competitive integrated employment.

(g) Each member receiving residential supports, per OAC 340:100-5-22.1, or group-home services is employed for thirty (30) hours per week or receives a minimum of thirty (30) hours of employment services each week, excluding transportation to and from his or her residence.

(1) Thirty (30) hours of employment service each week may be a combination of community-based services, center-based services, employment training specialist (ETS) intensive training services, stabilization services, or job coaching services. Center-based services cannot exceed fifteen (15) hours per week for members receiving services through the Homeward Bound Waiver.

(2) When the member does not participate in thirty (30) hours per week of employment services, the Team:
(A) documents the outcomes and/or action steps to create a pathway that moves toward employment activities;
(B) describes a plan to provide a meaningful day in the community;
(C) increases the member's employment activities to thirty (30) hours per week.

(h) Adult members receiving In-Home Supports waiver services can access individual placement in job coaching, stabilization, and employment training specialist services not to exceed limits specified in OKDHS Appendix D-26, per POC year.

[OAR Docket #21-412; filed 6-14-21]
Permanent Final Adoptions

SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-14. Description of services

Services included in the Medically Fragile Waiver program are as follows:

(1) Case Management.

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility. Case managers develop the member's comprehensive service plan, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate service plan reviews. If a member requires hospital or skilled nursing facility (NF) services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case managers must meet Medically Fragile Waiver program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to self-direct their services, case managers are required to receive training and demonstrate knowledge regarding the self-directed service delivery model.

(B) Providers may only claim time for billable case management activities described as follows:

(i) A billable case management activity is any task or function defined under OAC Oklahoma Administrative Code (OAC) 317:50-1-15(1)(A)_ that only a Medically Fragile case manager because of skill, training, or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time, or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities. Payment is not allowed for written reports or record documentation.

(C) Case Management services are prior authorized and billed per fifteen-minute fifteen

(15) minute unit of service using the rate associated with the location of residence of the member served.

(i) Standard rate: Case Management services are billed using a standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than twenty-five (25) persons per square mile.

(ii) Very rural/difficult service area rate: Case management services are billed using a very rural/difficult/outside providers' service rate for billable service activities provided to a member who resides in a county with population density equal to or less than twenty-five (25) persons per square mile. An exception would be services to members that reside in zip codes in Osage county.

(iii) The latest United States Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than twenty-five (25) persons per square mile, or resides in a county with a population density greater than twenty-five (25) persons per square mile.

(D) Case managers providing case management services to Medically Fragile waiver members must submit monthly monitoring case notes on a monthly basis to the OHCA Medically Fragile Waiver staff.

(E) Providers of Home and Community-Based Services (Community-Based waiver services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

(2) Institutional transitional case management.

(A) Institutional Transition case management services are required by the member's service plan, which are necessary to ensure the health, welfare, and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.

(B) Institutional transition case management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, and other services to assist the transition, regardless of the funding source for the services which access is gained.
(C) Institutional transition case management services may be authorized for periodic monitoring of a waiver member's progress during an institutional stay, and for assisting the member's transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution.

(3) Respite.

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven (7) hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the service plan when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the service plan.

(B) In-Home Respite: In-home respite services are billed per fifteen (15) minute unit service. Within any one day, one (1) day period, a minimum of eight (8) units must be provided with a maximum of twenty-eight (28) units provided. The service is provided in the member's home.

(C) Facility-Based Extended Respite: Facility-based extended respite is billed per diem rate, if provided in Nursing Facility. Extended Respite services must be at least eight (8) hours in duration.

(D) In-Home Extended Respite: Respite services are billed per diem rate. A minimum of eight (8) hours must be provided in the member's home.

(4) Environmental Modifications.

(A) Environmental modifications are physical adaptations to the home, required by the member's service plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the Waiver member are excluded.

(B) All services require prior authorization.

(C) All services shall be provided in accordance with applicable state and local building codes and conform to the Americans with Disabilities Act Accessibility Guidelines, Title 28 of the Code of Federal Regulations Part 36 Appendix A.

(D) Payment for these services is made on an individual basis following a uniform process approved by the Medicaid agency.

(5) Specialized Medical Equipment and Supplies.

(A) Specialized medical equipment and supplies are devices, controls, or appliances. Medical supplies, equipment, and supplies are specified in the service plan, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and supplies not available under the Medicaid State Plan. This service excludes any equipment and or supply items which are not of direct medical or remedial benefit to the Waiver member. This service is necessary to prevent institutionalization.

(B) Specialized medical equipment and supplies are billed using the appropriate HCPCS healthcare common procedure code. Recurring supplies which are shipped to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled nursing facility, or other type of care.

(6) Advanced Supportive/Restorative Assistance.

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance services are billed per fifteen (15) minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the service plan.

(7) Nursing.

(A) Nursing services are services listed in the service plan which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational...
nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the service plan. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the Medically Fragile Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced support/rehabilitative care member.

(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:
(I) the member's general health, functional ability and needs and/or
(II) the adequacy of personal care and/or advanced support/rehabilitative care services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced support/rehabilitative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the case manager may recommend authorization of Skilled Nursing services for the following:
(I) preparing a one (1) week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;
(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;
(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;
(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;
(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per fifteeen (15) minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight (8) units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) Home Delivered Meals.

(A) Home Delivered Meals provide one (1) meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third (1/3) of the recommended daily allowance as established by the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.
(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's service plan. The
provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(9)  **Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B)  Occupational Therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(10)  **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(11)  **Speech and Language Therapy services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B)  Speech/Language Therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(12)  **Respiratory Therapy Services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes
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education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Respiratory Therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(13) **Hospice Services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six (6) months or less to live and orders hospice care. Medically Fragile Waiver hospice care is authorized for a six (6) month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty (30) days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of sixty (60) days increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Medically Fragile Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any thirty (30) day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Medically Fragile hospice services.

(C) Hospice services are billed per diem of service for days covered by a hospice plan of care and during which the hospice provider is responsible for providing hospice services as needed by the member or member's family.

(14) **Personal Care.**

(A) Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) Medically Fragile Home Care Agency Skilled Nursing staff working in coordination with a case manager are responsible for development and monitoring of the member's Personal Care plan.

(C) Personal Care services are prior authorized and billed per fifteen (15) minute unit of service with units of service limited to the number of units on the approved service plan.

(15) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a help button is activated. The response center is staffed by trained professionals. For an Medically Fragile program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

(i) A recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;

(ii) Lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) Demonstrates capability to comprehend the purpose of and activate the PERS;
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(iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;
(v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,
(vi) the service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate health care procedure codes for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the Medically Fragile approved service plan.

(16) Prescription drugs. Members are eligible for a maximum of six (6) prescriptions per month with a limit of three (3) brand-name prescriptions. Seven (7) additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three (3) brand-name or thirteen (13) total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at OAC 317:30-5-72.

(17) Self-Direction.

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved service plan prior to initiation of any Self-Directed activities.

(B) The OHCA uses the following criteria to determine a member's eligibility to participate in the Self-Directed option:

(i) The member does not have an existing need for Self-Directed services to prevent institutionalization;
(ii) The member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;
(I) The member does not have the ability to make decisions about his/her care or service planning and the member's authorized representative is not willing to assume Self-Directed services responsibilities; or
(II) The member is not willing to assume responsibility, or to enlist an authorized representative to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Care Assistant (PCA) or Advanced Supportive/Restorative (ASR) service provider, or in monitoring and managing health or in preparation for emergency backup;

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the case manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their Personal Care Assistant (PCA).

The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer able to participate in the Self-Directed services option:

(i) The member does not have the ability to make decisions about his/her care or service planning and the member's authorized representative is not willing to assume Self-Direction responsibilities; or
(ii) The member is not willing to assume responsibility, or to enlist an authorized representative to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PCA or ASR service providers, or in monitoring and managing health or in preparation for emergency backup;

(iii) The member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past twelve (12) months and does not have an authorized representative with capacity to assist with Self-Direction responsibilities;

(iv) The member abuses or exploits their employee;

(v) The member falsifies time-sheets or other work records;

(vi) The member, even with case manager and financial management services assistance, is unable to operate successfully within their Individual Budget Allocation (IBA); or

(vii) Inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member

August 16, 2021
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requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's case manager or the OHCA staff.

(i) A person having guardianship or legal power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Respite and Advanced Supportive/Restorative Care. The member employs the Respitecare, or PCA and/or the ASR provider and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with state and federal labor law requirements. The member:

(i) recruits, hires and, as necessary, discharges the PCA and ASR;

(ii) provides instruction and training to the PCA or ASR on tasks to be done and works with the case manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an ASR provider task for the first time, the ASR must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ASR provider personnel file;

(iii) determines where and how the PCA or ASR works, hours of work, what is to be accomplished and, within IBA limits, wages to be paid for the work;

(iv) supervises and documents employee work time; and,

(v) provides tools and materials for work to be accomplished.

(G) FMS are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. FMS are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PCA or ASR provider;

(ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's IBA;

(iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PCA or ASR provider;

(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with IBA planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's respite or PCA or ASR provider; and

(H) The service of Respite or PCA is billed per fifteen (15) minute unit of service. The number of units of PCA a member may receive is limited to the number of units approved on the Service Plan.

(I) ASR services are billed per fifteen (15) minute unit of service. The number of units of ASR a member may receive is limited to the number of units approved on the Service Plan.

(J) Self-Directed Services rates are determined using the IBA expenditure accounts determination process for each member. The IBA expenditure accounts determination process includes consideration and decisions about the following:

(i) The IBA expenditure accounts determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PCA and ASR service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The allocation of portions of the PCA and/or ASR rate to cover salary, mandatory taxes, and optional benefits (including worker's compensation insurance, if available) is determined individually for each member using the Self-Directed services IBA expenditure accounts determination process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed 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, the case manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, 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 PCA or ASR rate. The member, with assistance from the FMS, reviews and revises the IBA expenditure account calculation annually or more often to the extent appropriate and necessary.

18 Self-Directed Goods and Services (SD-GS).
(A) Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's service plan.
(B) These goods and services are purchased from the self-directed budget. All goods and services must be approved by the Medically Fragile waiver staff. Documentation must be available upon request.

19 Transitional case management.
(A) Transitional case management are one-time billable expenses for members who transition from within the community to the Medically Fragile waiver.
(B) Transitional case management must be reasonable and necessary as determined through the transition plan development process and must be clearly identified in the plan.
(C) Transitional case management assist members that are eligible to receive waiver services in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, and other services to assist the transition, regardless of the funding source for the services which access is gained.
(D) Transitional case management may be authorized for assisting the member transition to the Medically Fragile Waiver by updating the service plan, including preparing for necessary services and supports to be in place or to start on the date the member is effective with the waiver.

OAR Docket #21-412; filed 6-14-21]

TITLE 320. OKLAHOMA HISTORICAL SOCIETY
CHAPTER 15. OKLAHOMA HERITAGE PRESERVATION GRANT PROGRAM

[OAR Docket #21-465]

AUTHORITY:
Oklahoma Historical Society; 53 O.S. Section 411-417

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
March 26, 2021

COMMENT PERIOD:
February 16, 2021, though March 18, 2021

PUBLIC HEARING:
March 18, 2021

ADOPTION:
March 20, 2021

SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:
March 26, 2021

LEGISLATIVE APPROVAL:
Approved June 11, 2021, by HJR 1046

FINAL ADOPTION:
June 11, 2021

EFFECTIVE:
August 26, 2021

SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
The Oklahoma Heritage Preservation Grant Program provides financial assistance to cities, counties, nonprofit organizations, and tribal governments to operate and improve the effectiveness of museums and historical organizations. The purpose of the Heritage Preservation Grant Program is to encourage the collecting, preserving, and sharing of Oklahoma history. Following the completion of the 2nd cycle of grant applications it was identified that clarification and modification should be made to definitions, eligibility requirements and eligible projects and expenses. These changes are intended to create better definitions for terms used in the rules, and make a clearer determination of ineligible and eligible expenses.

CONTACT PERSON:
Nicole Harvey, Director of Strategic Initiatives, Oklahoma Historical Society, 800 Nazih Zuhdi Drive, Oklahoma City, OK 73105, 405-522-5202, Nharvey@okhistory.org

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS

320:15-1-3. Definitions
The following words and terms, when used in this chapter, shall have the following meaning, unless the context clearly indicates otherwise:
"Administrative Rules Liaison" means or refers to the OHS staff member that has been designated by the OHS Executive Director to serve as the liaison to the Office of Administrative Rules (OAR) in the Oklahoma Secretary of State's Office. They shall act as liaison between the OHS and the OAR in all matters concerning documents submitted by the OHS. All documents submitted by the OHS shall be coordinated through the liaison, and require the verification and signature of the liaison.

"Authorizing official" means or refers to the individual authorized on behalf of the institution to approve the submission of proposals and accept any resulting project grants or contracts.
"Capital Improvement" means or refers to a durable upgrade, adaptation, or enhancement of a property that increases its value, often involving a structural change. Provided, however, it does not include any improvements to items in collections, or collections care, nor any modification or improvements made to exhibits or installing exhibits.

"Cash match" means or refers to the money that the applicant organization will provide toward the project. This money can be from a number of sources, examples include: general operations, donation, or a fundraiser. Cash match would not include the salary of a staff member already working for the applicant organization. Matching funds must be expended after the grant contract is signed.

"Collections" means or refers to the objects, photographs, manuscripts, videos, audio recordings, maps, periodicals, microforms, books, vertical files, archaeological material, historic buildings, or oral histories under the care of an institution.

"Conserved" means or refers to the act of stabilizing or protecting an artifact or archival collection.

"County government" means or refers to Oklahoma county governments as defined in Oklahoma law.

"Exhibits" means or refers to the public display either physical or online of collections with contextual interpretation informing the public on the topic being explored.

"Historic Buildings" means or refers a structure listed or eligible for listing on the National Register of Historic Places.

"Indirect costs" means or refers to an organization's overhead, administrative, or other expenses not directly related to the project and also possibly supporting other projects or functions. An example of this would be another division of the applicant organization managing the financial aspects of the grant and wanting a percentage of the grant funds to pay for the financial overhead costs incurred.

"Key staff" means or refers to the staff member(s) or individual(s) who will play a major role in the proposed project.

"Libraries with special collection(s)" means or refers to historical collections held by libraries that may include anything other than published books.

"Major component" means or refers to the mission of the institution and the inclusion of Oklahoma history.

"Municipal government" means or refers to Oklahoma municipalities as defined in Oklahoma law.

"Not-for-profit historical organization" means or refers to museums, historic sites, historical associations, archives, libraries with special collections, or genealogical associations. These organizations must be located in the state of Oklahoma, be registered and in good standing with the Oklahoma Secretary of State as a domestic not for profit, and feature Oklahoma history as a major component of their mission.

"OHS" means or refers to the Oklahoma Historical Society.

"OHS project teams" means or refers to employees or volunteers under the jurisdiction of the Oklahoma Historical Society who may serve as consultants or contractors to the grant recipient to accomplish all or part of an awarded project.

"OHS staff review committee" means or refers to the OHS staff members selected by the OHS Executive Director who will evaluate applications based on the weighted criteria and adherence to program requirements. The OHS Grants Administrator is excluded from appointment to this committee and has no grant decision making power.

"Oklahoma Heritage Preservation Grant Review Committee" means or refers to the committee appointed by the Oklahoma Historical Society Board President and confirmed by the Oklahoma Historical Society Board of Directors. As authorized by 53 O.S. Section 416(a) this committee will be made up of no less than five (5) and no more than seven (7) individuals.

"Oklahoma Historical Society Board of Directors" means or refers to the governing body of the Oklahoma Historical Society as authorized by 53 O.S. Section 1.6.

"Operating budget" means or refers to the most recent operating budget approved for the applicant organization. This budget shall include staff salaries but exclude non-recurring costs. Applicants of tribal or municipal governments may use the operating budget of the division in which the project will take place. If an applicant organization is a sub-entity of tribal or municipal government but is a historical organization (museum, historic site, historical association, archive, library with special collection or genealogical association) they will use the sub-entity's operating budget. Support organizations must use the operating budget of the primary beneficiary of the grant funds, regardless of the funding source of that operating budget. Libraries with special collections may use the operating budget allotted to special collections. An example of this would be a city government applying for a grant to digitize historic maps. This applicant would use the operating budget for the division which oversees archives, not the entire budget of the city government.

"Programs" means or refers to organized educational activities available to the public. Examples of this might include a tour, lecture series, or workshop.

"Project" means or refers to an inclusive term to convey any eligible proposal.

"Publications" means or refers to publishing content of an educational nature in print or electronic form. For this purpose, publications would not include paid advertisements or invitation cards.

"Repair" means or refers to fix or mend a thing suffering from damage or fault, or refers to fixing or repairing of facilities, not the repair of items in collections.

"Strategic plan" means or refers to an organization's process of defining its strategy, or direction, and making decisions on allocating its resources to pursue this strategy. The applicant organization's strategic plan should address the following: organization's mission statement, long-range planning, major issues and opportunities facing the organization, and an action plan for accomplishing goals.

"Support groups" means or refers to a not-for-profit organization whose purpose is to support the mission and provide financial support to the applicant organization. This term could also include friend's groups or foundations. An example of this would be a library operated by an institute of higher learning having a friend's group that supports the organization through applying for grants, receiving and managing donations, or hosting donor events.
"Theme" means or refers to broad categories of Oklahoma history such as "American Indian," "Transportation," or "Military."

"Third-party consultant" means or refers to a contracted third party who conducts work for the grant recipient as it relates to the project grant funds awarded.

"Tribal government" means or refers to federally recognized American Indian tribes located in Oklahoma.

SUBCHAPTER 2. GRANT APPLICATIONS

320:15-2-1. Eligibility
(a) Eligible Entities. Only entities that meet the following eligibility requirements shall be considered for a grant:
(1) Applicants must be municipal, county, or tribal governments, not-for-profit historical organizations as defined in section 320:15-1-3, or a support group of a municipal, country, or tribal government or a not-for-profit historical organizations.
(2) Applicant organizations must be engaged in the collection, preservation, and sharing of collections that may include but are not limited to: objects, photographs, manuscripts, videos, audio recordings, maps, periodicals, microforms, books, vertical files, archaeological material, or historic buildings.
(3) Applicant organizations must have a strategic plan for their organization. If an organization does not have a strategic plan, the only project that will be eligible for consideration is the development of a strategic plan.
(4) Applicant organizations must have an operating budget under $300,000.
(b) Eligible Projects. Only projects that meet the following eligibility requirements shall be considered for a grant.
(1) The minimum amount requested shall be $1,000 and the maximum amount requested shall be $20,000, with the exception of grant requests for the development of a strategic plan which shall be a minimum of $500 to and a maximum of $5,000.
(2) Applicants must provide a cash match of ten (10) percent of the total grant funds awarded by the OHS.
(3) Proposed projects must be completed within twelve (12) months of receipt of grant contract.
(c) Ineligible Project Expenses. The following expenses will not be eligible for a grant funding:
(1) Repair, maintenance, or expansion of facilities
(2) Rent or mortgage payments
(3) Utilities or insurance
(4) Salaries, wages, or benefits for employees (project-specific salaries will be considered)
(5) Creation of new monuments, sculptures, murals, or other works of art, unless it serves as an integral part of a larger exhibit
(6) Acquisition of real estate
(7) Landscaping or site work, unless it serves as an exhibit, an integral part of an exhibit or educational program
(8) Planning for new construction
(9) Indirect costs
(10) Food or drink
(11) Fundraising events
(12) Digitization of materials for which the applicant organization or primary beneficiary does not hold copyright or permission from the copyright holder.

320:15-2-2. Grant selection weighted criteria
All project proposals will be evaluated and ranked using the following weighted criteria:
(1) Historical importance of the collections or theme of the applicant organization as defined by the most current OHS Historic Context Review Report (available upon request), which is in effect at the time of the solicitation of proposals. This criteria shall be weighted at a factor of three (3).
(2) Project potential, which may include, fulfilling a demonstrated need in the community or for the applicant organization, economic impact on community or organization, publicly accessible product/service, project sustainability, possible impact on the scope of collections, or produces measurable outcomes. This criteria shall be weighted at a factor of five (5).
(3) Institutional readiness of applicant organization, which may include past accomplishments, programming/activities, facilities, base of support, strength of organizational strategic plan, community engagement, participation of board members/volunteers, accessibility to the public, or record of collecting experience/care. This criteria shall be weighted a factor of three (3).
(4) Implementation of project, which may include a clear and comprehensive explanation of the project, a clear explanation of how the project will be accomplished, identification of staff, volunteer, and/or third party vendor responsibilities, identification of deadlines, method for gauging project impact, or ability to complete project within one year. This criteria shall be weighted at a factor of three (3).
(5) Organizational impact, which may include a description of how the project fits into the long-term goals of the applicant organization, a description of how the project will increase the ability to attract and diversify future funders, and the ability to capitalize on the project’s success to springboard into future projects/collaborations. This criteria shall be weighted at a factor of three (3).
(6) Failure to meet requirements from past Heritage Preservation Grant award (if applicable). This criteria shall be weighted at a factor of negative two (-2).

[OAR Docket #21-465; filed 6-15-21]
Permanent Final Adoptions

TITLE 365. INSURANCE DEPARTMENT
CHAPTER 1. ADMINISTRATIVE OPERATIONS

[OAR Docket #21-416]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
365:1-1-4. Requests for information [AMENDED]

AUTHORITY:
Insurance Commissioner; 36 O.S. §§ 307.1, 1541, 1641, 6123, 6958-6968; 59 O.S. § 358

COMMENT PERIOD:
December 2, 2020 through January 4, 2021

PUBLIC HEARING:
January 4, 2021

ADOPTION:
January 29, 2021

EFFECTIVE:
September 1, 2021

SUPERSEDED EMERGENCY ACTIONS:
N/A

GIST/ANALYSIS:
Updates the Insurance Departments Address.

CONTACT PERSON:
Ashley Scott, Government and Community Affairs Director, 400 NE 50th Street, OKC, OK 73105, (405) 521-6616, Ashley.scott@oid.ok.gov.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS

365:1-1-4. Requests for information
(a) The public may obtain information relating to insurance and regulation thereof by writing to: The Insurance Commissioner, 3625 NW 56th Street, Suite 100, 400 NE 50th Street, Oklahoma City, Oklahoma 73105 or by calling (405) 521-2828.
(b) Where the request is for materials of which copies are not available and photocopying or reproduction by other means is required, such service will be provided upon payment of the costs involved.
(c) Annually, subsequent to the end of the fiscal year, the Commissioner makes a report to the Governor summarizing his/her work during the year. Such reports are available for inspection and copies thereof may be obtained from the Commissioner. The Commissioner's rules of practice and procedure and a description of its organization and policy are published in the Oklahoma Register. Copies thereof may be obtained from the Commissioner upon request.

[OAR Docket #21-416; filed 6-14-21]

TITLE 365. INSURANCE DEPARTMENT
CHAPTER 25. OTHER LICENSEES

[OAR Docket #21-417]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 15. Captive Insurance Companies Regulation
365:25-15-23. Dormant captive insurance companies [AMENDED]
Subchapter 17. Consumer Protection in Annuity Transactions Regulation
365:25-17-3. Authority [REVOKED]
Subchapter 29. Pharmacy Benefits Managers
365:25-29-10. Penalty for noncompliance [AMENDED]

AUTHORITY:
Insurance Commissioner; 36 O.S. §§ 307.1, 1541, 1641, 6123, 6958-6968; 59 O.S. § 358

COMMENT PERIOD:

PUBLIC HEARING:
January 4, 2021

ADOPTION:
January 29, 2021

EFFECTIVE:
November 1, 2021

SUPERSEDED EMERGENCY ACTIONS:
N/A

GIST/ANALYSIS:
The rules approved will assist us when competing to obtain new captive companies, it also adds incentives for smaller captive companies. Rules are adjusted to ensure they correlate with statutory references. Two rules were revoked to stay in alignment with the Governors Executive Order on rule regulation (EO 2020-03). Rules add penalty for noncompliance with PBM statutes.

CONTACT PERSON:
Ashley Scott, Government and Community Affairs Director, 400 NE 50th Street, OKC, OK 73105, (405) 521-6616, Ashley.scott@oid.ok.gov.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S.,
SUBCHAPTER 15. CAPTIVE INSURANCE COMPANIES REGULATION

(a) Except as provided in 36 O.S. § 6470.11, a captive insurance company doing business in this State shall annually, prior to March 1, submit to the Insurance Commissioner a report of its financial condition, verified by oath of two of its executive officers. The report shall be that prescribed by the Insurance Commissioner as "Oklahoma Captive Insurance Company Annual Report."

(b) A company that elects to file its annual report on a fiscal year basis pursuant to 36 O.S. § 6470.11(C), shall file such report no later than 60 days following the close of such fiscal year.

(c) A company that elects to file its annual report on a fiscal year basis shall submit, concurrently with each premium tax return required in connection with premium taxes due under 36 O.S. § 6470.19 pages 1 through 7 of the "Captive Annual Statement: Pure or Industrial Insured," verified by oath of two of its executive officers.

(d) In order to verify results reported in the company's annual report, each company shall cause its books and records to be audited annually by an independent certified public accounting firm approved in accordance with Section 4 of this Subchapter.

(e) In order to further verify results reported in the company's annual report each company shall cause to be prepared an actuarial opinion by a qualified actuary certifying the accuracy of the company's life, health, or annuity insurance reserves, or its loss reserves and loss expense reserves, as reported in the annual report. "Qualified actuary" means an individual who is a member of the American Academy of Actuaries or the Casualty Actuarial Society and who has met the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinions in the United States—or an individual who has demonstrated competence in loss reserve evaluation to the satisfaction of the insurance commissioner. Upon request by the company and for good cause shown, the Commissioner may grant an exemption from the annual actuarial opinion requirement for any company having direct written and assumed premiums of Two Million Dollars ($2,000,000.00) or less in the preceding year.

(f) A risk retention group doing business in this State shall annually submit to the Insurance Commissioner a report of its financial condition, verified by oath of two of its executive officers. The report shall be that required by Section 311 of Title 36 of the Oklahoma Statutes.

365:25-15-3. Annual Audit
(a) All companies shall have an annual audit by an independent certified public accountant, authorized by the Insurance Commissioner, and shall file such annual audited financial report with the Insurance Commissioner on or before June 30 for the year ending December 31 immediately preceding.
(b) A pure captive insurance company may make written application to file its annual report on a fiscal year basis and, if approved by the Commissioner, shall file such report no later than one hundred eighty (180) days following the close of the fiscal year.

(c) A company that elects to file its annual report on a fiscal year basis shall submit, concurrently with each premium tax return required, a schedule detailing the net direct written premium and assumed premium for the fiscal year in question.

(d) The annual audited financial report shall be considered part of the company's annual report of financial condition except with respect to the date by which it must be filed with the Insurance Commissioner.

(e) The annual audited financial report shall consist of the following:

1) Opinion of Independent Certified Public Accountant.
(A) Financial statements furnished pursuant to this section shall be examined by independent certified public accountants in accordance with generally accepted accounting principles, or as required by any other comprehensive basis of accounting in use by the company and approved by the Insurance Commissioner.
(B) The opinion of the independent certified public accountant shall cover all years presented.
(C) The opinion shall be addressed to the company on stationery of the accountant showing the address of issuance, shall bear original manual signatures and shall be dated.

(A) In addition to the annual audit, each company shall furnish the Commissioner with a written report, prepared in accordance with SAS No. 112, or any successor thereto, by the independent certified public accounting firm describing significant deficiencies and material weaknesses in the company's internal control structure.
(B) The review shall be conducted in accordance with generally accepted accounting principles, or as required by any other comprehensive basis of accounting in use by the company and approved by the Insurance Commissioner, and the report shall be filed with the Insurance Commissioner.
(C) The company is required to provide a description of remedial actions taken or proposed to correct material weaknesses and, at the Commissioner's discretion, significant deficiencies, if such actions are not described in the independent certified public accounting firm's report.

3) Accountant's Letter. The independent certified public accountant shall furnish the company, for inclusion on the filing of the annual audited financial report, a letter stating:
(A) That he or she is independent with respect to the company and conforms to the standards of his/her
profession as contained in the Code of Professional Ethics and pronouncements of the American Institute of Certified Public Accountants and pronouncements of the Financial Accounting Standards Board.

(B) The general background and experience of the staff engaged in audit including the experience in auditing captives or other insurance companies.

(C) That the accountant understands that the audited annual report and his opinions thereon will be filed in compliance with this regulation with the Department, and that the Commissioner will be relying on this information in the monitoring and regulation of the financial position of the company.

(D) That the accountant consents to the requirements of 365:25-15-4(c) of this regulation and that the accountant consents and agrees to make available for review by the Insurance Commissioner, or his appointed agent, the work papers as defined in 365:25-15-4(c).

(E) That the accountant is properly licensed by an appropriate state licensing authority and that he or she is a member in good standing in the American Institute of Certified Public Accountants.

(4) Financial Statements. Statements required shall be as follows:

(A) Balance sheet,

(B) Statement of gain or loss from operations,

(C) Statement of changes in financial position,

(D) Statement of changes in capital paid up, gross paid in and contributed surplus and unassigned funds (surplus), and

(E) Notes to financial statements. The notes to financial statements shall generally be required by generally accepted accounting principles, or as required by any other comprehensive basis of accounting in use by the company and approved by the Insurance Commissioner, and shall include:

(i) A reconciliation of differences, if any, between the audited financial report and the statement or form filed with the Insurance Commissioner.

(ii) A summary of ownership and relationship of the company and all affiliated corporations or companies insured by the captive.

(iii) A narrative explanation of all material transactions and balances with the company. "Material transactions" means sales, guarantees, purchases, exchanges, loans or extensions of credit or investments which, based upon an annual aggregate, involve more than three percent (3%) of the insurer's admitted assets.

(f) Upon request by the company and for good cause shown, the Commissioner may grant an exemption from the annual audit requirement for any company having direct written and assumed premiums of Two Million Dollars ($2,000,000.00) or less in the preceding year.


(a) Every company shall report to the Insurance Commissioner within thirty (30) days after any change in its executive officers or directors, including in its report a statement of the business and professional affiliations of any new executive officer or director. Every executive officer or director shall provide a biographical affidavit to the Insurance Commissioner within forty-five (45) days of his/her appointment as an executive officer or to the board of directors of the company.

(b) Except as otherwise permitted under the company's plan of operation approved by the Commissioner, no director, officer, or employee of a company shall, except on behalf of the company, accept, or be the beneficiary of, any fee, brokerage, gift, or other emolument because of any investment, loan, deposit, purchase, sale, payment or exchange made by or for the company, but such person may receive reasonable compensation for necessary services rendered to the company in his or her usual private, professional or business capacity.

(c) Any profit or gain received by or on behalf of any person in violation of this section shall inure to and be recoverable by the company.


(a) Except as otherwise provided, any change in the nature of the captive business from that stated in the company's plan of operation filed with the Insurance Commissioner upon application requires prior approval from the Insurance Commissioner.

(b) For purposes of this Section, "nature of the captive business" includes, but is not limited to, nonrecurring transactions such as loans or extensions of credit, reinsurance agreements or modifications thereto, management agreements, service contracts and all cost-sharing arrangements and changes in certificate of incorporation or bylaws.

(c) All business plan changes, both in the nature of the captive business or otherwise, shall be filed with the Insurance Commissioner thirty (30) days in advance of the effective date of the change.

365:25-15-23. Dormant captive insurance companies

(a) As used in this Section, unless the context requires otherwise, "dormant captive insurance company" means a captive insurance company which has:

(1) at no time insured controlled unaffiliated business;

(2) ceased transacting the business of insurance, including the issuance of insurance policies;
(32) no remaining liabilities associated with insurance business transactions; and
(43) no unpaid premium taxes.

(b) A captive insurance company domiciled in Oklahoma which meets the criteria of paragraph (a) of this Section may apply to the Commissioner for a certificate of dormancy. The certificate of dormancy shall be subject to renewal every five years and shall be forfeited if not renewed within such time. If, after a period of five (5) years from the date of the written notice being sent to the Commissioner, a dormant captive insurance company has not resumed transacting the business of insurance by assuming risk through the issuance of insurance policies, reinsurance contracts, or both, and accepting premium, whether direct, assumed via reinsurance, or both, the nonrefundable license renewal fee payable under § 6470.3 (D) of this title and the minimum Five Thousand Dollars ($5,000.00) payable under § 6470.19 (D) shall become applicable for the sixth year of dormancy and for every year of dormancy thereafter.

(c) A dormant captive insurance company which has been issued a certificate of dormancy shall:
(1) possess and thereafter maintain unimpaired, paid-in capital and surplus of not less than Twenty-five thousand dollars ($25,000.00);
(2) prior to March 15 of each year, submit to the Commissioner a report of its financial condition, verified by oath of two of its executive officers, in a form as may be prescribed by the Commissioner; and
(3) pay a license renewal fee as provided in 36 O.S. § 6470.3.

(d) A dormant captive insurance company shall not be subject to or liable for the payment of any premium tax.
(e) A dormant captive insurance company shall apply to the Commissioner for approval to surrender its certificate of dormancy and resume conducting the business of insurance prior to issuing any insurance policies.
(f) A certificate of dormancy shall be revoked if a dormant captive insurance company no longer meets the criteria of paragraph (a) of this Section.
(g) The Commissioner may establish guidelines and procedures as necessary to carry out the provisions of this section.


If any provision of this Subchapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provisions to other persons or circumstances shall not be affected thereby.

SUBCHAPTER 17. CONSUMER PROTECTION IN ANNUITY TRANSACTIONS REGULATION

365:25-17-3. Authority [REVOKED]

This regulation is issued under the authority of the Unfair Trade Practices Act, 36 O.S. § 1201, et seq.

SUBCHAPTER 29. PHARMACY BENEFIT MANAGERS

365:25-29-10. Penalty for noncompliance

(a) After notice and opportunity for hearing, and upon determining that the PBM has violated any of the provisions of 36 O.S. §§ 357-360 of the Oklahoma Statutes, or this Subchapter as it relates to 36 O.S. §§ 357-360, or upon finding the existence of grounds to refuse the issuance or renewal of such license, the Commissioner may suspend or revoke a PBM's license or assess a civil penalty of not less than Five Hundred Dollars ($500.00) nor more than Five Thousand Dollars ($5,000.00) for each instance of violation, or both. Each day that a pharmacy benefits manager conducts business in the State of Oklahoma without a license shall be deemed to be an instance of violation. The payment of the penalty may be enforced in the same manner as civil judgments may be enforced.

(b) After notice and opportunity for hearing, and upon determining that the PBM has violated any of the provisions of 36 O.S. §§ 6958-6968 of the Oklahoma Statutes, or this Subchapter as it relates to 36 O.S. §§ 6958-6968, the Commissioner may suspend or revoke a PBM's license and/or levy fines not to exceed Ten Thousand Dollars ($10,000.00) for each count for which any PBM has violated the provisions of 36 O.S. §§ 6958-6968. The payment of the penalty may be enforced in the same manner as civil judgments may be enforced.

(c) After notice and opportunity for hearing, and upon determining that the health insurer has violated any of the provisions of 36 O.S. §§ 6958-6968 of the Oklahoma Statutes, the Commissioner may suspend or revoke a health insurer's certificate of authority license or assess a civil penalty of not less than Five Hundred Dollars ($500.00) nor more than Five Thousand Dollars ($5,000.00) for each instance of violation, or both. The payment of the penalty may be enforced in the same manner as civil judgments may be enforced.

(d) Every health insurer and PBM upon receipt of any inquiry from the Commissioner or the Commissioner's representative shall, within thirty (30) twenty (20) days from the date of inquiry, furnish the Commissioner or the Commissioner's representative with an adequate response to the inquiry.

[OAR Docket #21-417; filed 6-14-21]
Permanent Final Adoptions

377:1-1-6. Rates and Standards Committee [AMENDED]
377:1-1-7. Legal Base for Rates and Standards Committee [AMENDED]
377:1-1-8. Rates and Standards Committee membership [AMENDED]
377:1-1-9. Conduct of Committee meetings [AMENDED]
377:1-1-10. Public hearing regarding a fixed rate [AMENDED]
377:1-1-11. Executive Director [AMENDED]

AUTHORITY:
The Board of Juvenile Affairs; 10A O.S. §§ 2-7-101(H)(3) and 2-7-101(i)(1)

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND
CABINET SECRETARY:
January 25, 2021

COMMENT PERIOD:
Tuesday, February 16, 2021 through Thursday, March 18, 2021

PUBLIC HEARING:
March 19, 2021

ADOPTION:
March 30, 2021

SUBMISSION OF ADOPTED RULES TO GOVERNOR AND
LEGISLATURE:
April 1, 2021

LEGISLATIVE APPROVAL:
Approved June 11, 2021 by House Joint Resolution 1046

FINAL ADOPTION:
June 11, 2021

EFFECTIVE:
August 26, 2021

SUPERSEDED EMERGENCY ACTIONS:
N/A

INCORPORATIONS BY REFERENCE:
N/A

GIST/ANALYSIS:
The proposed change to 377:1-1-1 through 377:1-1-11 were made as a result of HB 2479 (2019) and Executive Order 2020-03. The proposed amendments provide clarity and correctly reference provisions of law.

CONTACT PERSON:
Audrey Rockwell, Executive Assistant, (405) 530-2806, audrey.rockwell@ojak.org

PURSUANT TO THE ACTIONS DESCRIBED HEREIN,
THE FOLLOWING RULES ARE CONSIDERED
FINALLY ADOPTED AS SET FORTH IN 75 O.S. §§
250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF
AUGUST 26, 2021:

SUBCHAPTER 1. FUNCTION AND STRUCTURE
OF THE OFFICE OF JUVENILE AFFAIRS

377:1-1-1. Purpose
The purpose of this Chapter is to describe the organizational structure and function of the Office of Juvenile Affairs (OJA). This Chapter indicates the legal bases of the Office of Juvenile Affairs (OJA), identifies OJA divisions and units, and outlines other rules governing the overall operation of the OJA.

377:1-1-2. Legal Basis
The Office of Juvenile Affairs (OJA) operates under the statutory authority of "The Oklahoma Juvenile Code", Title 10A O.S., § 2-1-101 et seq.

377:1-1-3. Description of the Office of Juvenile Affairs (OJA)
(a) History. The Office of Juvenile Affairs (OJA) was created on July 1, 1995, as a result of legislation enacting the Oklahoma Juvenile Code.
(b) Organization. The Office of Juvenile Affairs consists of programs providing services to juveniles involved in the juvenile justice system and administrative components which provide administrative support.

(1) Office of the Executive Director.
(A) Within the Office of Juvenile Affairs, programs and divisions which report directly to the Executive Director include, but are not limited to, the:
(i) Office of Public Integrity;
(ii) Division of the Advocate Defender; and
(iii) Office of General Counsel Service;
(B) The Executive Director of OJA is designated by the Governor as the Interstate Compact Liaison.
(C) Additional responsibilities of the Executive Director are listed in OAC 377:1-1-11.
(D) The Executive Director shall establish divisions within OJA in addition to those required by law 10A O.S. § 2-7-202 and may employ staff as necessary to perform the duties of the Office of Juvenile Affairs as authorized by statute. Organizational charts are available upon request from the Office of the Executive Director.
(2) Division of Community-based Youth Services. The Division of Community-based Youth Services operates under the authority of 10A O.S., §§ 2-7-202, 2-7-303, 2-7-305 and 2-7-306.
(3) Advocate Defender Division. The Advocate Defender Division is a Division of the OJA established by 10A O.S., § 2-7-302. Compliance with Oklahoma statutes is obtained by assignment of the Advocate Defenders to the OJA institutions. The Division of Advocate Defender shall be separate and apart from the Office of General Counsel.
(4) Support Services Division. The Support Services Division shall provide centralized support function for the Office of Juvenile Affairs.
(5) Financial Services Division. The Financial Services Division shall provide the centralized accounting, procurement, reporting, and budgeting for OJA.
(6) Institutional Services Division. The Institutional Services Division shall be responsible for all secure institutional services.
(7) Juvenile Services Division. The Juvenile Services Division shall be responsible for intake, probation and parole services, supervision and placement of juveniles.
(8) Office of the Parole Board. The Office of the Parole Board shall have responsibilities as set forth in 377:5.
(c) Purpose/mission. The purpose of the Office of Juvenile Affairs as stated in Title 10A O.S., § 2-1-102, is to promote the public safety and reduce delinquency. To execute the purpose of the statutes, OJA has developed its mission to include:
(1) protection of the public from juvenile offenders;
(2) prevention of juvenile delinquency;
(3) implementation of programs ensuring accountability of juveniles for their behavior; and
(4) involvement of the community in creating and implementing solutions to juvenile delinquency and establishing individual accountability.

377:1-1-5. **Board of Juvenile Affairs**

(a) **Composition.** Title 10A O.S., § 2-7-101, authorizes the Board of Juvenile Affairs (Board) as the governing body for the Office of Juvenile Affairs. The Board shall consist of seven (7) members appointed by the Governor with the advice and consent of the Senate in accordance with 10A O.S. § 2-7-101. The Board of Juvenile Affairs (Board), per 10A O.S. § 2-7-101, is the governing body for the Office of Juvenile Affairs-OJA. The Board consists of nine (9) members; five (5) members appointed by the Governor, two (2) members appointed by the President Pro-Tempore of the Senate, and two (2) members appointed by the Speaker of the House, all members serve at the pleasure of their appointing authority.

(b) **Meetings.** Regularly scheduled meetings of the Board shall be held at places, dates, and times fixed by the Board and after appropriate notice. Special meetings may be called by the Chair or by five (5) members of the Board by delivery of written notice to each member of the Board. Emergency meetings of the Board may be called as provided by Oklahoma statutes.

(c) **Voting.** A majority of members serving on the Board shall constitute a quorum.

(d) **Election of officers.** At the first meeting of each calendar year, the Board shall elect one of its members to serve as Chair and another of its members to serve as Vice Chair. The Chair and Vice-chair shall be elected in accordance with 10A O.S. § 2-7-101(E), and shall hold office until his or her successor has been duly elected or until his or her own death, resignation, or removal.

(e) **Vacancies.** A vacancy in the elected position of Chair or Vice-chair because of death, resignation, removal, disqualification, or otherwise, may be filled by the Board for the unexpired portion of the term of the position.

(f) **Duties of the position of Chair and Vice-chair.** The Chair, or in his or her absence, the Vice-chair, shall preside at all meetings of the Board, including executive sessions. The Chair, or Vice chair as the case may be, shall be the final authority on all procedural issues, and may, when appropriate, refer to and follow the recommendations of legal counsel for the Office of Juvenile Affairs-OJA or "Robert's Rules of Order" to resolve a procedural issue.

(1) The Chair, within two (2) weeks of a member's new appointment, shall:
(A) brief the member of the Board regarding the duties and responsibilities of the Board and its members;
(B) provide the new member a copy of the statutes pertinent to the Board and its duties;
(C) provide a copy of the monthly operating budgets of OJA to the Office of Juvenile Affairs for the preceding twelve months;
(D) provide a copy of the rules under which OJA the Office of Juvenile Affairs functions and operates; and
(E) provide such other information as is necessary to assure that the new member is advised of his or her duties and responsibilities.

(2) The Chair may delegate the briefing described in paragraph (1) of this subsection in whole or in part to the Executive Director of the Office of Juvenile Affairs or a managing officer of that agency, but the responsibility for its accomplishment shall remain with the Chair.

(g) **Resolutions.** The purpose of the Board of Juvenile Affairs, in addition to the duties required by 10A O.S. §§ 2-3-103, 2-4-103, 2-7-101, 2-7-201, 2-7-305(D), 2-7-306, 2-7-608, 2-7-613, 2-7-614, 2-7-616, 2-7-704, and 2-8-112, may, in addition to its other duties, act as the governing board for the Office of Juvenile Affairs and to implement and direct the mandates of the Oklahoma Legislature with respect to the custody, care, and supervision of juveniles adjudicated to be delinquent or in need of supervision or persons sentenced as youthful offenders. The Oklahoma Juvenile Code, Title 10A O.S. §§ 2-1-101 et seq., and other provisions of law related to children and youth gives the Board the responsibility for:

(1) promulgating rules for the Office of Juvenile Affairs and for its own governance;
(2) adopting an official seal for the Office of Juvenile Affairs;
(3) appointing and setting the salary of the Executive Director of the Office of Juvenile Affairs;
(4) reviewing and approving OJA's budget request to the Governor;
(5) assisting OJA in conducting regular reviews and planning activities related to the goals, objectives, priorities, and policies of the Office of Juvenile Affairs.
(6) providing a public forum for receiving comments and disseminating information to the public regarding the goals, objectives, priorities, and policies of the Office of Juvenile Affairs;
(7) adopting and/or nonbinding resolutions requesting action by OJA to the Office of Juvenile Affairs in response to comments from the public or upon the Board's own initiative;
(8) establishing OJA contracting procedures and guidelines for rates of payment for services provided by contract; provided the Board may not increase payment rates during the time the Legislature is not in session;

(9) serving as the rulemaking body for the Office of Juvenile Affairs, including promulgating rules which implement the duties and responsibilities of the Office of Juvenile Affairs pursuant to the Oklahoma Juvenile Code;

(10) developing performance standards for programs implemented by the Office of Juvenile Affairs, either directly or by contract;

(14) if necessary and in accordance with 10A O.S. § 2-7-201(G), designate an interim or acting Executive Director or the event of a vacancy, designating an interim or acting Executive Director, including the Chief of Staff of the Office of Juvenile Affairs; until a new permanent Executive Director is appointed;

(12) establishing fee schedules;

(14) advising the Office of Juvenile Affairs with respect to real estate leases;

(14) approving criteria for designation of organizations as "Youth Service Agencies";

(15) establishing an administrative hearing and appeal process for denial of "Youth Service Agency" designation;

(16) reviewing annually the OJA report (OJA Annual Report) which analyzes and evaluates the effectiveness of OJA programs and services;

(17) reviewing annually the OJA report (OJA Annual Report) which analyzes and evaluates the effectiveness of the Youthful Offender Act;

(18) promulgating rules for OJA the Office of Juvenile Affairs to obtain national criminal history records searches for personnel working with or around juveniles in OJA the Office of Juvenile Affairs' institutions and Office of Juvenile Affairs' contracted operated facilities, pursuant to 10 O.S. § 404.1(A)(14);

(19) promulgating rules, outlining policies and procedures governing the operation of facilities operated by or through contract with OJA;

(20) promulgating rules defining contraband for purposes of inspection;

(21) promulgating rules governing the use of mechanical restraints in institutions and other facilities operated by or through contract with the Office of Juvenile Affairs;

(22) receiving and reviewing institutional inspection reports of the State Fire Marshal and Commissioner of Public Health;

(23) establishing standards for regimented juvenile training programs;

(24) establishing the proposal submission and education procedures and criteria for the implementation of the Delinquency and Youth Gang Intervention and Deterrence Act;

(25) promulgating rules necessary for the implementation of the "Juvenile Offender Victim Restitution Work Program";

(26) adopting rules as required to implement the Serious and Habitual Juvenile Offender Program and Juvenile Justice Information System;

(27) establishing certification standards for municipal juvenile facilities for temporary detention;

(28) promulgating standards for certification of juvenile detention facilities;

(29) developing, adopting, and implementing the "State Plan for the Establishment of Juvenile Detention Services";

(30) establishing procedures for the letting of contracts or grants for juvenile detention services or facilities; 

(31) approving rules for the statistical reporting of detention of persons under the age of 18;

(32) establishing standards for the certification of detention services;

(33) with the State Department of Health, establishing standards for certification of jails, adult lock-ups and adult detention facilities used to detain juveniles;

(34) establishing guidelines and procedures for Juvenile Bureaus to ensure uniformity in the performance of the Juvenile Bureau's statutory duties;

(35) promulgating rules and forms necessary for the implementation of the juvenile sex offender registry;

(36) establishing Foster Care licensing standards for Office of Juvenile Affairs' foster home placements;

(37) promulgating rules for the expansion for criminal records searches for foster care eligibility assessments beyond the records searches conducted by the Oklahoma State Bureau of Investigation;

(38) Designating Youth Service Agencies;

(39) Adopting the State Plan for Youth Services Agencies;

(40) promulgating rules as necessary for the establishment and operation of a charter school pursuant to 10A O.S. § 2-7-616; and

(41) promulgating rules, creating policies and procedures governing the operation of detention beds, pursuant to 10A O.S. § 2-7-608

377:1-1.6. Rates and Standards Committee

The Board of Juvenile Affairs (Board) is the official rate-setting body for the programs administered by the Office of Juvenile Affairs (OJA). The Rates and Standards Committee (Committee) is responsible for making recommendations to the Board regarding fixed fiscal rates and standards for service contracts entered into by OJA the Office of Juvenile Affairs. The Rates and Standards Committee is not authorized to make decisions regarding rate setting. The Committee's purpose is to advise and make recommendations to the Board.

377:1-1.7. Legal Base for Rates and Standards Committee

The legal base for establishing fixed and uniform rates is found at 10A O.S. § 2-7-101(F)(6) and 74 O.S. § 85.7(A)(6), 24 O.S. § 85.7(A)(11)(d) and (e) (Oklahoma Central Purchasing Act), and 10A O.S. § 2-7-101(H)(7).
377:1-1-8. Rates and Standards Committee membership

The Chairman of the Rates and Standards Committee shall be a member of the Board of Juvenile Affairs (Board) and shall be appointed by the Board. In addition to the Chair, the Committee shall be comprised of the Board's Finance Sub-Committee Chair, and the Executive Director of OJA, or his/her designee.

377:1-1-9. Conduct of Committee meetings

(a) Committee meetings are called by either the Chairman, Executive Director, or Board of Juvenile Affairs. A majority of the Committee constitutes a quorum. Recommendations of the Committee are approved by a majority of the members present and voting.

(b) During a meeting in which the Committee intends to vote on a rate setting recommendation for the Board of Juvenile Affairs, the public, vendors, or OJA staff shall provide evidence to support rate recommendations.

(c) A party requesting a rate shall supply the following information and data to justify the proposed rate recommendation:
   (1) a description of the program or service, including the target population and an annual estimate of the number of juveniles to whom the service will be provided;
   (2) any historical rate information regarding previous rates established for the program, or rates for similar programs or services if no rate exists;
   (3) an explanation and cite of cite and explain any Federal, State, and other regulations and standards which apply;
   (4) the rate being proposed, a summary of the program and cost variables included in the rate, and a program and fiscal impact statement on the juvenile justice system;
   (5) the operational budget and narrative justification for each budget category, including the methodology and cost computations used to arrive at the proposed rate; and
   (6) an estimated total cost of the service.

(d) If the Committee determines additional information is needed, the Chair may recess the meeting until a later date to allow interested parties or staff additional time to secure the information.

(e) In making its recommendations, the Committee shall consider any relevant data which is consistent with applicable state plans, OJA all relevant administrative rules, OJA policies and procedures, and statutory provisions.

(f) Once the Committee establishes a recommendation, notification of the proposed rates and standards along with any supporting documentation will be sent to the Office of Management and Enterprise Services (OMES). The Chair shall place the item on the agenda of a Board of Juvenile Affairs meeting for a public hearing to set the rate, after proposed rates and standards have been approved by OMES. The Office of Management and Enterprise Services must be given 30 days advance notice of the public hearing. In addition to the Hearing agenda, the Committee shall submit to the Office of Management and Enterprise Services, documentation and other materials which support the proposed rate. The public hearing may be held during any Board meeting.

377:1-1-10. Public hearing regarding a fixed rate

(a) Any comments from OMAE, the Director of the Office of Management and Enterprise Services, whether made in person or in writing, are included in the minutes of the Board meeting.

(b) During the Board meeting, the Chair of the Rates and Standards Committee, or a designee, shall present the proposed rate and provide the Committee's recommendation to the Board.

(c) After the Chair's presentation, interested parties shall be given the opportunity for public comments regarding the proposed rates. Any further testimony. Each rate must be openly and separately discussed before the Board's vote. The Board may vote to approve, deny, or modify the recommendation of the Rates and Standards Committee.

377:1-1-11. Executive Director

(a) The OJA Executive Director of the Office of Juvenile Affairs shall be appointed by the Board of Juvenile Affairs is appointed by the Governor and shall report agency business directly to the Board. As the OJA administrator of the Office of Juvenile Affairs, the Executive Director is responsible for supervising OJA activities and establishing internal policy and procedures for the administration of OJAs of the Office of Juvenile Affairs.

(b) The Executive Director shall be responsible for selecting staff or contracting with personnel capable of carrying out OJA's mission, goals, and statutory requirements.

(c) The Executive Director shall have the authority to assume all duties and responsibilities of the Chief of Staff of OJA.


All activities, administrative and operational, within the Office of Juvenile Affairs OJA shall be performed in a manner resulting in an audit trail; consisting of dual controls; and complying with Generally Accepted Accounting Principles (GAAP), Governmental Accounting Standards Board (GASB), and other fundamentals of sound financial management.

[OAR Docket #21-413; filed 6-14-21]

TITLE 377. OFFICE OF JUVENILE AFFAIRS
CHAPTER 3. ADMINISTRATIVE SERVICES

[OAR Docket #21-414]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 9. Office of Policy
Part 7. Policy and Accreditation
377:3-9-40. Legal basis [AMENDED]
377:3-9-41. Purpose [AMENDED]
377:3-9-42. Public hearings [AMENDED]
377:3-9-43. Availability of OJA Rules, policies, and procedures [AMENDED]
377:3-9-44. Petitions for the promulgation, amendment, or repeal of rules [AMENDED]

August 16, 2021 1123 Oklahoma Register (Volume 38, Number 23)
377:3-9-43. Availability of OJA rules, policies, and procedures

The OJA manual contains rules and procedures for all OJA operations. The manual is made available to all staff. In accordance with the Open Records Act, Title 51 O.S., § 24A.1 et seq., the manual is all OJA rules, policies, and procedures are available upon request. Requests should be submitted by letter to the Office of Juvenile Affairs, Attention: General Counsel, 3812 North Santa Fe Avenue, Suite 400, Oklahoma City, OK 73116, or by telephone call 405-530-2800 and ask to speak with the General Counsel, or via email at records@oja.ok.gov, to the Office of Policy, P.O. Box 268812, Oklahoma City, Ok., 73126-8812, (405)530-2800.

377:3-9-44. Petitions for the promulgation, amendment, or repeal of rules

(a) Submission. Any person may petition OJA requesting the promulgation, amendment, or repeal of a rule. The person making the request shall submit a petition to the Office of Juvenile Affairs, Administrative Services Division by mailing or delivering the petition to P.O. Box 268812, Oklahoma City, OK 73126-8812, Attention, Office of Policy, the Office of Juvenile Affairs, Attention: General Counsel, 3812 North Santa Fe Avenue, Suite 400, Oklahoma City, OK 73116, or delivery to the Office of Juvenile Affairs, 3814 N. Santa Fe, Suite 400, Oklahoma City, Oklahoma. A petition mailed to OJA is considered submitted upon receipt by the General Counsel/Office of Policy. A designated staff member shall stamp the petition upon receipt to show the date of submission.

(b) Form. The petitioner shall submit the petition in the form given in paragraphs (1) - (5) below.

(1) The petition must contain a clear statement of the action requested and the solution desired as a result of the request, requested rule, or rule change.

(2) When the petition seeks to amend or repeal an existing rule, the existing rule must be identified in the petition in the following format OAC Title:Chapter-Subchapter-Part. If the petition is submitted electronically, please hyperlink the current rule in the petition. If the petition is submitted via mail, please include a copy of the current rule. If the petitioner knows which OJA rule he or she is seeking to amend or repeal, the petitioner shall:

(A) list the Title, Chapter, and Subchapter; or

(B) submit a copy of the rule.

(3) The petition must contain a statement of the facts supporting the requested rule or rule change, including any legal grounds, if known, and other relevant information or views on which the petitioner relies. A copy of any reference or source cited in the statement must be submitted or hyperlinked with the petition unless the reference or source is readily available to OJA. When a petition requests more than one rule change, a single statement which supports and justifies each proposed change meets the requirements of this subsection.

Under circumstances set forth in Title 75 O.S., § 303(C), the Office of Policy shall arrange for a public hearing relating to proposed OJA rules. Public hearings will be held in accordance with 75 O.S. § 303(C).
(4) The petition must describe the class or classes of persons, if known, who most likely will be affected by the proposed change.

(5) The petition must be signed by the petitioner or his/her authorized representative, and contain the printed name, address, email, and day time telephone number of the petitioner or his/her authorized representative.

(6) A petitioner may supplement or revise a petition at any time prior to approval by the Executive Director or submission of the proposed change to the Board. However, if significant changes are made, the petitioner should withdraw the petition and submit a revised petition.

(c) Notification of receipt. The General Counsel, or designee, Office of Policy staff shall send the petitioner written notification of receipt of the petition within five (5) working days after receipt.

(d) Consideration and disposition. Title In accordance with 75 O.S., 1991, § 305 provides that if rulemaking action has not occurred by the 30th day after receipt of the petition, the petition shall be deemed denied. Within fourteen (14) calendar days after the submission of the petition, the administrative services division administrator, General Counsel, or designee, shall review the request with the Office of General Counsel Services and recommend to the Executive Director that he or she:

(1) approve the petition for Board action;

(2) deny the petition, in whole or in part, on any of the following grounds:

(A) the petition requests promulgation of a rule that OJA clearly lacks authority to promulgate;

(B) the petition requests a rule or rule change inconsistent with any applicable statutory or constitutional authority;

(C) the petition requests promulgation, amendment, or repeal of an OJA policy that does not constitute a rule as defined in the Oklahoma Administrative Procedures Act (75 O.S., § 250.2(2));

(D) the petition is frivolous and not pursued in good faith; or

(E) the petition is not feasible, taking into consideration available and anticipated agency resources for the category of the subject matter of the proposed change and the public policy or other grounds supporting the proposed change; or

(F) for other just cause; or

(3) request additional material from the petitioner.

(e) Executive Director responsibilities. The Executive Director, or designee, shall send his or her recommendation and other pertinent material to each member of the Board of Juvenile Affairs within two (2) calendar days of decision receipt.

(1) If the next regularly scheduled Board meeting falls within twenty (20) calendar days of receipt of the petition by Office of Policy, the Executive Director, or designee, shall ensure that the petition is placed as an action item on the agenda of the Board's next regularly scheduled meeting.

(2) If the next regularly scheduled Board meeting does not fall within thirty (30) calendar days of receipt of the petition by Office of Policy, the Executive Director, or designee, shall notify the Board Chair or the Board and all Board members. The Board may choose to be responsible for calling to call a Special meeting, in accordance with rulemaking action as provided in OAC 377:1-1-5(b) within the thirty (30) day period to consider the petition.

(f) Responsibilities of the Board of Juvenile Affairs. The Board shall decide whether to approve or deny the petition.

(g) Notification of approval or denial of petition. The Office of Policy supervisor, General Counsel, or designee, shall notify the petitioner of the decision to approve or deny the petition within thirty (30) days of the Office of Policy's original receipt of the petition.

(h) Rulemaking process. If the Board approves the petition, the Office of Policy supervisor, General Counsel, or designee, shall initiate OJA's rulemaking process in accordance with 75 O.S. Supp. 1996, § 303 by submitting a Notice of Rulemaking Intent to the Office of Administrative Rules. The rulemaking process shall follow the time frames and other requirements of the Administrative Procedures Act for all proposed rules.

(i) Notice to petitioner. If the petitioner does not attend the Board meeting in which the vote on the rule revision is made, the General Counsel, or designee Office of Policy supervisor shall provide written notice within five (5) working days after the Board's meeting of the Board's decision.

[OAR Docket #21-414; filed 6-14-21]

TITLE 377. OFFICE OF JUVENILE AFFAIRS
CHAPTER 3. ADMINISTRATIVE SERVICES

[OAR Docket #21-415]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 13. Office of Public Integrity
377:3-13-1. General purpose, legal basis and authority [AMENDED]
377:3-13-2. Office of Public Integrity’s internal investigations [AMENDED]
Part 3. Requirements for Secure Juvenile Detention Centers
377:3-13-35. Legal basis [AMENDED]
377:3-13-37. Organization, administration and finances [AMENDED]
377:3-13-38. Policy and procedure manual [AMENDED]
377:3-13-39. Admission procedure and criteria [AMENDED]
377:3-13-40. Records [AMENDED]
377:3-13-42. Juvenile rights [AMENDED]
377:3-13-43. Staff requirements [AMENDED]
377:3-13-44. Security and control [AMENDED]
377:3-13-45. Program and services [AMENDED]
377:3-13-46. Physical plant or facility [AMENDED]
377:3-13-47. Food service, sanitation and hygiene [AMENDED]
377:3-13-48. Safety and emergency [AMENDED]
Part 11. Requirements for Certification of Secure Juvenile Facilities
377:3-13-127. Physical plant requirements [AMENDED]

AUTHORITY:
The Board of Juvenile Affairs; 10A O.S. §§ 2-7-101(H)(3) and 2-7-101(I)(1)
Permanent Final Adoptions

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY: 
January 25, 2021

COMMENT PERIOD: 
Tuesday, February 16, 2021 through Thursday, March 18, 2021

PUBLIC HEARING: 
March 19, 2021

ADOPTION: 
March 30, 2021

SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE: 
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LEGISLATIVE APPROVAL: 
Approved June 11, 2021 by House Joint Resolution 1046

FINAL ADOPTION: 
June 11, 2021

EFFECTIVE: 
August 26, 2021

SUPERSEDED EMERGENCY ACTIONS: 

Superseded rule: 
Subchapter 13. Office of Public Integrity
Part 11. Requirements for Certification of Secure Juvenile Facilities
377:3-13-127. Physical plant requirements [AMENDED]

Gubernatorial approval: 
December 18, 2020

Register Publication: 
38 OK Reg 458
Docket number: 
20-991

INCORPORATIONS BY REFERENCE: 
N/A

GIST/ANALYSIS: 
The proposed change to 377:3-1-1 through 377:3-1-11 were made as a result of HB 2479 (2019) and Executive Order 2020-03. The proposed amendments provide clarity and correctly reference provisions of law.

CONTACT PERSON: 
Audrey Rockwell, Executive Assistant, (405) 530-2806, audrey.rockwell@oja.ok.gov

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. §§ 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 13. OFFICE OF PUBLIC INTEGRITY

PART 1. GENERAL PROVISIONS

377:3-13-1. General purpose, legal basis and authority

(a) Unit Purpose. The Office of Public Integrity (OPI) is a unit division established within the Oklahoma State Office of Juvenile Affairs (OJA) and is directly responsible, organizationally and administratively, to conduct investigations, performs on-site assessments, licensing visits, and financially monitors OJA state contracts, functions and activities to ensure compliance with, state statutes, OJA policies/procedures, contractual provisions, and other applicable professional rules and standards, the OJA Executive Director. The division unit is composed of three sections: (1) Internal Affairs/Employment Discrimination Investigations; (2) OJA-licensing and Programs Assessment Section; and (3) Financial Contract Monitoring/Reviews Section, each section is under the supervision of the Executive Director, or designee, and other duties as assigned by the Executive Director. The unit conducts investigations, performs on-site assessments, licensing visits, and financially monitors OJA state contracts, functions and activities to ensure compliance with, state statutes, OJA policies/procedures, contractual provisions, and other applicable professional rules and standards.

1. Internal Affairs/EEO Investigations Section may among other activities and functions include investigations of:

   (A) Allegations of serious misconduct and/or criminal violations committed by OJA personnel as assigned to the unit division by the agency’s Executive Director, or designee;

   (B) Allegations of discrimination (Equal Employment Opportunity) either by or against OJA employees as received and assigned by the affirmative action officer, or the agency’s grievance manager, agency’s Executive Director, or designee, affirmative action officer, or the agency’s grievance manager; and

   (C) Specifically assigned Caretaker Conduct Reviews (CCR) that are returned to the OJA operated juvenile institutions by the state Oklahoma Department of Human Services’ Office of Client Advocacy (OCA) or other entity as prescribed by law for administrative review, as well as major incidents (i.e., serious assaults, riots, escapes) that occur at the OJA operated institutions.

2. OJA—Licensing and Programs Assessment Section division includes the licensing and assessing of the following:

   (A) On-site licensing and unannounced monitoring visits to OJA state contracted juvenile detention centers, community intervention centers (CIC) and municipal juvenile detention facilities, See OJA Rule OAC 377-3-13-6;

   (B) Announced and unannounced assessments of contracted residential care, non-residential services and shelters as directed by the OJA—Executive Director, or designee;

   (C) On-site assessments and licensing of a Secure Juvenile Facility;

   (D) On-site or electronic assessments of the OJA Juvenile Services Unit (JSU) offices located throughout the state;

   (E) Assessments of State Office units as directed by the OJA—Executive Director, or designee;

3. Financial Contract Monitoring/Review Section division includes but is not limited to the financial monitoring of the following:

   (A) Secure Juvenile Facilities;

   (B) OJA contracted detention centers and community intervention centers;

   (C) OJA contracted residential care and shelter services as directed by the OJA—Executive Director, or designee;
(D) OJA contracted non-residential services provided by designated youth services agencies; by performing
(i) On-site contractor visits to reconcile claims against supporting documentation with a documented recommended corrective action, if appropriate;
(ii) Reviews of reimbursed claims for payment by OJA, to include: compliance with contract requirements; applicable laws, rules and regulations; and adequate supporting documentation.
(E) In addition to the above duties, the financial contract monitoring/review section shall perform in-depth financial audits as directed by the OJA Executive Director, or designee.

(b) Legal Basis/Authority. Authorization for the monitoring/assessment functions of the Office of Public Integrity is found in 10A O.S., § 2-7-301(E)(1)(c). Authorization for certification is found in 10A O.S. § 2-3-103(C)(1). Authorization for certification of community intervention centers (CIC) is found in 10A O.S. § 2-7-305(D)(1).

(c) Unit Independence. The Office of Public Integrity is organizationally and administratively independent from the other units and divisions of the agency that actually provide, or contract for, programs and services. Communication and coordination with agency and contractor personnel is necessary and desirable during the investigative, assessment, and monitoring procedures.

(d) Frequency of Assessments/Monitoring.
(1) OPI shall conduct announced certification assessments of contracted facilities, i.e. detention centers and community intervention centers, and municipal juvenile detention facilities shall occur on a bi-annual basis, with announced annual inspections during the interim year. OPI may conduct unannounced assessments shall occur at the direction of the OPI administrator/Division supervisor or Executive Director. OPI shall conduct announced assessments of Juvenile Services Units (JSU) in each county of the state shall occur on a bi-annual basis and unannounced assessments as requested by the Juvenile Services Division Director with approval of the OJA Executive Director, or designee. OPI shall conduct program assessments of OJA institutions, State Office units, contracted residential care facilities, non-residential services and shelters as directed by the OJA Executive Director, or designee.

(2) OPI shall financially monitor the OJA contracts with the youth services agencies shall be monitored at a minimum of twice per fiscal year. OPI shall financially monitor other contracted facilities and services, OJA institutions, and State Office units shall be monitored at the direction of the OJA Executive Director.


(a) Certification. The certification of secure detention facilities, municipal juvenile facilities, and community intervention centers by OJA is to ensure maintenance of minimum standards for the care and protection of juveniles detained in these facilities. OJA issues a permanent two-year certificate to operate a secure detention facility, a municipal juvenile facility, or a community intervention center when satisfied the facility meets the standards set forth in this subchapter. The certificate is non-transferable.

(b) Provisional certificate. OJA shall issue a ninety (90)-day provisional certificate to operate a newly established secure juvenile detention facility, municipal juvenile facility, and community intervention center after determining the facility meets the respective requirements to include: physical plant, staffing ratio, and written policies. Prior to the conclusion of the ninety (90) days, OJA shall conduct a full certification assessment of the facility. If the facility is in compliance OJA will issue a permanent two-year (2)-year certificate to operate the facility. If the facility is not in compliance, OJA may issue a second ninety (90)-day provisional certificate to operate the facility, as long as the health and safety of juveniles are not substantially at risk. OJA shall conduct a second full certification assessment of the facility prior to the conclusion of the ninety (90) days. Based on the findings of the second certification assessment,
OJA will either issue the two-year certificate to operate the appropriate facility or deny the application. Only the OJA executive director may authorize more than two ninety (90)-day provisional certificates. Any facility that has been closed, sold, or had a change in operators may not operate as a juvenile detention facility, municipal juvenile facility, or a community intervention center until it has gone through this certification process.

(c) **Probationary Certificate.** If a facility fails to meet/comply with the requirements of certification, but is not considered an immediate risk to the health and safety of the juveniles, OJA may place the facilities certificate on a probationary status to allow the facility time to regain compliance. The probationary status will not last more than ninety (90) days. During this time, OJA can opt to reduce the licensed capacity of the facility, implement additional safety plans or measures, and conduct unannounced inspections as needed. Should the facility fail to regain compliance during this time, the certificate shall be revoked. The facility will receive official notice of the decision to place the facilities certificate on probationary status and the grounds for such action.

(ef) **Revocation of certification.** If a facility is unable or unwilling to comply with requirements or has failed to adequately protect the health and safety of the juveniles, OJA may revoke the facility's permanent two (2)-year certification or its ninety (90)-day provisional certification. The OJA executive director must authorize the revocation of the certificate and the facility shall receive notice in writing of the decision and the grounds for such action.

(ge) **Monitoring.** The OJA Licensing and Programs Assessment division Office of Public Integrity monitors for compliance with the certification requirements and offers technical assistance upon request. Allegations that a facility is not in compliance with certification requirements may necessitate an OPI investigation. The name of the complainant is kept confidential, if possible. OPI The investigator shall advise the facility administrator of the outcome of the investigation.

(gf) **Development and revision of standards.** The OPI and other OJA staff After compliance monitoring, staff may propose new or modified certification standards to the Board of Juvenile Affairs. The development and revision of standards are subject to the rulemaking requirements of the Administrative Procedures Act.

**PART 3. REQUIREMENTS FOR SECURE JUVENILE DETENTION CENTERS**

377:3-13-35. **Legal basis**

Statutory authority for the Office of Juvenile Affairs OJA to certify secure juvenile detention facilities is found in 10A O.S., § 2-3-103(C). All juvenile detention facilities, including those not incorporated in the State Plan as provided in 10A O.S., § 2-7-608(C), must be certified by the Office of Juvenile Affairs.

377:3-13-37. **Organization, administration and finances**

(a) **Organization.** A statement of the purposes or function of the secure juvenile detention facility is clearly defined and filed with OJA the Office of Juvenile Affairs. The statement includes the services available for the juveniles who are admitted. A secure detention facility may be organized in any manner provided in 10A O.S., § 2-3-103(C)(3).

(b) **Administration and responsibility of the governing body.** The governing body of a secure juvenile detention facility shall:

1. have responsibility for the program and services of the facility;
2. review and approve all policies and policy changes;
3. maintain a record of policy approvals in meeting minutes and in an organized form developed by the facility;
4. obtain all required licenses for operation and continued compliance with Requirements for Secure Juvenile Detention Facilities;
5. meet twice a year to assure proper operation of the facility;
6. document meetings of the governing body and keep the documentation on file; and
7. have responsibility for the physical facility and its use by the juveniles and staff.

(c) **Finances.** The agency shall maintain complete financial records of income and disbursements.

1. All financial records pertaining to the agency are audited annually by a certified public accountant or public accountant who has a valid current permit to practice in the State of Oklahoma and who is not a staff member of the agency or in accordance with the governmental funding source.

2. A copy of the auditor’s statement substantiating the solvency of the agency and a statement concerning receipts and disbursements is submitted to the Office of Juvenile Affairs annually.

377:3-13-38. **Policy and procedure manual**

(a) **Policy and procedures.** The facility shall have a policy and procedure manual which specifically describes its purpose, program, and the services offered. The manual is to be reviewed at least annually and updated if necessary. Prior to implementation, all updates or additions to the policy and procedure manual must be submitted electronically to the Licensing and Programs Assessment division for review. The manual is available to all staff and all authorized regulatory authorities. It includes, but is not be limited to:

1. screening criteria;
2. admission procedures;
3. visiting arrangements;
4. disciplinary procedures;
5. security and control;
6. discharge procedures;
7. personnel practices;
8. juvenile rights;
9. resident grievance procedures;
377:3-13-39. Admission procedure and criteria
(a) Juveniles shall be admitted to the secure detention facility only as provided by 10A O.S. § 2-3-101 et seq. and § 2-7-504. The facility's written policy and procedure for admitting juveniles includes, but is not limited to, provisions which require the facility to:

1. verify legal authority to detain;
2. verify a written medical release has been obtained before allowing a juvenile to enter the center, in the event any juvenile appears to be under the influence, or has a visible medical concern;
3. search the individual and the juvenile's possessions;
4. inventory the juvenile's clothing and personal possessions;
5. distribute personal hygiene items;
6. make provisions for shower and hair care;
7. issue clean, laundered clothing;
8. ensure that the juvenile's family, custodian or guardian is notified;
9. assist the juvenile in notifying his or her family, guardian, or custodian of the juvenile's admission;
10. supervise the juvenile while the juvenile makes two admission phone calls, if desired;
11. conduct an admission interview of the juvenile to answer questions and obtain information;
12. complete a medical history questionnaire;
13. provide an orientation which includes:
   A. juvenile rights;
   B. program description;
   C. program rules;
   D. grievance process; and
   E. discipline policy;
14. record basic personal data;
15. review procedures for mail and visiting; and
16. assign the juvenile to a sleeping unit.

(b) Procedure availability. Procedures that compromise safety and security are not available to the public and clients.

377:3-13-40. Records
(a) Facility staff shall complete a confidential record for each juvenile admitted to the facility and include, at the minimum, the following:

1. court case number, if any;
2. date and time of admission and release;
3. name and nicknames;
4. last known address;
5. custodian;
6. name of attorney, if any;
7. name, title, and signature of delivering officer;
8. specific charge(s);
9. sex;
10. date of birth;
11. place of birth;
12. race or nationality;
13. education and school attended;
14. religious preference;
15. medical history questionnaire;
16. medical consent forms, court orders authorizing medical treatment, or documentation of request for medical consent;
17. name, relationship, address, and phone number of parent, guardian, or person with whom the juvenile resides at the time of admission;
18. driver's license number, social security number and medical assistance number, if any;
19. statement signed by the juvenile that he/she has been advised of juvenile rights, program rules, grievance process, and discipline policy;
20. date of petition, if available;
21. additional notations including identifying marks, any open wounds or sores requiring treatment, evidence of disease or body vermin, or tattoos;
22. inventory of personal property;
23. emergency contact person; and
24. signature of person recording data.

(b) Facility staff shall maintain a confidential record on each juvenile and ensure that the record is safeguarded from unauthorized and improper disclosure. The case record includes, at a minimum, the information in (1)-(14) of this subsection, when and where applicable:

1. documented legal authority to accept juvenile;
2. referral source;
3. record of court appearances;
4. signed release of information forms when records are requested or distributed;
5. notations of temporary absences from the facility;
6. visitors' names and dates of visits;
7. a record of telephone calls;
8. a report of any accidents or injury occurring to a resident while detained;
9. probation officer or caseworker assignment;
10. progress reports on program involvement;
11. court dates and disposition, if any;
12. grievance and disciplinary record, if any;
13. referrals to other agencies; and
14. final discharge or transfer report.

377:3-13-42. Juvenile rights
Written policy and procedure provides that facility staff shall ensure the rights of a detained juvenile are preserved. Staff shall not diminish or deny a detained juvenile his or her
377:3-13-43. Staff requirements
   (a) General provisions. The requirements for facility staff are set forth in this Section.
   (1) Personnel policy. Every facility shall have written personnel policy which includes the maintenance of personnel records. The facility director shall make available to employees personnel policy and written job descriptions. The policy and job descriptions specify the person to whom the employee is responsible and the duties the employee is expected to perform.
   (2) Juveniles' tasks. A juvenile in detention shall not be used as an employee. A juvenile in detention is permitted to perform tasks, if the tasks teach the juvenile responsibility and the juvenile is supervised. A juvenile shall be allowed to perform tasks (chores) in any area (restricted to the facility) in which adequate security exists. The facility administrator shall approve all work assign-ments.
   (3) Supervision. Sufficient staff shall be available to provide continuous day and night supervision of the residents and protection of the facility as well as to allow staff relief from duty.
   (4) Auxiliary staff. There shall be sufficient auxiliary staff to maintain adequate support services. Auxiliary staff are all staff that are not direct-care staff.
   (5) Health requirements. Staff health requirements are given in (A)-(B) of this paragraph.
      (A) Each person employed shall have a physical examination by a licensed physician, within the first 90 days of employment. The physician shall verify in a written statement that the individual is physically able to perform his or her job-related functions. Each person employed must be physically fit and able to perform all job functions necessary to ensure the health, safety and well-being of the juveniles in their care. A physical examination by a licensed physician may be requested should the employee's ability to perform their mandatory job functions be in question.
      (B) Testing for tuberculosis is not required on a routine basis. Tuberculin skin testing shall be required when there is a local identified tuberculin exposure identified by the Oklahoma State Department of Health.
         (i) When a tuberculin skin test is required, employees with a positive skin test reaction must submit documentation by medical personnel that signs or symptoms of tuberculosis are not present.
         (ii) An employee who has ever had a positive skin test reaction must have or provide documentation of a chest x-ray. Additional tests or x-rays are not required unless symptoms develop that are suggestive of tuberculosis.
   (6) Background history records searches. The Office of Juvenile Affairs OJA, through direct request, shall require a records search for each applicant for employment, which shall include the following:
(A) the Office of Juvenile Affairs (OJA) shall make a direct request for background searches to be conducted on behalf of any:

(i) operator or responsible entity making a request to establish or operate a secure detention center, municipal juvenile facility, community intervention center or secure facility licensed or certified by the Office of Juvenile Affairs (OJA);
(ii) employee or applicant of a secure detention center, municipal juvenile facility, community intervention center or secure facility licensed or certified by the Office of Juvenile Affairs (OJA), or
(iii) persons allowed unsupervised access to children, including contract employees or volunteers, of a secure detention center, municipal juvenile facility, community intervention center or secure facility licensed or certified by the Office of Juvenile Affairs (OJA);

(B) a national criminal history records search based upon submission of fingerprints that shall be provided by the Oklahoma State Bureau of Investigation (OSBI), including Rap Back notification, and the Federal Bureau of Investigation (FBI), pursuant to National Child Protection Act, 42 U.S.C.A. § 5119a, and 74 O.S. § 150.9, provided both the OSBI and FBI act in their designated role;

(C) a search of the Oklahoma State Courts Network (OSCN) including Oklahoma District Court Records (ODCR);

(D) a search of the Department of Human Services (DHS) Child Care Restricted Registry, also known as Joshua's List;

(E) a search of the Department of Corrections (DOC) Sex Offender Registry;

(F) a search of the Department of Corrections (DOC) Violent Offender Registry, also known as the Mary Rippy Violent Crime Offenders Registry;

(G) a search of all out-of-state child abuse and neglect registries if the applicant has not lived continuously in Oklahoma for the past five (5) years;

(i) The prospective applicant is not approved without the results of the out-of-state maintained child abuse and neglect registry checks, when a registry is maintained in the applicable state;

(ii) When no child abuse and neglect registry is maintained in the applicable state, the facility shall request any information that can be provided; and

(H) a criminal history records search conducted by an authorized source, when an applicant has lived outside the United States within the last five (5) years.

(7) **Criminal history investigation.** The facility shall not employ or retain any person for whom there is documented evidence that the employee would endanger the health, safety, and/or well-being of juveniles.

(A) A facility shall not employ or retain an individual who has been:

(i) convicted of or entered a plea of guilty or nolo contendere to any felony involving:

(I) violence against a person;

(II) child abuse or neglect;

(III) possession, trafficking, manufacturing, sale or distribution of illegal drugs, or conspiracy to traffic, manufacture, sale, or distribute illegal drugs;

(IV) sexual misconduct;

(V) gross irresponsibility or disregard for the safety of others;

(VI) any crime against a child; or

(ii) in the case of child abuse and neglect, identified as a perpetrator in a juvenile court proceeding and/or has made an admission of guilt to a person authorized by state or federal laws or regulations to investigate child abuse and neglect.

(B) As to a simple drug possession offender, the facility may, at its own discretion, make exceptions to the prohibition of employment if five (5) years have passed from completion of the applicant's criminal sentence and the facility can document that the health, safety, and well-being of juveniles would not be endangered.

(i) The facility shall consider, document, and submit to the Licensing and Programs Assessment Division (LPAD) the Office of Public Integrity within ten (10) days of the employees first day of work the:

(I) type of crime or offense for which the individual was convicted or a finding was made; and

(II) reference letters concerning the individual in question.

(ii) The Licensing and Programs Assessment Division (LPAD) may make a recommendation to the facility administrator as to whether the applicant for employment should be approved or disapproved.

(C) If there is an allegation that a staff member has committed an act as described in OAC 377:3-13-43(a)(7)(A), the facility shall determine and document whether the staff member shall be removed from contact with juveniles until the allegation is resolved.

(D) If any person is formally charged with any of the offenses described in OAC 377:3-13-43(a)(7)(A), notification must be made to the OJA Licensing and Programs Assessment Division, and the employee be or she must be removed from contact with juveniles until the charges are resolved.

(E) No employee of the facility shall use or be under the influence of alcohol or illegal drugs during hours of work or shall any employee use or possess illegal drugs at any time.

(8) **Personnel records.** The facility shall keep on file a written personnel record available for review for every staff person employed by the facility.
(A) The personnel record includes, but is not limited to:
(i) an application, resume or staff information sheet that documents qualifications for the position, valid driver's license or other state ID, birth certificate, applicable educational diploma;
(ii) health records as required by the facility;
(iii) three (3) written references and/or documentation of telephone interviews;
(iv) any reports and notes relating to the individual's employment with the facility and an annual job performance evaluations;
(v) dates of employment; and
(vi) date and reason for leaving employment.
(B) When employment is involuntarily terminated, a statement regarding the reason for termination is to be included in the personnel file.
(C) Personnel records are maintained for at least three years following a staff member's separation.
(D) All employees' records are kept confidential subject to existing state and federal statutes.
(E) Staff members shall have access to their personnel files for reviewing purposes if a request is made to the facility administrator.
(9) Staff training. All staff shall be trained on facility policy and procedure and a training record shall be established for each staff member. A record of all annual training shall be maintained. At the end of the year, it shall become part of the personnel record.
(A) Each direct-care staff member shall be provided orientation before being allowed to work independently.
(B) Auxiliary staff shall receive orientation to the facility's policy and procedure and to their assigned duties.
(C) During orientation the trainer shall acquaint staff with the philosophy, organization, program practice, and goals of the secure juvenile detention facility.
(D) "Requirements for Secure Juvenile Detention Facilities" is reviewed as a part of the orientation process and is available to staff at all times.
(E) Within ninety (90) days of employment, by a detention facility, all direct-care staff shall have successfully completed a specific course of instruction in first aid as established by the Red Cross, American Safety and Health Institute (ASHI), American Heart Association (AHA), or its equivalent. This training must be presented by a certified instructor, or by a certified instructor in an equivalent professionally recognized CPR training program. There shall be a certificate or card issued to the employee and this card must be signed by the certified instructor attesting to the employee's successful completion of the professionally recognized CPR training program. The Red Cross, American Safety and Health Institute (ASHI), American Heart Association (AHA), or its equivalent CPR course of instruction shall be presented by a certified instructor, and shall be updated on an annual basis. Employees will maintain their certification as required by the certifying entity. The CPR training may count towards the employee's required annual training hours.
(G) Full-time direct-care staff and administrators shall obtain at least 24 clock-hours of training per employment year. Hours are prorated at two hours per month for staff who have not been employed for a full year.
(H) Part-time direct-care staff shall have training hours prorated based on the average number of hours of work per month.
(I) On-call staff shall have a minimum of six (6) hours of training per year.
(J) Support staff shall obtain a minimum of twelve (12) hours of training per employment year.
(K) The content of staff development courses for direct-care staff is relative to their roles and responsibilities. Content may include:
(i) crisis intervention;
(ii) child development;
(iii) behavior management;
(iv) discipline;
(v) stress management;
(vi) therapeutic relationship and intervention;
(vii) child abuse detection, reporting and prevention;
(viii) suicide prevention;
(ix) human sexuality;
(x) client grievance procedures;
(xi) communicable diseases, including sexually transmitted diseases; and
(xii) any other training deemed necessary to meet individual or group training needs.
(L) Attendance at professional conferences, workshops, seminars, formal education classes, or in-service training is counted toward the training requirements provided the training is documented and meets the content requirements.

(b) **Facility Administrator.** The duties and qualifications of the facility administrator are described in (1) - (2) of this subsection.

(1) **Responsibilities.** The facility administrator is responsible for implementing the policies adopted by the governing body, the ongoing operation of the facility, and compliance with the Requirements for Secure Juvenile Detention Facilities.

(A) In the facility administrator's absence a person shall be designated to act as administrator and shall be available to detention staff in person or by telephone.

(B) A designated person of responsibility shall be at the secure juvenile detention facility at all times. The designated person is directly responsible to the administrator who is to be notified of any irregularities in the general affairs of detention and follow through with directives given.

(C) The duties of the facility administrator include, but are not limited to:

(i) preparing and presenting the budget for the appropriate authority to review and approve;

(ii) administering the budget and maintaining accurate financial records;

(iii) employing and discharging staff according to the established personnel rules;

(iv) supervising the program overall;

(v) holding staff meetings on a monthly basis to discuss plans and interpret policies to the staff;

(vi) organizing a program for the continued training and development of staff;

(vii) establishing and maintaining working relationships with other social services agencies within the community; and

(viii) interpreting the program to professional and lay groups.

(2) **Qualifications.**

(A) The education, experience, and qualifications of the administrator of a large facility (20 beds or more) are specified in writing by the governing body of the facility and includes, at a minimum:

(i) bachelor's degree from an accredited college/university in an appropriate discipline;

(ii) two (2) years of experience working with juveniles; and

(iii) five (5) years in staff supervision and administration.

(B) The education, experience, and qualifications of the administrator of a small facility (less than 20 beds) are specified in writing by the governing body of the facility and includes, at a minimum:

(i) associate's degree from an accredited junior college/college/university in an appropriate discipline (i.e. social work, sociology, psychology, criminal justice, etc.); OR

(ii) sixty (60) hours of credits from an accredited junior college/college/university of which fifteen (15) hours must be in the appropriate discipline as indicated in (i); and

(iii) two (2) years in staff supervision; and

(iv) one (1) year of experience working with juveniles.

(C) A facility administrator hired prior to January 1, 2000 shall be exempt from the rules set forth in (A) of this paragraph.

(3) **Location.** All facilities administrators must maintain their primary office at the detention facility.

(4) **Hiring requirements.** A direct-care staff person can be hired when the person:

(A) has his or her character and fitness attested to by three (3) satisfactory written references and a criminal history background check is conducted as required and in conformance with 377:3-13-43(a)(6);

(B) is qualified and capable of satisfactorily performing assigned job responsibilities; and

(C) does not pose a known risk to juveniles.

(d) **Support staff.** Support staff shall be able to read and write; demonstrate knowledge and skills necessary to the job assignments; and meet the requirements for direct-care staff if responsible for direct care of juveniles for any part of the day.

377:3-13-44. **Security and control**

(a) The facility shall have policy and procedure for security and control.

(b) A list of in-house rules, outlining acts prohibited in the facility and the range of disciplinary procedures, is given to all juveniles. The list is posted in a conspicuous and accessible area.

(1) Staff members shall explain in-house rules to each juvenile admitted to the facility.

(2) When a literacy or language problem prevents a juvenile from understanding the list of rules, a staff member or translator shall assist the juvenile in understanding the rules.

(c) Required security control procedures are described in (1) - (15) of this subsection.

(1) **Resident count.** The facility shall have a system to physically count detained juveniles.
(A) The facility director shall designate one staff member per shift to conduct at least one uninterrupted population count during the shift.
(B) The staff member conducting the count shall be a trained employee in each living unit who shall see the juveniles being counted.
(C) Juveniles shall not be permitted to move about the facility during the count.
(D) Documentation of resident counts is available at the facility at all times.

(2) Mail security. Written policy and procedure provide that a juvenile may send or receive mail without limitation, censorship, or prior reading by staff. Staff may open a juvenile's mail in the presence of the juvenile to limit any cleansing, censorship, or prior reading by staff. Staff may open a juvenile's mail in the presence of the juvenile to limit any cleansing, censorship, or prior reading by staff. Staff may open a juvenile's mail in the presence of the juvenile to limit any cleansing, censorship, or prior reading by staff.

(3) Searches and control of contraband. The facility shall have written policy and procedure governing searches and control of contraband.
(A) Policy and procedure include, but are not limited to:
(i) control of contraband;
(ii) searches for contraband;
(iii) body searches;
(iv) property searches;
(v) searches of the facility; and
(vi) visitor searches;
(B) Residents and visitors shall be notified that they are subject to search.
(C) No resident shall be searched beyond what is necessary to maintain proper security.
(D) Searches are conducted by a staff member of the same sex as the resident or visitor.
(E) A body cavity search may be conducted only when there is a strong reason to believe that the juvenile is concealing contraband in a body cavity.

(i) The facility administrator must give authorization to medical personnel for any body cavity search.
(ii) Medical personnel are the only persons authorized to perform body cavity searches.
(iii) The body cavity search must be conducted in a private area of the facility, without windows, which ensures the privacy and dignity of the juvenile.
(iv) A supervisory witness of the same sex as the juvenile shall be present during the body cavity search.
(v) The detention facility shall contact the OJA Advocate General within 24-hours of conducting a body cavity search.

(4) Staff ratios and staffing patterns. There is a minimum ratio of 1:7 direct-care staff to residents during waking hours and 1:16 during residents' sleeping hours.
(A) When a female is placed in detention, there must be a female staff member on duty and when a male is placed in detention, there must be a male staff member on duty;
(B) A minimum of two direct-care staff are on duty at all times in the facility.
(C) Juveniles in detention shall be supervised at all times. The facility shall have enough staff available for staff to remain close to and in visual contact with the juveniles.

(i) If a resident is placed in their room for medical, safety, or behavioral concerns, this will be considered a room confinement and the facility licensing standards on resident visual observation checks will be adhered at all times.
(ii) During residents’ sleeping hours room checks will be completed not to exceed 30 minutes between checks.
(iii) All room checks should be documented daily in an observation log and maintained by the facility.

(5) Surveillance plan. The facility shall have a plan for surveillance of all areas of the perimeter of the facility. Outside lighting must be sufficient to provide visibility under all conditions with no blind spots.

(6) Door security. All doors that are security perimeter entrances, exterior doors, and doors which the facility administrator determines should be locked are kept locked. These doors are unlocked only for admission or exit of juveniles, employees, or visitors or in case of an emergency.

(A) Doors to vacant units, unoccupied areas, and storage rooms are kept locked when not in use.
(B) Staff members shall know what doors must be locked and under what circumstances they are opened.
(C) Once a door is locked, it is checked to see that it is secured.

(7) Key control. The facility's key-control system provides for the following:
(A) a log to record the number of keys given out, the location of the lock, the number of keys to that lock, and the names of employees possessing keys;
(B) a central administrative area from where the keys can be issued;
(C) a manner of storage that permits easy determination of either the presence or absence of keys;
(D) labeling of all keys and maintenance of at least one duplicate key for each lock; and
(E) readily available fire and emergency keys.

(8) Physical force. Rules relating to the use of physical force are set forth in this paragraph.
(A) Written policy and procedure limit the use of physical force:
(i) for self-protection;
(ii) to separate juveniles from fighting;
(iii) to restrain juveniles in danger of inflicting harm to themselves or others; and
(iv) to restrain juveniles who have escaped or who are in the process of escaping;
(B) The least amount of force is used.
(C) Physical force may not be used as punishment or retaliation.

(D) Facility personnel shall not encourage or knowingly permit any person to use physical force which is contrary to policy.

(E) Staff members shall not provoke physical confrontation by taunting, harassing, or cursing a resident or otherwise manipulating a resident into activities which would justify physical force.

(F) A written report is prepared following all uses of force and submitted to the facility administrator by the end of the shift detailing the incident which initiated the use of force, the type of force used and the beginning and end time of the use of force.

(G) Staff members shall receive written guidelines on the use of physical force and shall be informed that loss of employment may result if unauthorized use of physical force is proven.

(H) Medical attention shall be provided immediately upon the juvenile's release from restraint as a result of physical force even if there is not visible evidence or complaint of injury. Staff certified in first aid and CPR may provide medical attention and are responsible for referring the juvenile to licensed medical personnel, if warranted.

(9) Use of mechanical restraints. Any instrument of restraint must be approved by the facility administrator or designee.

(A) Restraints are used only:
   (i) for self-protection;
   (ii) to separate juveniles from fighting;
   (iii) to restrain juveniles in danger of inflicting harm to themselves or others;
   (iv) to restrain juveniles who have escaped or who are in the process of escaping; and
   (v) prevent destruction of property if reasonably related to (i) through (iv).

(B) Restraints are used only with the approval of the facility administrator or designee.

(C) Restraints may not be used as a form of punishment.

(D) Restraints are used only as long as necessary and are removed as soon as the juvenile regains control of his/her behavior.

(E) When restraints are placed on a juvenile, such placement must be made by a trained and authorized staff member in a humane manner that does not restrict the juvenile's blood circulation.

(F) Juveniles shall not be restrained to an immovable object.

(G) A juvenile's hands and feet may be restrained, however restraining of the juvenile's hands to his or her feet is prohibited.

(H) The use of hog-tying is prohibited.

(I) A juvenile placed in restraints shall not be left unattended and must be continually supervised.

(J) A full written report is submitted by the end of the shift to the administrator following every use of an instrument of restraint.

(10) Chemical agents. Facility staff shall not use chemical agents for security. Staff may not use tear gas, mace, pepper spray, and related chemical agents to control juveniles.

(11) Weapons. Weapons are not permitted except when authorized by state law.

(12) Procedures for separation from general population and/or general activities for disciplinary reasons. The following procedure shall be utilized as an intermediary level of intervention, which requires the continual line of sight and sound observation of the juvenile. If a juvenile is separated from the general population, the reasons for the separation and length of time shall be documented in the written daily observation of the juvenile. The separation should not be in excess of 60 minutes. Additional intervals shall be approved by a supervisor/administrator who was not involved in the original incident. Facilities which do not have another supervisor/administrator on site shall receive re-authorization from the on-call administrator. The reasons for the continued separation must be documented. The juvenile shall be released when staff determines that he or she can safely be returned to the group.

(13) Room restriction. Room restriction is one means of informally resolving minor juvenile misbehavior. It serves a "cooling off" purpose and has a short time period (up to 60 minutes) that is specified at the time of the assignment.

(14) Room confinement. Room confinement means locking a juvenile in his/her room when the juvenile has been charged with a major rule violation requiring confinement for his/her safety or the safety of others or to ensure the security of the facility.

(A) Room confinement is used with detained juveniles:
   (i) for self-protection;
   (ii) to separate juveniles from fighting;
   (iii) to restrain juveniles in danger of inflicting harm to themselves or others;
   (iv) to restrain juveniles who have escaped or who are in the process of escaping; and
   (v) prevent destruction of property if reasonably related to (i) through (iv).

(B) Room confinement of juveniles shall be re-authorized every 3 hours, except during normal sleeping hours, by a supervisor/administrator who was not involved in the original incident. Facilities which do not have another supervisor/administrator on site shall receive re-authorization every 3 hours from the on-call administrator. Reasons for continued room confinement shall be documented.
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(C) A juvenile shall not be in room confinement in excess of 24 hours without the opportunity of an administrative review by the administrator or designee who was not involved in the incident. Any juvenile for whom it is determined by the administrator, or designee, to continue room confinement in excess of forty-eight (48) hours, must complete a report detailing the reasons for continued room confinement and submit it to the OJA for review within twenty-four (24) hours of exceeding the forty-eight (48) hours.

(15) Procedure for room confinement or room restriction. When room restriction or confinement is used, the procedure given in (A) - (E) of this paragraph is followed.

(A) Prior to room restriction or confinement, facility staff shall explain the reasons for the restriction or confinement to the juvenile and shall give the juvenile an opportunity to explain his or her behavior.

(B) Any juvenile shall be visibly observed by a staff member every 15 minutes, and this must be documented.

(C) Juveniles placed in room confinement shall be afforded living conditions and essential services approximating those available to the general juvenile population. Exceptions shall be justified in writing by clear and substantial evidence.

(D) The juvenile shall be released when staff determines that he or she juvenile can safely be returned to the group and no longer presents a safety risk to self or others.

(E) A written record shall be maintained on any juvenile placed in room restriction or confinement. It includes a log stating who authorized the action, names of persons observing the juvenile and times of observation, the person authorizing release, and the time of release.

(16) Escape and absence without leave. The facility shall develop written policy and procedure for juveniles who escape from the facility or are absent without leave which shall include the notification of law enforcement agencies.

377:3-13-45. Program and services

(a) Activities and services are available to each juvenile outside their room at least twelve (12) hours a day. The facility shall provide or make available the minimum services and programs given in (1)-(7) of this subsection to detained juveniles.

(1) Education. The facility shall provide educational opportunities in compliance with federal and state laws, State Department of Education requirements, applicable local school district requirements, and the local school district's rules and regulations and OJA contract requirements. Facilities shall provide or make provisions for an educational program, which includes space for education, necessary equipment and supplies, and supervision.

(2) Visitation. Written policy and procedure specify the number of visitors a juvenile may receive and the length of visitation.

(A) Visits may be limited only by the facility's schedule, space, and personnel constraints or where there are substantial reasons to justify such limitations.

(B) Juveniles have the right to refuse visitation.

(C) Legal counsel for a detained juvenile may visit at any reasonable time a request is made.

(3) Social services. The facility's social services program shall make a range of resources available to meet the needs of juveniles.

(A) Juveniles shall be afforded access to emergency mental health counseling and crisis intervention services according to their needs.

(B) Counseling services include group or individual counseling and are provided at least weekly.

(4) Recreation. Written policy and procedure provide a recreation schedule that includes at least one hour per day of large muscle activity and one hour of structured recreational activities. A variety of recreational materials are made available to detained juveniles and kept in good condition at all times.

(5) Food service. Written policy and procedure provide that the dietary needs of juveniles are met.

(A) Special diets as prescribed by appropriate medical or dental personnel or as required by religious preference are provided.

(B) Menus are planned at least one week in advance, posted and dated, and kept on file for one year.

(C) Menus are approved before use and reviewed annually by a licensed dietician, nutritionist, or physician to ensure compliance with nationally recommended food allowances. Facilities participating in the National School Lunch Program are not required to have their breakfast and lunch menus approved by a licensed dietician, nutritionist, or physician.

(6) Medical and health care. The facility shall have written policy and procedure for delivery of health care services. When health care services are provided by someone other than a physician, the final medical judgment rests with the designated physician.

(A) Written health care policy and procedure is approved by a designated physician.

(B) Medical, mental health, and dental care involving medical judgment are the sole province of the designated physician, mental health professional or dentist.

(C) Personnel who provide health care services to juveniles shall be governed by a written job description approved by the medical authority.

(i) Responsibilities and job duties are in keeping with the individual's professional discipline.

(ii) Verification of current credentials and job descriptions are on file in the facility.

(D) Security regulations applicable to facility personnel also apply to health personnel.
(E) The secure juvenile detention facility shall develop and maintain written policy and procedure which:

(i) requires medical screening upon arrival of any juveniles, including intra system transfers at the facility.

(ii) records all findings on a medical screening form approved by the physician;

(iii) accounts for receiving, storing, dispensing, administering and distributing all medications and first aid supplies;

(iv) prohibits the use of juveniles for medical, pharmaceutical or cosmetic experiments;

(v) assures that detention staff and other personnel are trained to respond to health related situations; and

(vi) establishes a training program that includes:

(I) recognition of signs and symptoms of illness or injury and knowledge of action required in potential emergency situations;

(II) administration of first aid and cardiopulmonary resuscitation (CPR);

(III) methods of obtaining assistance;

(IV) signs and symptoms of mental illness, intellectual and/or developmental disorders, trauma retardation and drug and alcohol abuse; and

(V) procedures for transfer to appropriate medical facilities or health care providers.

(7) Medication. Medication is administered by persons properly trained in medical administration and under supervision of the physician and facility administrator.

(A) Prescription medication is only administered as directed by a physician.

(B) When any medication is administered, a precise record is kept of the juvenile's name, reason for dosage, route, date and time given, and signature of the person who administered it. Any adverse reaction to the medication is documented.

(C) When prescription medications are used, the juvenile, custodian, and all staff members shall be made aware of side effects of the medication.

(D) All medications, syringes, and needles are protected by maximum-security storage and are under the supervision of staff on duty.

(E) The facility will ensure proper notification is made to the juvenile's custodian and OJA, five (5) days before any medications need to be refilled. If needed medications are not received after five (5) days, facility administrator will contact the OJA District Supervisor or Assistant District Supervisor for assistance in obtaining the medications.

377:3-13-46. Physical plant or facility

(a) Building plans. Prior to new construction or remodeling existing structures to be used for secure juvenile detention facilities, building plans are first presented to and approved by the:

(1) Office of Juvenile Affairs to assure compliance with ACA Standards for Detention and Section 504 of the Rehabilitation Act of 1973 as amended. The plan shall be submitted to the OJA Licensing and Programs Assessment division OJA Office of Public Integrity for review. Consultation may be obtained from the Oklahoma Office of Handicapped Concerns. OJA shall provide consultation on building plans and suggest requirements for environmental design as they impact program and services. The population using housing or living units may not exceed the designed or rated capacity of the facility and exceed designed use standards;

(2) the State Fire Marshal's Office to assure compliance with the National Fire Protection Association Life Safety Code as adopted by the State Fire Marshal's Commission and administered by the Office of the State Fire Marshal. The State Fire Marshal will determine the rated capacity for the facility; and

(3) Commissioner of Health, State Health Department, Environmental Health Services to assure compliance with the adopted rules and regulations of the State Board of Health. Juvenile detention facilities are designed and comply with the duly adopted codes for plumbing, electrical, water supply and sewage disposal.

(b) Space. Space requirements for secure juvenile detention facilities are set forth in this subsection.

(1) Single sleeping rooms consist of at least 70 square feet of floor space. There shall be no double-ceiling of juveniles unless:

(A) the room has been specifically constructed to house two (2) juveniles;

(B) the Office of Juvenile Affairs approved the construction plans prior to construction of the facility/room; and

(C) the room meets the space requirements set forth in the American Correctional Association's (ACA) "Standards for Juvenile Detention Facilities".

(2) Male and female residents shall not occupy the same sleeping room.

(3) Not less than 35 square feet of floor space per juvenile is provided in the day room on each living unit.

(4) The facility shall provide at least 15 square feet of floor space per person for individuals occupying the dining room or dining area.

(5) The total indoor activity area outside the sleeping area provides space of at least 100 square feet per resident.

(6) School classrooms are designed in conformity with local or state educational requirements.

(7) Where the facility provides food service, the kitchen has at least 200 square feet of floor space.

(c) Bathrooms. All housing and activity areas provide, at a minimum, one toilet, one wash basin, and one shower for every six residents. All juveniles and staff shall have access to a drinking fountain by residents and staff.
Flush urinals may be substituted for not more than one-half the required number of toilets when provided to serve males only.

Every lavatory basin, bathtub or shower is supplied with hot and cold water under pressure at all times.

All showers and bathtubs must have temperature control equipment.

All fixtures must be maintained in good working condition.

Toilet paper, soap and individual sanitary towels are provided within easy access of the residents.

General. General requirements related to food service, sanitation, and hygiene are set forth in this subsection.

Minimum health requirements for secure juvenile detention facilities are determined by the Health Department and enforced by the Office of Juvenile Affairs. An annual inspection of the facility is conducted to determine compliance with health codes. Documentation is kept on file at the facility.

The facility shall have a written plan for housekeeping that is posted and followed at all times.

The facility shall be weather tight and kept in sound condition.

The facility's written policy and procedure specify that its food services comply with the Board of Health Food Service Code and regulations.

Plumbing is sized, installed, and maintained in a safe manner and according to the Oklahoma Plumbing License Act. Plumbing constructed after the effective date of these rules will be installed in compliance with the Building Officials and Code Administrators Plumbing Codes or applicable local ordinances.

There may not be cross-connection between the potable water supply and any non-potable or questionable water supply or any source of pollution through which the potable water supply might be contaminated.

The facility's potable water source and supply, whether owned and operated by the public water department or the facility, must be approved by an independent, outside source to be in compliance with jurisdictional laws and regulations.

The electrical distribution system must be sized, installed, and maintained in a safe manner according to the Oklahoma Electrical Licensing Act. Portions of the electrical system constructed, repaired, or replaced after the effective date of these rules will be installed in compliance with the National Electrical Code.

Solid waste disposal must comply with the appropriate local ordinance where in effect and otherwise with the Oklahoma Public Health Code and adopted rules and regulations. Sewage disposal must comply with the Oklahoma Health Code and adopted rules and regulations.

Requirements regarding lighting in the facility are set forth in this subsection.

The facility shall have sufficient air and lighting to ensure the health of the detained juveniles.

(1) Any room designated as a sleeping room shall have natural lighting by a room window to the exterior or from a source within 20 feet of the room. This rule does not prohibit OJA from issuing a provisional certificate if a sleeping room does not meet this criteria.

(2) All window panes must be of shatter-resistant material.

(3) Thirty foot-candles of artificial light are provided in all areas and additional light of at least 50 foot-candles is provided in study areas.

Every hallway and stairway in each secure juvenile detention facility is lighted by natural or electric light at all times to provide at least ten foot-candles of light at floor level. Every hall and stairway in structures containing not more than two sleeping areas may be supplied with conveniently located light switches controlling an adequate lighting system which may be turned on when needed instead of full-time lighting.

Non-habitable areas, such as bathrooms and food preparation areas, provide other approved ventilation systems in lieu of windows or skylights. Adequately designed, maintained, and operated central heating and cooling systems must meet the ventilation requirements. Window area requirements may be reduced but must be adequate to meet requirements of the State Fire Marshal.

Every window, exterior door, and hatchway, or similar devices, must be rodent proof and weather tight and kept in working condition and good repair.

During the portion of the year when there is a need for protection against mosquitoes, flies and other flying insects, every door and window must have a properly fitting stainless steel mesh detention screen.

Air conditioned habitable areas are deemed adequate to meet this requirement when properly operated unless vectors are able to enter to such extent that a nuisance or hazard is created.

Every habitable area must have heating facilities which are properly installed and maintained in working condition. The heating system must be capable of safely and adequately heating all habitable rooms, bathrooms, and water closets at a temperature of at least 68 degrees Fahrenheit at a distance of eighteen (18) inches above floor level under ordinary winter conditions.

An acceptable temperature zone for maintaining year round comfort is sixty-six (66) to eighty (80) degrees Fahrenheit in the summer, optimally seventy-one (71) degrees, and sixty-one (61) degrees to seventy-three (73) degrees Fahrenheit in the winter, optimally seventy (70) degrees.

Written policy, procedure, and practice require that at least three meals, two of which are hot, be provided at scheduled times during each 24-hour time period on regular business weekdays, with no more than 14 hours between the evening meal and breakfast meal. Only on weekends and state recognized holidays may a hot brunch and a hot
evening meal, both of which meet basic nutritional goals, be provided at scheduled times during each 24 hour time period.

(1) The facility provides or arranges for the meals and at least one snack per 24 hour day from food that is selected, stored, prepared, and served in a sanitary and palatable manner. Each meal contains a sufficient amount of food for every juvenile and additional servings are permitted.

(2) Facilities recognize the social and emotional needs of juveniles during mealtime. Juveniles and the staff who eat with them are served the same food, except for tea and coffee, unless differences in age or special dietary needs are factors.

(h) Hygiene. Juveniles shall have the opportunity for daily showers.

377:3-13-48. Safety and emergency

(a) Fire protection. Minimum state fire safety requirements for secure juvenile detention facilities are enforced by the State Fire Marshal’s office. Documentation of compliance is available at the facility at all times.

(1) Secure juvenile detention facilities for juveniles must comply with the Building Officials Administrators Code (BOCA) as enforced by the State Fire Marshal's office.

(2) The facility's written policy and procedure provide for a qualified fire and safety officer to regularly inspect the facility for compliance with safety and fire prevention requirements. The facility director and designated staff shall conduct an annual review of policy and procedure. An administrative staff member or designee shall conduct a fire and safety inspection of the facility at least weekly.

(3) The facility's written policy and procedure relating to fire safety is reviewed at least annually by certification staff.

(4) Written policy and procedure specify the facility's fire prevention regulations and practices to ensure the safety of staff, juveniles, and visitors. Fire prevention practices include, but are not limited to:

(A) a provision for an adequate fire protection service; and

(B) annual inspection and testing of equipment by a fire service company approved by the local fire official.

(5) Fire hoses or extinguishers are available at appropriate locations throughout the facility.

(6) Specifications for the selection and approval of facility furnishings indicate the fire safety performance requirements of the materials selected.

(A) Materials selected are subjected to careful fire safety evaluation before purchase or use.

(B) Only mattresses manufactured from materials that are not highly flammable are used.

(7) The facility is equipped with non-combustible receptacles for smoking materials. Separate containers are provided in other locations throughout the facility for other combustible refuse.

(8) A fire alarm and automatic detection system is required as approved by the state and/or local fire marshal.

(9) Special containers are provided for flammable liquids and for rags used with flammable liquids.

(10) All plans for exiting the building during time of fire emergencies are posted in a conspicuous place on all levels of the facility.

(b) General emergency procedures. Written policy and procedure specify the means for the prompt release of juveniles from locked areas in case of emergency and provide for a secondary release system if electrically equipped.

(1) All facility personnel shall be trained in the implementation of written emergency plans.

(2) Written policy and procedure govern the control and use of all flammable, toxic, and caustic materials.

(3) The facility director or designee shall develop written plans which specify procedures to be followed in emergency situations, e.g., fire, disturbances, taking of hostages. These plans are made available to all applicable personnel and are reviewed and updated at least annually.

(4) The facility shall have access to an alternate power source to maintain essential services in an emergency.

Essential services include but are not limited to:

(i) access to drinking water;

(ii) security lighting;

(iii) appropriate food storage; and

(iv) ability to maintain safe building temperatures

(c) Exits. The facility shall have exits that are properly positioned and clearly, distinctly, and permanently marked in accordance with fire prevention regulations and practices to ensure the timely evacuation of juveniles and staff in the event of fire or other emergency.

(1) Two identifiable exits are located in each juvenile housing area and other high density areas to permit the prompt evacuation of juveniles and staff under emergency conditions.

(2) The facility shall have exits that are continuously visible at all times, kept clear, and maintained in usable condition.

(d) Emergency evacuation. The facility shall create, and review annually, an emergency evacuation plan. The plan, or any annual amendments to the plan, shall be submitted for approval to the OJA Licensing and Programs Assessment division. The plan must contain at a minimum:

(1) A secondary site will be identified by the facility in the event the facility needs to evacuate in case of emergency or natural disaster.

(2) Should the emergency necessitate an absence from the facility in excess of twenty-four (24) hours, the secondary site must be emergency certified by the OJA Licensing and Programs Assessment division and meet all Safety, Security, and Control, and Physical Plant Requirements for Secure Detention.

(3) Should a detention facility be damaged, OJA Licensing and Programs Assessment division may require
an inspection be conducted prior to allowing the continued certification of the facility. The Licensing and Programs division will arrange to conduct the inspection with the detention provider.

(4) If necessary, OJA shall assist with moving youth from facility due to damage or factors that make the facility unable to operate.

(de) Facility maintenance. Requirements for maintenance of the facility are set forth in this subsection.

(1) Housekeeping. All habitable and non-habitable areas are maintained in a condition free of litter.

(2) Laundry. Work areas are maintained in a clean and safe condition. Equipment is installed in such a way as to meet safety requirements.

(3) Maintenance of the activity area. Equipment is maintained in good repair and activity areas are free of hazards.

(4) Maintenance of the interior structure. The interior of the building, including appliances, machinery, and equipment, is maintained in proper working order at all times. Interior walls, carpeting, and furniture is repaired, replaced, and kept in acceptable condition.

(5) Interior finish materials. All interior surfaces, including walls, ceilings and floors, must have flame-spread ratings as outlined by the BOCA Building Code. Documentation of appropriate flame-spread ratings must be obtained from the manufacturers of the material. Examples of interior finishing materials include, but are not limited to, paint, paneling, wallpaper, carpets, and tile.

(6) Furnishings and decorations. Draperies, curtains, and similar furnishings and decorations must be flame resistant.

(A) Proof of flame resistance is documented from the material manufacturer that the material passed the criteria of NFPA 701, small and large scale tests.

(B) Waste baskets and other waste containers must be of noncombustible or self-extinguishing materials.

(C) Mattresses and upholstered or cushion furniture may not be of a highly flammable character.

(7) Exterior surfaces. All exterior wood surfaces, other than decay-resistant woods, must be protected from the elements and decay by a lead-free paint or other product to provide a protective covering or treatment. Toxic paint and materials may not be used where readily accessible to juveniles.

PART 11. REQUIREMENTS FOR SECURE JUVENILE DETENTION CENTERS

377:3-13-127. Physical plant requirements

(a) The secure juvenile facility shall conform to applicable federal, state and/or local building codes and zoning ordinances.

(b) The secure juvenile facility shall be clean and sanitary and shall comply with standards, rules and regulations promulgated by the Oklahoma State Department of Health.

(c) Each juvenile shall have at a minimum a bed, storage space for clothing and access to a writing area. Multiple-occupancy rooms, including open-bay dormitories, and single occupancy rooms shall provide at least 270 square feet per juvenile.

(e) Dayrooms are situated adjacent to sleeping areas and provide a minimum of 35 square feet per juvenile for the maximum number of juveniles who use the dayroom at one time (exclusive of lavatories, showers and toilets).

(f) Clean and sanitary bathrooms are convenient to sleeping rooms and dayrooms:

(1) One flush toilet, hand sink and bathtub or shower in good working order is available for each six juveniles.

(2) Flush urinals may be substituted for up to one-half the required number of toilets to serve male juveniles only.

(3) Hand sinks, bathtubs and showers have cold and hot water with temperatures between 100 and 120 degrees Fahrenheit.

(4) Toilet paper, soap and individual sanitary towels are provided to juveniles.

[OAR Docket #21-415; filed 6-14-21]

TITLE 390. COUNCIL ON LAW ENFORCEMENT EDUCATION AND TRAINING

CHAPTER 15. BASIC PEACE OFFICER CERTIFICATION TRAINING

[OAR Docket #21-448]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:

Subchapter 1. Basic Academy Programs
390:15-1-1. [AMENDED]
390:15-1-2. [AMENDED]
390:15-1-3. [AMENDED]
390:15-1-5. [AMENDED]
390:15-1-6. [AMENDED]
390:15-1-7. [AMENDED]
390:15-1-8. [AMENDED]
390:15-1-9. [AMENDED]
390:15-1-13. [AMENDED]
390:15-1-18. [AMENDED]
390:15-1-19. [AMENDED]
390:15-1-20. [REVOKED]

Subchapter 3. Collegiate Officer Program
390:15-3-1. [AMENDED]
390:15-3-2. [AMENDED]
390:15-3-3. [AMENDED]
390:15-3-6. [AMENDED]
390:15-3-7. [AMENDED]
390:15-3-8. [AMENDED]
390:15-3-9. [AMENDED]
390:15-3-10. [AMENDED]

Subchapter 4. Basic peace officer certification academy program
390:15-4-1. [AMENDED]
390:15-4-2. [AMENDED]
390:15-4-3. [AMENDED]
390:15-4-5. [AMENDED]
390:15-4-6. [AMENDED]
390:15-4-7. [AMENDED]
390:15-4-8. [AMENDED]
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390:15-4-9. [AMENDED]
390:15-4-10. [AMENDED]
Subchapter 5. Reserve Officer Bridge Academy
390:15-5-2. [AMENDED]
390:15-5-3. [AMENDED]
390:15-5-4. [AMENDED]
390:15-5-5. [AMENDED]
390:15-5-6. [AMENDED]
390:15-5-7. [AMENDED]
390:15-5-8. [AMENDED]
390:15-5-10. [AMENDED]
390:15-5-11. [AMENDED]
390:15-5-12. [AMENDED]
390:15-5-13. [AMENDED]
390:15-5-14. [AMENDED]

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Amendments to 390:15-1-19. Council-approved Basic Peace Officer Certification training. Adding and removing verbiage (a) (c) (d) (1). Adding (i).
Subchapter 3. Collegiate Officer Program
Amendments to 390:15-3-1. Purpose. Adding and removing verbiage.
Amendments to 390:15-3-2. Program Administration. Amend language (b).
Amendments to 390:15-3-3. CLEET oversight and program administration. Removed (d) (e).

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Amendments to 390:15-3-9. Instructor requirements. Amending verbiage (a) (b). Removing (b) (c) (e).
Amendments to 390:15-3-10. Student responsibilities. Amending verbiage to (b) (e) and adding (i).
Subchapter 4. Basic Peace Officer Certification Academy Program
Amendments to 390:15-4-1. Purpose. Amended verbiage.
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Amendments to 390:15-4-7. Course testing. Adding and removing verbiage to (c).
Amendments to 390:15-4-8. Certification or qualification examination. Adding and removing verbiage. Removed (a) (b) (c) (d) (e).
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Amendments to 390:15-4-10. Student responsibilities. Added under (a) (1) and (2). Amended verbiage (b). Added verbiage to (e). Added (h).
Subchapter 5. Reserve Officer Bridge Academy
Amendments to 390:15-5-2. Eligibility. Amending verbiage in (b) and adding (c).
Amendments to 390:15-5-3. Curriculum and courses of study. Amending verbiage in (b) and removing (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (c) (d).
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Amendments to 390:15-5-5. Attendance; Academy administration. Amended language.
Amendments to 390:15-5-7. Bridge Academy participation. Amended language. Remove (a) (b) (c) (d) (e).
Amendments to 390:15-5-10. Council instructors. Amended language. Removed (a) (b) (c) (1) (2) (3).
Amendments to 390:15-5-11. Bridge Academy Rules. Added language. Removed (a) (b) (c).
Amendments to 390:15-5-12. Academic requirements. Added language. Removed (a) (b) (c) (d) (f) (g) (h) (i) (j) (k) (l) (m).
Amendments to 390:15-5-13. Administrative discipline. Added language. Remove (a) (b) (c).
Amendments to 390:15-5-14. Suspension, dismissal, and reinstatement to academy. Added language. Remove (a) (b) (c) (d) (e).

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 1. BASIC ACADEMY PROGRAMS
Permanent Final Adoptions

390:15-1-1. Purpose
(a) This chapter is devoted to basic peace officer certification training. Basic peace officer certification requires curriculum and courses of study validation through testing, course file maintenance, academy participation and academy rules.
(b) Further, this chapter outlines basic procedures for CLEET-conducted academies and for approved academies providing basic peace officer training to their own officers. Collegiate Officer Programs (COP) sponsored by CLEET-approved institutions of higher education, approved Basic Peace Officer Certification (BPOC) academies operated by technology centers of the Oklahoma Department of Career and Technology Education (Career Tech) or its successor or other higher education institutions, and any other CLEET-approved basic peace officer certification training. Specific rules related to COP and BPOC training programs are included in subchapters 3 and 4.
(c) This chapter also provides the employment, attendance and academic requirements for those enrolled in the Council’s basic peace officer training.

390:15-1-2. Curriculum and courses of study
(a) The Council shall formulate and promulgate a program of instruction for peace officer certification, comprised of fundamental law enforcement skills and knowledge, which shall be designated as the Basic Peace Officer Certification Academy, known herein as the Basic Academy, and which will constitute the minimum required course of study for basic peace officer certification regardless of which approved academy entity is attended.
(b) The curriculum of the Basic Academy is established by the Curriculum Review Board. The curriculum shall include functional areas as prescribed by the Council through the Curriculum Review Board. Functional areas may include, but shall not be limited to the following:
   (1) Orientation/Legal Matters
   (2) First Aid
   (3) Firearms
   (4) Criminal Investigation
   (5) Custody Control and Defensive Tactics
   (6) Traffic
   (7) Patrol
   (8) Community Relations
   (9) Law Enforcement Driver Training
   (10) DWI Detection and Standardized Field Sobriety Testing (SFST)
   (11) Radar
   (12) Ethics
(c) The Basic Academy shall meet at least the minimum hourly requirements as provided by O.S. 70 Section 3311 et seq.
(d) Additional hours of study and/or CLEET approved activity may be required to fulfill Basic Academy requirements.
(e) Approved academy entities must meet instructional objectives established by CLEET but they may establish an hourly schedule that meets their needs and may provide or require additional hours in the functional areas mandated by CLEET or in functional areas not mandated by CLEET.

390:15-1-3. Examinations and testing; remedial training; missed time
(a) For objectives that demand performance of observable behavior by a trainee, the test method, where appropriate, shall be performance oriented and shall duplicate, to the extent possible, realistic job situations.
(b) For objectives that demand mastery of cognitive material, the test method shall involve a written examination and, wherever possible, the written examination should test a trainee's ability to apply methods, concepts, and techniques taught in the classroom.
(c) Examinations shall be given at designated intervals during the Basic Academy to determine trainee achievement of objectives.
(d) Successful achievement on each cognitive examination or performance test shall be at a standard established by CLEET or a higher standard if so required by an approved academy entity.
(e) Examination and re-examination scores will be recorded on individual profile forms of peace officers.
(f) Practical application exercises may be evaluated at a standard established by CLEET.
(g) Approved academy entities shall establish their own procedures for testing and retesting except that CLEET shall administer the certification or qualification examination for purposes of certification.

390:15-1-5. Certification and qualification examination
(a) CLEET shall develop and administer a final comprehensive examination to each trainee who otherwise successfully completes all phases of the Basic Academy. The examination shall be known as the Oklahoma Basic Peace Officer Certification Examination and for non-commissioned trainees this examination shall be known as the Oklahoma Basic Peace Officer Qualification Examination. No person who successfully completes is enrolled in a Basic Academy, conducted or approved by the Council, shall receive peace officer certification until satisfactorily passing such examination at a standard established by CLEET.
(b) Non-commissioned officer trainees in COP and BPOC programs may take the qualification examination prior to their twenty-first birthday but shall not be certified until their twenty-first birthday.
(c) Trainees who pass the qualification examination prior to becoming commissioned shall have two years from the date of passing the qualification examination, or two years from their twenty-first birthday, whichever is latest, to obtain certification. However, certification is contingent upon being commissioned as a peace officer or reserve peace officer by a recognized law enforcement agency in the State of Oklahoma and having met all statutory employment and background requirements. Regardless of age, no trainee will be certified more than three
years following the completion of or graduation from a COP or BPOC program.
(d) COP and BPOC trainees will be certified as fulltime officers upon commission and meeting all applicable requirements regardless of whether the commission is as a fulltime or reserve peace officer.
(e) Students who fail the initial certification or qualification examination may be given only one opportunity to retest.
(f) Prior to taking or retaking the certification or qualification examination, COP and BPOC trainees will be assessed a testing fee and retesting fee to be set by CLEET.

390:15-1-6. Basic Academy participation
(α) All trainees shall be capable of full participation and fully participate in all Basic Academy activities and shall comply with all statutory and rules-based requirements for participation.
(β) All trainees shall be required to score a minimum of seventy percent (70%) on a reading, writing and comprehension examination pursuant to 70 O.S. 3311.11.
(γ) All trainees shall be required to score a minimum of seventy percent (70%) on a physical assessment test pursuant to 70 O.S. 3311.11.
(δ) All trainees shall execute a promissory note for academy training expenses pursuant to 70 O.S. 3311.11 whereby the trainee promises to repay the note by remaining in the law enforcement profession in the state of Oklahoma as a fulltime peace officer for four (4) years following graduation from the basic law enforcement academy.
(ε) The conduct of all trainees shall be consistent with the Law Enforcement Code of Ethics.

390:15-1-7. Administrative course files
CLEET shall maintain an administrative file that pertains to each Basic Academy class it conducts. Other approved academy entities shall also maintain an administrative file for each Basic Academy class conducted. This file shall minimally include the following:
(1) A final course schedule showing the actual instructor used for each topic;
(2) Attendance records for each trainee;
(3) Disciplinary actions taken against any trainee, provided that the details of trainee misconduct shall be retained in the trainee's individual file;
(4) Examination and testing records, including retests and remedial training needed; and
(5) Additional training documentation as deemed necessary.

390:15-1-8. Safety rules
CLEET shall establish written safety rules for skills training. Approved academy entities may also establish written safety rules for skills training that occurs in locations other than the CLEET training facility campus.

390:15-1-9. Council instructors
(a) Instructors who teach in the Basic Academy shall possess CLEET instructor certification recognized by the academy, or shall possess professionally recognized training and experience in the assigned subject area. Instructors for the Legal Block must be attorneys currently licensed by the Oklahoma Supreme Court.
(b) Basic Academy instructors shall adhere to the performance objectives and lesson plans in all cases, except when changes in the law, or other circumstances dictate that more current instructional material be substituted. In such cases, proper revisions shall be made to the lesson plan in question as soon as possible. Such changes shall be forwarded to the appropriate instructors and to all Council-approved Basic Peace Officer Certification Academy coordinators in a timely manner.
(c) Basic Academy instructors of record or lead instructors must attend and successfully complete a CLEET-approved instructor refresher/update course at least once every three years.
(d) Basic Academy skills instructors must possess CLEET specialized instructor certification. Skills instructors must teach or assist in a Basic Academy at least once every three years.
(e) CLEET shall establish written guidelines for CLEET, contract, adjunct and volunteer instructors regarding classroom demeanor and attire. All instructors who are scheduled to teach for the Council in a Basic Academy program shall be provided with and comply with the written guidelines. Rules shall include but shall not be limited to the following:
(1) Instructors who are lodging or visiting facilities owned, operated, or rented by CLEET may not use or bring any alcoholic beverages, intoxicants, or any controlled dangerous substances, onto the property, grounds, or into the facilities.
(2) It shall be prohibited for any instructor to attend any training session while under the influence of any of the above named substances.
(3) Instructors who arrive at lodging, eating, classroom, or training facilities, who appear impaired, may be subject to standard field sobriety testing, or other tests, and to disciplinary action.

390:15-1-13. Academic requirements
(a) In order to successfully complete the basic academy program, trainees must achieve a minimum passing score as designated by CLEET or a higher standard if so required by an approved academy entity. All training standards and academic requirements must be completed in accordance with statutory requirements within the time frame specified in Section 3311 of Title 70 of the Oklahoma Statutes.
(b) Any trainee who fails a specific block examination will be permitted to retake that block examination within a time frame established by CLEET.
(c) If the trainee fails the block examination a second time, the trainee's agency head may request that the trainee repeat the block of instruction and take the examination for a third time.
(d) If a trainee fails to complete any block of instruction the trainee will not be allowed to take the certification or qualification examination.

(e) Trainees who fail the certification or qualification examination will be permitted to retake the examination within ten (10) business days. A second failure will necessitate reenrollment into a basic academy. In accordance with 390:10-1.2 (d) for not completing basic certification according to 70 O.S., section 3311 (E) (4).

(f) If the trainee fails a proficiency test in the Custody Control block, the Law Enforcement Officer Training block or firearms block, the trainee will not be certified, and shall be required to obtain additional training through his/her employing agency; such training to be conducted by a CLEET certified instructor, discipline specific, within ninety (90) calendar days of the student's original academy completion date. Upon completion of such training, the student's employing agency administrator must, in writing, notify the Director of CLEET or the director's designee that the student is ready to be scheduled for remedial proficiency testing by CLEET staff. Such testing shall be completed by allowing the student up to three (3) attempts to attain the CLEET required proficiency in the skills area needed. If the trainee does not successfully complete remedial testing, no further testing will be allowed until the student has retaken the entire block of instruction.

(g) Trainees are expected to attend all blocks of instruction. If a trainee misses any time during the academy, the trainee must state in writing the reasons for the absence.

(h) Absences due to unforeseen emergencies, illnesses, subpoenas, or other unusual circumstances may be approved by the academy coordinator or CLEET director Training Division, Manager or Assistant Director for make-up during the current academy. Each case will be reviewed to evaluate the length of time missed and the impact upon the instructional staff and class to remediate the trainee. The trainee may be required to provide documentation for excused absences such as a copy of the subpoena, doctor's statement, etc. Absences of more than five (5) hours in any training block may require the trainee to attend the entire block in the next subsequent academy.

(i) Each applicant is required to attend all class sessions, subject to previously stated exceptions. Unexcused absences or repeated tardiness requires makeup work during a current or future academy, and may result in administrative discipline. Decisions that the Training Manager or Assistant Director make, regarding attendance and makeup requirements, may be appealed to the Director.

(j) It is mandated by the Council that all examinations, and all proficiency tests must be successfully completed to meet the requirements for peace officer certification.

(k) If a health condition or an injury occurs that prohibits a trainee from fully participating in any block of instruction, a signed release from the trainee's physician must be submitted before the trainee will be allowed to further participate in that block.

(l) If the trainee cannot be so released by a physician to fully participate in that block then participation is prohibited.

(m) Approved academy entities shall establish their own requirements for academy testing, retesting, and attendance except that no academic standards shall be less than those established by CLEET in 390:15-1-13.

390:15-1-18. Administrative discipline

(a) In the event that a trainee's personal conduct or academic performance falls below accepted standards, appropriate reports shall be submitted by the academy coordinator to the training division manager. Reports shall outline the nature and scope of the trainee's substandard performance or conduct, the nature of any counseling or remedial action taken by coordinator/instructors, and recommendations for resolution of the matter. A copy of these reports shall be retained in the trainee's file.

(b) The training division manager shall make every effort to resolve the matter in the best interest of the trainee, the sponsoring agency, and CLEET. Should it become necessary, matters may be referred to the Assistant Director, and the trainee's agency head may be notified.

(c) Trainees who wish to register a complaint regarding some aspect of his or her treatment at the academy, shall make every effort to resolve the matter with the class coordinator. In the event this is not possible, the class coordinator shall consult with the Training Division Manager on the matter. If necessary, arrangements shall be made for the trainee to discuss the complaint with the manager. If the matter cannot be resolved, the manager shall consult with the Assistant Director. Students wishing to appeal the decision of the Assistant Director may submit a request for appeal in writing to the Director.

(d) Approved academy entities shall establish their own requirements for administrative discipline.

390:15-1-18.1. Suspension, dismissal and reinstatement to academy

(a) Trainees may be removed from active participation, but not dismissed from the academy by a CLEET or approved academy entity instructor, for violations of academy rules, guidelines, safety rules or other justified reasons.

(b) Trainees will not be dismissed from the academy except upon instructions from the Director or Director's designee.

(c) The Director, or Director's designee, may take disciplinary action, up to and including, suspension and dismissal from the academy, for violations of academy rules, guidelines, safety rules, or other justified reasons.

(d) A trainee that has been suspended or dismissed from a basic academy and desires to return to the academy must make written request to the Director. The written request to return to the academy must also be signed by the head of the employing agency.

(e) Upon receipt of a written request to return to the academy, the Director or the director's designee will review the request for remittance admission together with the reasons for suspension or dismissal, and decide if and when the trainee may return. In the discretion of the Director, or the director's designee the trainee may or may not be placed into the same academy from which the trainee was suspended or dismissed.
(f) Approved academy entities shall establish their own requirements for suspension, dismissal, and reinstatement to the academy.

390:15-1-19. Council-approved Basic Peace Officer Certification training

(a) Municipalities and counties who obtain Council approval to conduct Basic Peace Officer Certification training for their own personnel are only authorized to retain monies pursuant to provisions in applicable statutes 70 O.S., Section 3311.5(H) and 20 O.S., Section 1313.2.

(b) Any municipal or county law enforcement agency that desires to obtain Council approval of said agency's Basic Peace Officer Certification training program must make written request to the Council, providing satisfactory evidence that the agency will conduct such training in accordance with the Council's prescribed minimum training standards, and utilize hiring practices in accordance with minimum employment standards designated by law, and in accordance with the rules of this chapter; that the agency maintains adequate training facilities and equipment; and that the agency will provide qualified instructors.

(c) This request shall be submitted to the Council. The Director or the director's designee, shall make written notification of the Council's approval or denial of the request. If approved, the notification shall include an agreement between the Council and the agency making the request. This agreement shall set forth the responsibilities of each party to the agreement, pursuant to 70 O.S. Section 3311 and 20 O.S. Section 1313.2 if applicable.

(d) Requests for Council approval to conduct Basic Peace Officer Certification training as authorized by statute 70 O.S., Section 3311.5(H) shall minimally include the following information:

1. **Justification.** The agency making the request must demonstrate to the Council that it meets criteria set forth in statute 70 O.S., Section 3311.5(H).

2. **Employment standards.** The agency making the request shall report to CLEET, under oath, that all persons to be trained have satisfactorily met the peace officer employment standards set forth by 70 O.S. Section 3311, and in accordance with rules set forth by the Council, in a format approved by the Council.

3. **Program documentation.** The agency making the request shall submit the following information not less than thirty (30) calendar days prior to the beginning of each Basic Peace Officer Certification Academy to be conducted:

   (A) The name of the person designated as the Director or coordinator of that agency's Basic Peace Officer Certification Academy to be conducted;

   (B) The proposed course schedule, clearly indicating the inclusion of CLEET mandated functional areas and units of instruction to include identified instructional objectives;

   (C) The instructors for each unit of instruction;

   (D) A statement as to the process of examination and testing to be used, and the process of evaluating instructors.

   (E) Upon timely notification, CLEET shall administer the Basic Peace Officer Certification Examination to trainees of CLEET-approved Basic Peace Officer Certification Academies who are otherwise qualified to take the examination.

   (f) Agencies conducting Council approved Basic Peace Officer Certification Training shall submit the following documentation to CLEET within fifteen (15) calendar days following the completion of each basic academy class:

   1. A final roster of graduates and their social security numbers;

   2. Trainee Academic and proficiency scores from all examinations and proficiency tests, including the Peace Officer Certification Examination.

   3. A final course schedule clearly indicating the actual instructors of each unit of instruction.

   4. A formal request that all trainees who successfully completed the Basic Academy class be granted full-time peace officer certification.

   (g) Instructors who teach in Council approved Basic Peace Officer Academies shall possess CLEET recognized instructor training, or shall possess professionally recognized training and experience in their assigned area of instruction.

   (h) CLEET shall issue identification cards and certificates as evidence of peace officer certification to trainees who successfully complete Council-approved Basic Peace Officer Academies, and who have been certified by their employing agency to be otherwise qualified pursuant to Section 3311 of Title 70 of the Oklahoma Statutes.

   (i) The Council may revoke academy status for failure to adhere to the CLEET rules.

   (j) Municipalities and counties who are approved academy entities may be authorized by the CLEET Director, or designee, to provide training to commissioned officers from other law enforcement agencies upon written application. Such approval is not guaranteed and will be based upon need, justification, availability of other training opportunities, and inter-departmental agreements.

390:15-1-20. College and University Law Enforcement Officers Training [REVOKED]

Municipalities and counties who have obtained Council approval to conduct Basic Peace Officer Certification training for their own personnel, are also authorized to train personnel from a college or university law enforcement department, pursuant to the following:

1. The college or university is located completely within the municipality of the approved Basic Peace Officer Academy;

2. Administrators from the college or university and the approved Peace Officer Academy, must provide a written agreement to CLEET prior to the start of the approved academy.
SUBCHAPTER 3. COLLEGIATE OFFICER PROGRAM

390:15-3-1. Purpose
The Collegiate Officer Program (COP) provides an alternative route to full time and reserve peace officer certification via degree granting institutions of higher education as approved by CLEET. It supplements the two other routes available, i.e., through the completion of a Council on Law Enforcement Education and Training Basic Peace Officer Certification Academy, or through the completion of a CLEET approved academy city/agency basic academy.

390:15-3-2. Program Administration
(a) The Council on Law Enforcement Education and Training shall provide a route to peace officer certification by providing degree granting institutions of higher education authority to conduct courses of study which are designed to include and cover all CLEET mandated Basic law Enforcement Academy course objectives. Courses that include CLEET objectives must be within the confines of an academic degree, i.e., the courses must count towards academic credit.
(b) CLEET shall establish minimum COP standards for instructors, curriculum, program evaluation, student enrollment, achievement and certification. Except as otherwise provided in this subchapter, standards established in subchapter 1 are applicable to COP.

390:15-3-3. CLEET oversight and program administration
(a) CLEET shall require institutions offering the COP to request and receive accreditation from the Executive Director of the Council.
(b) COP institutions shall be required to appoint a COP Director.
(c) CLEET shall require a COP to extend over a two semester period of time in order to accommodate course prerequisites.
(d) CLEET may waive course work completed by students, at a COP institution, between January 1, 1993 and the implementation date of the COP program by the Council.
(e) COP are required to meet minimum curriculum requirements as set forth in 390:15-1.2.
(f) All academic COP testing shall be subject to the sponsoring institution's testing and grading system, except in no case shall a passing grade be lower than 70 percent. First Aid skills area testing shall meet the minimum grading requirements set forth by CLEET.
(g) CLEET shall support the student attendance policy of any COP institution with the exception that skills area testing requires 100 percent attendance.

390:15-3-6. Curriculum mandates
(a) COP will comply with the minimum Basic Academy curriculum outlined in subchapter 1. courses shall include, but are not limited to, instruction in the following topical areas:

(1) Orientation/Legal Matters
(2) First Aid/CPR
(3) Firearms
(4) Criminal Investigation
(5) Traffic
(6) Custody Control
(7) Patrol
(8) Community Relations
(9) Law Enforcement Drivers Training
(10) DWI Detection and Standardized Field Sobriety Testing (SEST)
(11) RADAR
(b) CLEET shall make functional area instructional objectives, as well as current Basic Academy lesson plans, available to all COP institutions. COP institutions may utilize a collegiate accredited First Aid course and a collegiate accredited CPR course as a substitute for CLEET's First Aid course.

390:15-3-7. Course testing
(a) All academic COP course testing shall be subject to the higher education institution's testing and grading system with the exception that under no circumstances shall a course grade of less than 80 percent for First Aid, and successful achievement on other cognitive examinations or performance tests shall be at a standard established by CLEET for a course offering which contains a portion of the CLEET basic Academy instructional goals and objectives.
(b) COP skills training courses shall meet the minimum grading standards set forth for the CLEET Basic Academy skills training programs.
(c) Practical application exercises may be evaluated at a standard established by the COP institution so long as such standard meets or exceeds CLEET standards.

390:15-3-8. Qualification examination
(a) COP trainees will be administered a qualification examination as outlined in subchapter 1. The CLEET qualification which is administered to COP students by an authorized CLEET representative, is a comprehensive objective examination which covers, at a minimum, those topical areas set forth in 390:15-1.2 and 390:15-3.6. Should additional topical areas be added, the qualification examination may be expanded to cover such additions.
(b) The examination shall be administered on a regular basis at times and locations to be determined by CLEET.
(c) Students may take the qualification examination prior to their twenty-first birthday but shall not be certified until their twenty-first birthday.
(d) Students who pass the qualification examination prior to becoming commissioned shall have two years from the date the associate's or bachelor's degree is conferred, or two years from their twenty-first birthday, whichever is later, in which to obtain their certification. Certification shall be withheld until they have been commissioned and all requirements of 70 O.S., Section 3311 have been met.
(e) Successful achievement of the qualification examination will be at a standard established by CLEET.

(f) Students who fail their initial qualification examination may be given only one retest.

390:15-3-9. Instructor requirements
(a) COP instructors of record or lead instructors and legal block instructors shall meet the instructor requirements outlined in subchapter 1 Skills area instructors of record, or lead instructors, are required to meet the instructor specifications set forth in 390:25-1-9 through 390:25-1-12.
(b) Instructors of record (lead instructors) shall attend and complete a CLEET three (3) day skills refresher/update course for instructing in a basic academy setting (the academy first day classroom, and the two days thereafter) once every three years. This requirement may be accomplished during any CLEET approved basic law enforcement academy offered in the state.
(c) Skills instructors who are not lead instructors or instructors of record shall meet the CLEET specialized instructor requirements set forth in 390:25-1-9 through 390:25-1-12. They must also assist in a CLEET basic academy or an approved city/agency basic academy every three years.
(d) Instructors, other than skills and legal block instructors, shall meet the requirements of the institution sponsoring the COP.
(e) Instructors for portions of the COP legal block identified by CLEET must be taught by an attorney currently licensed by the Oklahoma Bar Association.

390:15-3-10. Student responsibilities
(a) All students admitted to a COP must meet the admission requirements of the sponsoring college or university.
(b) COP students, when commissioned, must meet any statutory employment standards the requirements set forth in 70 O.S., Section 3311 and the requirements set forth in 390:10-1-4.
(c) COP student class absences shall be recorded in accordance with individual university/college policies.
(d) COP tract students shall be accountable for 100 percent attendance in skills level courses.
(e) Prior to enrolling in a COP Firearms Training course, students shall request a current local records check from their county of residence and the Oklahoma State Bureau of Investigation, and shall submit the returns to the COP school Director prior to the first day of firearms training. Additionally, prior to any firearms training all COP students must undergo a psychological evaluation.
(f) COP students are responsible for submitting documentation to CLEET of COP course completion, and any other documents required by CLEET, prior to taking the qualification examination.
(g) COP students must present a picture identification when taking the qualification examination.
(h) COP students must successfully complete all COP course work and receive an associate or bachelor degree, and successfully pass the qualification examination at a standard established by CLEET to be eligible for peace officer certification.
(i) Upon employment and commissioning as a peace officer by a recognized law enforcement agency in the State of Oklahoma, a COP student shall submit an application on forms acceptable to CLEET for certification as a peace officer. CLEET may charge an application fee at a rate established and published by CLEET.
(j) COP students who do not complete the COP curriculum and re-enter the program at a later date, must retake course work that is more than five years old.

SUBCHAPTER 4. BASIC PEACE OFFICER CERTIFICATION ACADEMY PROGRAM

390:15-4-1. Purpose
The Basic Peace Officer Certification Academy Program (BPOC) provides an alternative route to full time and reserve peace officer certification for individuals interested in a career in law enforcement who are not commissioned or appointed as peace officers, via any state supported technology center school or higher education institutions as approved by CLEET. It supplements the three other routes available, i.e., through the completion of a Council on Law Enforcement Education and Training Basic Peace Officer Certification Academy, through the completion of a CLEET approved academy city/agency basic academy, or through the completion of a CLEET approved Collegiate Officer Program.

390:15-4-2. Program administration
(a) The Council on Law Enforcement Education and Training shall provide a route to peace officer certification by providing state-supported technology center schools or higher education institutions authority to conduct courses of study which are designed to include and cover all CLEET mandated Basic law Enforcement Academy course objectives for actual classroom training. Outside the classroom training shall be provided at the CLEET training facility, unless authorized by CLEET to conduct outside the classroom training to include skills training.
(b) CLEET shall establish minimum BPOC standards for instructors, curriculum, program evaluation, student enrollment, achievement and certification.
(c) CLEET shall provide two (2) outside the classroom training sessions for BPOC at the CLEET training facility (one in the spring and one in the fall). Each training session shall be a minimum of 22 days in duration and shall include: Law Enforcement Driver Training, Defensive Tactics, Firearms, Practical Exercises and the administration of the final qualification examination. All costs for the training sessions at the CLEET training facility shall be paid to CLEET in advance, unless other arrangements are made with the CLEET Financial Manager. Student limits for each session are 30 students per session unless otherwise approved by the Executive Director.
(d) BPOC entities who in making their application to host a basic law enforcement academy request approval to conduct
the outside of classroom training shall meet the training instructor and facilities requirements found in the CLEET policies for conducting off-site Firearms Instructor, LEAT Instructor, and Defensive Tactics Instructor training. Facilities will be inspected by a CLEET employee to confirm compliance.

390:15-4-3. CLEET oversight and program administration

(a) CLEET shall require state-supported technology center schools and higher education institutions to complete an application for review and vote by the Council. The Council may approve up to two (2) new entities each year to offer the BPOC. Applications rejected by the Council will receive a notice providing a clear and concise statement pertaining to the reason behind the denial.

(b) BPOC entities shall be required to appoint a BPOC Director.

(c) CLEET shall set the schedule for each outside the classroom session to be held at the CLEET training facility by the 1st of October in the preceding year.

(d) Approved entities shall arrange their BPOC training schedule so that the training to be completed at the CLEET training facility occur at the end of the program.

(e) CLEET shall provide approved BPOC entities the session costs for all BPOC training to be completed at the CLEET training facility.

(f) BPOC's are required to meet minimum curriculum requirements as set forth in OAR 390:15-1-2.

(g) All academic BPOC testing shall be subject to the sponsoring institution's testing and grading system, except in no case shall a passing grade be lower than 75 percent. First Aid skills area testing shall meet the minimum grading requirements set forth by CLEET or the certifying First Aid institution.

(h) CLEET shall support the student attendance participation policy of any BPOC institution with the exception that all skills training shall be 100 percent participation. All training completed at the CLEET training facility shall be 100 percent participation.

390:15-4-5. Director's functions

(a) BPOC Directors are responsible for applying for their institutions BPOC accreditation by CLEET, for resource allocation, ensuring adequate facilities are available, records maintenance, course scheduling and delivery, selection and scheduling of instructors and instructor evaluations.

(b) BPOC Directors are responsible for their institutions advisement of interested students and for enrollment completing the following:

(1) The entity’s application and seeking Council approval for the program;
(2) program resource allocation;
(3) ensuring adequate facilities are available throughout the program;
(4) program records maintenance;
(5) selection of instructors; and
(6) instructor evaluations.

(h) BPOC Directors are responsible for their entity's efforts toward basic law enforcement training, including maintaining the academy schedule (subject and instructors), student attendance records and disciplinary actions, curriculum and test/exam security and all other records pertaining to each student enrolled who may graduate or may be removed from training.

(e) BPOC Directors are responsible for ensuring that all course participants complete the required background investigation pursuant to 70 O.S., subsection 3311.16 (B).

(d) All files associated with approved BPOCs shall be maintained for audit review by CLEET upon request by a representative of CLEET.

(f) BPOC Directors are responsible for submitting documentation to CLEET of BPOC course completion, and any other documents required by CLEET, prior to a student taking the qualification examination.

390:15-4-6. Curriculum mandates

(a) BPOC entities will comply with the minimum Basic Academy curriculum outlined in subchapter 1. The curriculum of the Basic Academy, and through association the BPOC, is established by the Curriculum Review Board. The curriculum shall include functional areas as prescribed by the Council through the Curriculum Review Board. Functional areas may include, but shall not be limited to the following:

(1) Orientation/Legal Matters
(2) First Aid
(3) Firearms
(4) Criminal Investigation
(5) Custody Control and Defensive Tactics
(6) Traffic
(7) Patrol
(8) Community Relations
(9) Law-Enforcement Driver Training
(10) DWI-Detection and Standardized Field Sobriety Testing (SFST)
(11) Radar
(12) Ethics

(b) CLEET shall make functional area instructional objectives, as well as current Basic Academy lesson plans, available to all BPOC entities. BPOC entities shall abide by the provisions of 70 O.S., subsection 3311.16 (D). BPOC entities may utilize a collegiate accredited First Aid course and a collegiate accredited CPR course as a substitute for CLEET's First Aid course.
390:15-4-7. Course testing
(a) All academic BPOC course testing shall be subject to the entity's testing and grading system with the exception that under no circumstances shall a course grade of less than 80 percent for First Aid, and successful achievement on other cognitive examinations or performance tests shall be at a standard established by CLEET for a course offering which contains a portion of the CLEET basic Academy instructional goals and objectives.
(b) BPOC skills training courses shall meet the minimum grading standards set forth for the CLEET Basic Academy skills training programs.
(c) Practical application exercises may be evaluated at a standard established by the BPOC entities so long as such standard meets or exceeds CLEET standards approved by the Council to conduct outside of classroom training.

390:15-4-8. Certification or qualification examination
(a) BPOC trainees will be administered a certification or qualification examination as outlined in subchapter 1, the CLEET qualification examination, administered to BPOC students by an authorized CLEET representative, is a comprehensive objective examination which covers, at a minimum, those topical areas set forth in 390:15-1-2 and 390:15-3-6. Should additional topical areas be added, the qualification examination may be expanded to cover such additions.
(b) The qualification examination shall be administered at the conclusion of the two CLEET training facility training sessions (one in the spring and one in the fall).
(e) Students who pass the qualification examination shall have two years from the date they pass the qualification examination to obtain a commission or appointment with recognized Oklahoma law enforcement agency. Certification shall be withheld until they have been commissioned and all requirements of 70 O.S., subsection 3311 have been met.
(d) Successful achievement of the qualification examination will be at a standard established by CLEET.
(e) Students who fail their initial qualification examination may be given only one retest.

390:15-4-9. Instructor requirements
(a) BPOC instructors of record or lead instructors and legal block instructors shall meet the instructor requirements outlined in subchapter 1, Skills area instructors of record, or lead instructors, are required to meet the instructor specifications set forth in OAR 390:25-1-9 through 390:25-1-12.
(b) Instructors of record (lead instructors) shall attend and complete a CLEET three (3) day skills refresher/update course for instructing in a basic academy setting (the academy first day classroom, and the two days thereafter) once every three years. This requirement may be accomplished during any CLEET approved basic law enforcement academy offered in the state.
(e) Skills instructors who are not lead instructors or instructors of record, shall meet the CLEET specialized instructor requirements set forth in OAR 390:25-1-9 through 390:25-1-12. They must also assist in a CLEET basic academy or an approved city/agency basic academy every three years.
(d) Instructors who teach in the BPOC shall possess CLEET recognized instructor training, or shall possess professionally recognized training and experience in the assigned subject area.
(e) Instructors for portions of the BPOC legal block identified by CLEET must be taught by an attorney currently licensed by the Oklahoma Bar Association.

390:15-4-10. Student responsibilities
(a) All students admitted to a BPOC must meet the admission requirements of the Council approved state-supported technology center school or higher education institution entities.
(1) BPOC applicants who are employed and/or commissioned as a peace officer by a law enforcement agency must submit a fulltime basic academy application to CLEET for approval to attend a BPOC entity's academy. An application fee may be charged at a rate set by CLEET. Such applicants may also be required by the BPOC entity to submit an application to the entity.
(2) BPOC applicants who are not employed or commissioned as a peace officer by a law enforcement agency must submit an application to the approved BPOC entity for approval to attend a BPOC entity's academy. An application fee may be charged at a rate set by the BPOC entity.
(b) BPOC students, when commissioned, must meet any statutory employment standards the requirements set forth in 70 O.S., Section 3311 and the requirements set forth in 390:10-1-4.
(c) BPOC student class absences shall be recorded in accordance with individual training entity's policies.
(d) BPOC tract students shall be accountable for 100 percent participation in skills level courses.
(e) Prior to enrolling in a BPOC course, students shall request a current local records check from their county of residence and the Oklahoma State Bureau of Investigation, and shall submit the returns to the BPOC school Director prior to the first day of training. Additionally, prior to any firearms training all BPOC students must undergo a psychological evaluation.
(f) BPOC students must present a picture identification when taking the qualification examination.
(g) BPOC students must successfully complete all BPOC course work and successfully pass the certification or qualification examination at a standard established by CLEET to be eligible for peace officer certification.
(h) Upon employment and commissioning as a peace officer by a recognized law enforcement agency in the State of Oklahoma, a BPOC student who was not a commissioned officer during BPOC training shall submit an application on forms acceptable to CLEET for certification as a peace officer. CLEET may charge an application fee at a rate established and published by CLEET.
(jh) BPOC students who do not complete the BPOC curriculum have one year to complete the training from the date the student began the BPOC training. If the student fails to complete the training within one year, the student shall be required to retake the training, paying again for the training.

SUBCHAPTER 5. RESERVE OFFICER BRIDGE ACADEMY

390:15-5-2. Eligibility
(a) Beginning January 1, 2014, any reserve officer who has completed a CLEET two-hundred-forty-hour reserve peace officer certification program, and who has been in active service in a reserve capacity for the past six (6) months shall be eligible to attend a Bridge Academy pursuant to 70 O.S., Section 3311 to become certified as a full-time police or peace officer.
(b) The individual officer must meet the full-time employment standards found in statute and CLEET Rules.
(c) State-supported technology center schools and other entities which are approved by CLEET to provide basic peace officer certification training may, upon written application to the CLEET Director, or designee, be authorized by CLEET to operate Bridge Academies under the same standards as applicable to the Basic Academy.

390:15-5-3. Curriculum and courses of study
(a) The Council shall formulate and promulgate a program of instruction for peace officer bridge certification, comprised of fundamental law enforcement skills and knowledge, which shall be designated as the Basic Peace Officer Certification Bridge Academy, known herein as the Bridge Academy.
(b) The curriculum of the Bridge Academy is established by the Curriculum Review Board and shall include functional areas similar to the Basic Academy as outlined in subchapter 1. The curriculum shall include functional areas as prescribed by the Council through the Curriculum Review Board. Functional areas may include, but shall not be limited to the following:
   (1) Orientation/Legal Matters
   (2) First Aid
   (3) Firearms
   (4) Criminal Investigation
   (5) Custody Control and Defensive Tactics
   (6) Traffic
   (7) Patrol
   (8) Community Relations
   (9) Law Enforcement Driver Training
   (10) DWI Detection and Standardized Field Sobriety Testing (SFST)
   (11) Radar
   (12) Ethics
   (e) The Bridge Academy shall meet the hourly requirements as provided by 70 O.S. Section 3311 et seq.
   (d) Additional hours of study and/or CLEET approved activity may be required to fulfill Bridge Academy requirements.

390:15-5-4. Examinations and testing; remedial training; missed time
Basic Academy standards outlined in subchapter 1 are applicable to the Bridge Academy.
(a) For objectives that demand performance of observable behavior by a trainee, the test method, where appropriate, shall be performance oriented and shall duplicate, to the extent possible, realistic job situations.
(b) For objectives that demand mastery of cognitive material, the test method shall involve a written examination and, wherever possible, the written examination should test a trainee’s ability to apply methods, concepts, and techniques taught in the classroom.
(c) Examinations shall be given at designated intervals during the Bridge Academy to determine trainee achievement of objectives.
(d) Successful achievement on each cognitive examination or performance test shall be at a standard established by CLEET.
(e) Retaking examination scores will be recorded on individual profile forms of peace officers.
(f) Practical application exercises may be evaluated at a standard established by CLEET.

390:15-5-5. Attendance; Academy administration
Basic Academy standards outlined in subchapter 1 are applicable to the Bridge Academy. CLEET shall establish rules governing trainee conduct, attendance requirements, trainee equipment needs, and other matters necessary to the administration of the Bridge Academy.

390:15-5-6. Certification examination
The certification examination and related procedures outlined in subchapter 1 are applicable to the Bridge Academy. CLEET shall develop and administer a final comprehensive examination to each trainee who otherwise successfully completes all phases of the Bridge Academy. This examination shall be known as the Oklahoma Basic Peace Officer Certification Examination. No person who is enrolled in a Bridge Academy shall receive peace officer certification until satisfactorily passing such examination.

390:15-5-7. Bridge Academy participation
(a) All trainees shall be capable of full participation and fully participate in all Bridge Academy activities and shall comply with all statutory and rules-based requirements for participation.
(b) All trainees shall be required to score a minimum of seventy percent (70%) on a reading, writing and comprehension examination pursuant to 70 O.S. 3311.11.
(c) All trainees shall be required to score a minimum of seventy percent (70%) on a physical assessment test pursuant to 70 O.S. 3311.11.
(d) All trainees shall execute a promissory note for academy training expenses pursuant to 70 O.S. 3311.11 whereby the trainee promises to repay the note by remaining in the law enforcement profession in the state of Oklahoma as a full-time
peace officer for four (4) years following graduation from the basic law enforcement academy.
(c) The conduct of all trainees shall be consistent with the Law Enforcement Code of Ethics.

390:15-5-8. Administrative course files
Course file requirements for the Basic Academy as outlined in subchapter I are applicable to the Bridge Academy. CLEET shall maintain an administrative file that pertains to each Bridge Academy class it conducts. This file shall minimally include the following:
(1) A final course schedule showing the actual instructor used for each topic;
(2) Attendance records for each trainee;
(3) Disciplinary actions taken against any trainee, provided that the details of trainee misconduct shall be retained in the trainee's individual file;
(4) Examination and testing records, including retests and remedial training needed; and
(5) Additional training documentation as deemed necessary.

390:15-5-10. Council instructors
(a) Instructors who teach in the Bridge Academy shall meet the same standards outlined in subchapter I for Basic Academy instructors, possess CLEET recognized instructor training, or shall possess professionally recognized training and experience in the assigned subject area.
(b) Bridge Academy instructors shall adhere to the performance objectives and lesson plans in all cases, except when changes in the law, or other circumstances dictate that more current instructional material be substituted. In such cases, proper revisions shall be made to the lesson plan in question as soon as possible. Such changes shall be forwarded to the appropriate instructors in a timely manner.
(c) CLEET shall establish written guidelines for CLEET, contract, adjunct and volunteer instructors regarding classroom demeanor and attire. All instructors who are scheduled to teach for the Council in a Bridge Academy program shall be provided with and comply with the written guidelines. Rules shall include but shall not be limited to the following:
(1) Instructors who are lodging or visiting facilities owned, operated, or rented by CLEET may not use or bring any alcoholic beverages, intoxicants, or any controlled dangerous substances, onto the property, grounds, or into the facilities.
(2) It shall be prohibited for any instructor to attend any training session while under the influence of any of the above named substances.
(3) Instructors who arrive at lodging, eating, classroom, or training facilities, who appear impaired, may be subject to standard field sobriety testing, or other tests, and to disciplinary action.

390:15-5-11. Bridge Academy Rules
Basic Academy rules as outlined in subchapter I are applicable to Bridge Academy participants.
(a) Specific rules governing the administration of Bridge Academy classes shall be published and have the same effect as the rules published herein. Said rules shall be designated as the Bridge Academy Rules and Regulations.
(b) All Basic police trainees who have been accepted into a CLEET Bridge Academy program shall be provided with and comply with academy policies and procedures set forth by the Council.
(c) Failure of trainees to abide by the policies and procedures set forth by the Council may lead to disciplinary action and possible dismissal from the academy.

390:15-5-12. Academic requirements
Basic Academy academic requirements as outlined in subchapter I are applicable to Bridge Academy participants.
(a) In order to successfully complete the bridge academy program, trainees must achieve a minimum passing score as designated by CLEET. All training standards and academic requirements must be completed within the time frame specified in Section 3311 of Title 70 of the Oklahoma Statutes.
(b) Any trainee who fails a specific block examination will be permitted to retake that block examination within a time frame established by CLEET.
(c) If the trainee fails the block examination a second time, the trainee's agency head may request that the trainee repeat the block of instruction and take the examination for a third time.
(d) If a trainee fails to complete any block of instruction the trainee will not be allowed to take the certification examination.
(e) Trainees who fail the certification examination will be permitted to retake the examination within ten (10) business days. A second failure will necessitate reenrollment into a Basic academy.
(f) When a trainee fails a proficiency test in the Custody Control block, or the Law Enforcement Driver Training block, the trainee will not be certified, and will be scheduled for up to two remedial training sessions at a later time. If the trainee does not successfully complete remedial training, no further testing will be allowed.
(g) If the trainee fails a proficiency test in the Firearms Block, the trainee will not be certified, and shall be required to obtain additional firearms training through his/her employing agency. Such training to be conducted by a CLEET certified firearms instructor within ninety (90) calendar days of the student's original academy completion date. Upon completion of such training the student's employing agency administrator must, within ninety (90) calendar days of the student's original academy completion date, in writing, notify the Director of CLEET that the student is ready to be scheduled for firearms proficiency testing by CLEET firearms staff. Such testing shall be completed by allowing the student up to three (3) attempts to attain the CLEET required proficiency in firearms. If the student does not successfully complete additional training, no further testing will be allowed until the student has retested the entire firearms block of instruction.
(h) Trainees are expected to attend all blocks of instruction. If a trainee misses any time during the academy, the trainee must state in writing the reasons for the absence.
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(i) Absences due to unforeseen emergencies, illnesses, subpoenas, or other unusual circumstances may be approved by the Training Division Manager or Assistant Director for make-up during the current academy. Each case will be reviewed to evaluate the length of time missed and the impact upon the instructional staff and class to remediate the trainee. The trainee may be required to provide documentation for excused absences such as a copy of the subpoena, doctor's statement, etc. Absences of more than five (5) hours in any training block may require the trainee to attend the entire block in the next subsequent academy.

(j) Each applicant is required to attend all class sessions, subject to previously stated exceptions. Unexcused absences or repeated tardiness requires makeup work during a current or future academy, and may result in administrative discipline. Decisions that the Training Manager or Assistant Director make, regarding attendance and makeup requirements, may be appealed to the Director.

(k) It is mandated by the Council that all examinations, and all proficiency tests must be successfully completed to meet the requirements for peace officer certification.

(l) If a health condition or an injury exists, prohibiting a trainee from fully participating in any block of instruction, a signed release from the trainee's physician must be submitted before the trainee will be allowed to further participate in that block.

(m) If the trainee cannot be released by a physician to fully participate in that block then participation is prohibited.

390:15-5-13. Administrative discipline

Administrative discipline standards outlined in subchapter 1 for the Basic Academy are applicable to Bridge Academy participants.

(a) In the event that a trainee's personal conduct or academic performance falls below accepted standards, appropriate reports shall be submitted by the academy coordinator to the training division manager. Reports shall outline the nature and scope of the trainee's substandard performance or conduct, the nature of any counseling or remedial action taken by coordinator/instructors, and recommendations for resolution of the matter. A copy of these reports shall be retained in the trainee's file.

(b) The training division manager shall make every effort to resolve the matter in the best interest of the trainee, the sponsoring agency, and CLEET. Should it become necessary, matters may be referred to the Assistant Director, and the trainee's agency head may be notified.

(c) Trainees who wish to register a complaint regarding some aspect of his or her treatment at the academy, shall make every effort to resolve the matter with the class coordinator. In the event this is not possible, the class coordinator shall consult with the Training Division Manager on the matter. If necessary, arrangements shall be made for the trainee to discuss the complaint with the manager. If the matter cannot be resolved, the manager shall consult with the Assistant Director. Students wishing to appeal the decision of the Assistant Director may submit a request for appeal in writing to the Director.

390:15-5-14. Suspension, dismissal and reinstatement to academy

Basic Academy standards outlined in subchapter 1 are applicable to the Bridge Academy.

(a) Trainees may be removed from active participation, but not dismissed from the academy, by a CLEET instructor, for violations of academy rules, guidelines, safety rules or other justified reasons.

(b) Trainees will not be dismissed from the academy except upon instructions from the Director or Director's designee.

(c) The Director, or Director's designee, may take disciplinary action, up to and including, suspension and dismissal from the academy, for violations of academy rules, guidelines, safety rules, or other justified reasons.

(d) A trainee that has been suspended or dismissed from a bridge academy and desires to return to the academy must make written request to the Director. The written request to return to the academy must also be signed by the head of the employing agency.

(e) Upon receipt of a written request to return to the academy, the Director will review the request for readmittance together with the reasons for suspension or dismissal, and decide if and when the trainee may return. In the discretion of the Director, the trainee may or may not be placed into the same academy from which the trainee was suspended or dismissed.

[OAR Docket #21-448; filed 6-15-21]

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TITLE 390. COUNCIL ON LAW ENFORCEMENT EDUCATION AND TRAINING

CHAPTER 20. RESERVE OFFICER CERTIFICATION AND TRAINING

[OAR Docket #21-449]

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n/a

INCORPORATIONS BY REFERENCE:

n/a

GIST/ANALYSIS:


Amendments to 390: 20-1-16. Reserve academy instructor requirements. Adding verbiage and removing (a) (b) (c) (d) (e)

CONTACT PERSON:

Shelly Lowrance, Council on Law Enforcement Education and Training, 2401 Egypt Road, Ada, Oklahoma 74820-0669, shelly.lowrance@cleet.state.ok.us or 405-239-5152.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(S) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

390:20-1-3.1. Reserve Coordinator Qualifications

(a) All reserve academy coordinators must either:

(1) Be a certified full-time, salaried peace officer meeting all statutory requirements as set forth in 70 O. S. 3311.

(2) Have a minimum of two years of law enforcement experience after certification as a peace officer.

(3) Be employed by a municipal, county, state or tribal law enforcement agency.

(4) Be a CLEET certified basic instructor or:

(2) Be an approved BPOC Director at an approved academy entity.

(b) All reserve coordinators must successfully complete a CLEET Reserve Academy Coordinators’ school prior to being given approval to conduct a reserve academy.

(c) If a Reserve Coordinator has not conducted a reserve academy within the last five (5) years, the coordinator will be required to attend a current Reserve Coordinator School prior to being given approval to conduct a reserve academy.

(d) The director or the director’s designee may grant reserve academy coordinator status to an individual who has completed comparable training, education or experience that equal or exceed the qualifications for reserve academy coordinator.

390:20-1-4. Application to conduct Reserve Peace Officer Academy

Reserve Academies shall be sponsored by the heads of law enforcement agencies or by a BPOC Director at an approved academy entity. Requests to conduct Reserve Academies shall be in letter form, on the appropriate agency letterhead. Such request must be made not less than ninety (90) days prior to the proposed opening date of the Basic Reserve Peace Officer Academy.

(1) Justification. Agencies making application must demonstrate to the Council that there is a significant need to conduct a Basic Reserve Peace Officer Academy and that a minimum of ten (10) trainees will be enrolled.

(2) Employment standards. Agencies having trainees enrolled in the Basic Reserve Peace Officer Academy must, in conjunction with the Reserve Academy Coordinator, ensure that the trainee satisfactorily meets the peace officer employment standards set forth in 70 O. S. 3311 and rules established by the Council.

390:20-1-12. Materials returned to CLEET

The Reserve Academy Coordinator shall submit the following to a CLEET representative on the date of the Reserve Officer Certification Examination:

(1) Master Grade Sheet, showing the actual grades scored by each trainee, for each examination given;

(2) List of CLEET certified firearms instructors, record of inspection of all firearms used by trainees for firearms qualification and record of all firearms scores, including handgun and shotgun.

(3) Master Attendance Rosters, showing actual attendance of each trainee during each class conducted;

(4) All audio visual aids, and other material on loan from CLEET. BPOC Directors will be authorized to retain any materials provided by CLEET unless their return is specifically requested.

390:20-1-16. Reserve academy instructor requirements

Reserve Academy instructors will meet the same requirements for Basic Academy instructors as provided in Chapter 15 of this Title.

(a) Skills area instructors of record, or lead instructors, are required to meet the instructor specifications set forth in 390:25-1-9 through 390:25-1-12.

(b) Instructors of record (lead instructors) shall attend and complete a CLEET three (3) day skills refresher/update course for instructing in a basic academy setting (the academy first day classroom, and the two days thereafter) once every three years. This requirement may be accomplished during any CLEET approved basic law enforcement academy offered in the state.

(c) Skills instructors who are not lead instructors or instructors of record, shall meet the CLEET specialized instructor requirements set forth in 390:25-1-9 through 390:25-1-12, and must instruct within a CLEET or approved academy city/agency basic academy every three (3) years.

(d) Instructors, other than skills instructors, shall meet the requirements set forth in 390:25-1-9 through 390:25-1-12.

(e) Instructors for portions of the reserve academy legal block identified by CLEET must be taught by an attorney currently licensed by the Oklahoma Bar Association.

[OAR Docket #21-449; filed 21-449]
TITLE 395. OKLAHOMA LAW ENFORCEMENT RETIREMENT SYSTEM
CHAPTER 1. ADMINISTRATIVE OPERATIONS

[OAR Docket #21-466]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
395:1-1-3. Board meetings and records [AMENDED]
395:1-1-5. Actual and necessary expenses [AMENDED]
395:1-1-7. Change of Status [AMENDED]

AUTHORITY:
Oklahoma Law Enforcement Retirement System; 47 O.S., §§ 2-300 et seq.

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SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
The proposed rule amendment to 395:1-1-3 removes the requirement that the written minutes from the Oklahoma Law Enforcement Retirement System (the "System") Board meetings be signed by the President. The proposed rule amendment to 395:1-1-5 amends the statute crossreference to include two additional sections. The proposed rule amendment to 395:1-1-7 adds language allowing members to make certain changes to member information remotely through a member self-service website.

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., SECTIONS 250.3(5) AND 308(E), WITH THE EFFECTIVE DATE OF AUGUST 26, 2021:

395:1-1-3. Board meetings and records
(a) Conduct of meetings. The Board will normally meet on the third Thursday of each month and at such other times, dates, and locations as may be set by the Board. Special and emergency meetings will be called in accordance with the provisions of the retirement law and the Open Meeting Law. Meetings will be held in accordance with the Open Meeting Law (Title 25, O.S. Section 301-314.) Written minutes shall be an official summary of the proceedings, signed by the President, and shall be on file in the Oklahoma Law Enforcement Retirement System's administrative office in Oklahoma City, Oklahoma, located at. 421 NW 13th, Suite.100. The minutes and other public records that are under the administration of the Oklahoma Law Enforcement Retirement System are open to the public for inspection during normal working hours of the Oklahoma Law Enforcement Retirement System.
(b) Voting. Seven (7) Board members shall constitute a quorum for the transaction of business. Any official action of the Board shall be based on a favorable vote of at least seven (7) Board members at a regular or special meeting of the Board at least a simple majority vote of the quorum.

395:1-1-5. Actual and necessary expenses
In accordance with the provisions of Title 47, O.S. Section 2300 through 2-332-315, the Oklahoma Law Enforcement Retirement System is directed to carry out the administration of the Plan, and pay for the actual and necessary expenses incurred in the operation of the System, when allowed and approved by the Board. All expenses shall be paid from the Fund by vouchers drawn against the Fund.

395:1-1-7. Change of Status
Any request for change of address, change of tax status, change of withholding, change of direct deposit, change of beneficiaries or other requested change, must be made in writing and received by the System at its principal place of business. Certain changes may also be completed remotely using the Member Self Service website.

[OAR Docket #21-466; filed 6-15-21]
The proposed amendments to 395:10-1-2 replace the Director of State Finance with the Director of Oklahoma Management and Enterprise Services or their Designee as a member of the Oklahoma Law Enforcement Retirement System (the "System") Board and acknowledge that the Assistant Commissioner of Public Safety may appoint a Designee to the Board. The proposed amendments simplify the President's and Secretary's duties by deleting the specific enumerated duties and leaving the general responsibility of administering the system.

The proposed amendments to 395:10-1-2.2 change the date requirement for receiving a retiree's documents to the fifteenth day of the month in which the first voucher is to be paid and removes language in subsection (a) that changed the date of the retirement due to a member's failure to timely submit documents. The proposed amendments simplify subsection (b) by referencing the forms on the System website rather than expressly listing each form that may be applicable. The proposed amendment to 395:10-1-2.3 will allow the System to acknowledge signatures on System forms made by non-members pursuant to a durable power of attorney. The proposed amendment to 395:10-1-2.4 deletes the specifically enumerated categories of member information that the System may use for recordkeeping purposes and leaves the general right to use "any information" contained in a member's file.

The proposed amendments to 395:10-1-3 and 395:10-1-4 change "his/her" to "their" and "his" to "their" and update the citation style of the referenced statutes.

The proposed amendment to 395:10-1-4.1 changes "his or her" to "theirs." The proposed amendments to 395:10-1-4.2 update the citation style of the referenced statutes.

The proposed amendment to 395:10-1-4.3 requires a member electing to have payments made directly to the provider for qualified health insurance premiums to comply with the requirements set forth in 47 O.S., Section 2-305.1C.

The proposed amendment to 395:10-1-5 provides that all survivor benefits must be paid in accordance with the System's rules set forth in OAC 395:10-1-11(b)(7) in addition to 47 O.S., Section 2-306.

The proposed amendment to 395:10-1-7.1 adds a hyphen to the phrase "skill based."

The proposed amendments to 395:10-1-9 update the citations to the statute references in subsections (a), (b) and (c).

The proposed amendment to 395:10-1-10 removes subsection (a) regarding unused sick leave as credit. The proposed amendment leaves in place subsection (b) allowing 1,920 hours of unused accumulated sick leave effective as of July 1, 2008.

The proposed amendments to 395:10-1-11 update the citations to statute references and change references to "his/her" and "his" to "their." The proposed amendment to 395:10-1-11(a)(7) leaves the requirement that members make payment selections in writing but removes the additional requirement that selections be made a minimum of 30 days prior to termination of employment. The proposed amendment to 395:10-1-11(b)(6) clarifies the requirement that interest and payments described in OAC 395:10-1-11(a)(6)(7) apply in regards to this subsection. The proposed new subsection 395:10-1-11(b)(7) addresses the rights of an eligible spouse to act as a member and elect Back DROP or Conversion from Front DROP in the event a member dies and was eligible for Back DROP.

The proposed amendments to 395:10-1-12 replaces the existing physical and psychological testing requirements with updated requirements, including, but not limited to, completion of the OLERS New Hire Forms Packet.

The proposed amendments to 395:10-1-13 replace the existing application for disability retirement requirements with updated requirements, including, but not limited to, a questionnaire that must be completed under oath.

The proposed deletion of 395:10-1-14 removes the rules disallowing certain members from engaging in any employment with similar performing job functions.

The proposed revisions to 395:10-1-15 remove the initial subsections (b) and (d). The proposed revisions remove the initial subsection (b) addressing review of Qualified Domestic Orders by attorneys for the Board. The proposed revisions remove the initial subsection (d) regarding alternate payees of a Qualified Domestic Order.

The proposed deletion of 395:10-1-16 removes the provisions concerning direct payment of qualified health insurance premiums.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

395:10-1-2. Definitions

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

"Board" means the Oklahoma Law Enforcement Retirement Board of the System.

(A) The Board shall consist of thirteen (13) members: The Assistant Commissioner of Public Safety or their Designee, the Director of State Finance, the Oklahoma Management and Enterprise Services or his/her Designee, three (3) members appointed by the Governor, a member to be appointed by the Speaker of the House of Representatives, one (1) member to be appointed by the President Pro-Tempore of the Senate, all terms to be for four years and/or coterminal with the term of office of the office of the appointing authority, two (2) members of the Highway Patrol Division, one (1) member of the Communications Division, one (1) member of the Oklahoma State Bureau of Investigation, one (1) member of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control, and one (1) member of the Alcoholic Beverage Laws Enforcement Commission, elected by and from the membership of the System.

(B) When an elected Board member's term expires, or he retires or resigns, they retire or resign causing a vacancy on the Board, the active members of said agency shall, by popular vote, nominate two (2) candidates, and present said candidates names to the office of the President of the Board. The President will then prepare a ballot with the two (2) named candidates and same shall be mailed to all members
of the System. The person receiving the majority vote will be elected to serve on the Board as provided by Statute and/or completes the resigned or retired member's term, whichever the case may be.

(C) Members elected shall serve for terms of three (3) years. Every two (2) years, one of the elected members of the Board shall be selected by the Board as President and another elected member shall be selected as Secretary of the Board.

(D) Any member of the Board elected by the membership of the System maybe recalled for cause at a special election held for that purpose by the members of the System. Such an election shall be called and held by the President and Secretary of the Board upon written request therefor signed by not less than one-third (1/3) of the members and shall be held pursuant to notice given to all members of the System, stating the date for such election which shall not be less than ten (10) days from the date of the issuance of such notice. All members of the System shall be entitled to vote by secret ballot and, if two-thirds (2/3) or more of the membership votes for his/her recall, the elected member of the Board designated in such request, notice and secret ballot, shall cease to be a member of the Board and the President and Secretary shall call and hold a special election by the members of the System to fill the remainder of the term of the member so recalled.

(E) The President and Secretary of the Board are appointed by the Board and are the Executive Officers for the Board. They are responsible for the general administration of the Retirement System. Their duties shall be as follows:

(i) Shall be responsible for maintaining records of the individual members, records of all types of funds, reserves and equipment necessary for the operation of the accounting procedures.

(ii) Shall under the direction of the Board, coordinate the investment of surplus funds, in accordance with the Statutes.

(iii) Shall sign all vouchers approved by the Board, including pension and retirement benefit payments, refunds, medical examinations and any administrative operational expenses as approved by the Board.

(iv) Seven (7) members of the Board shall constitute a quorum.

"Inactive vested member" means a member who has completed at least ten (10) years of vesting service and is no longer employed and is not receiving benefits.

"Retired member" means a member who has reached normal retirement date and is collecting benefits.

"Vested member" means a member who has completed at least ten (10) years of vesting service.

"Vesting service" means the period of service in which a member has been employed by an agency currently in this System and the member is still contributing.

395:10-1-2.2. Failure to submit documents
(a) A retiree's required documents must be received by the fifteenth day of the month in which the first retirement warrant voucher is to be paid. Mailed or the retiree's date of retirement will be changed to the first day of the month following receipt of the required documents.

(b) Required documents include, but are not limited to, written application for retirement benefits, selection or rejection of insurance coverage, tax withholding certificate and forms found on the OLERS website, approved agency personnel action indicating retirement and date of termination of employment.

395:10-1-2.3. Authorized member signature

A signature other than that of the member will not be accepted on System forms, applications or requests for confidential information except by order of the court or a durable power of attorney.

395:10-1-2.4. Recordkeeping requirements
(a) The System reserves the right to use any information contained in a member's file, in the appropriate format, for the recordkeeping, data processing and administrative use of the System. This includes, but is not limited to, use of member's names or initials, social security numbers, birth dates and zip codes. All formatting and data requirements shall be determined by the System.

(b) Any participating employer shall furnish all required information reasonably requested by the System in order to ensure compliance with all applicable federal and state laws, rules and regulations. The System reserves the right to withhold benefits, including but not limited to, refunds, withdrawal payments and retirement payments, pending timely receipt of this information.

395:10-1-3. Hearing procedures

The Board shall conduct hearings in accordance with the Administrative Procedures Act and the Open Meeting Laws of the State of Oklahoma. In regards to the Oklahoma Law Enforcement Retirement System, procedures for such hearings are as follows:

(1) Any person aggrieved by action or order of the Board may make request for a hearing to the Board in writing within thirty (30) days after notification of such allowance or disallowance of claim. The Board then shall schedule time for a hearing, and give written notice of said hearing to contestant not less than twenty (20) days prior to hearing date. The hearing shall be held in Oklahoma City, Oklahoma, unless otherwise directed by the Board. The person requesting a hearing before the Board shall supply to the Executive Director, not less than ten (10) days prior to the hearing, a copy of all exhibits that the person will offer during the hearing, together with a list of all witnesses that the person anticipates calling as a witness with a detailed description of the witnesses' proposed testimony. Failure to supply the foregoing information to
the Executive Director shall result in the exclusion of exhibits and witness testimony being presented on behalf of the person requesting the hearing. After such hearing the Board shall affirm, reverse, or modify its previous action, specifying the reasons therefor, and written notice of the action taken by the Board shall be forwarded immediately to the interested parties by the President of the Board.

(2) Hearings may be conducted by the President of the Board, or a hearing officer, or a hearing officer may be assigned to assist the President of the Board in conducting the hearing.

(3) Pre-hearing Conference: A pre-hearing conference may be used to determine legal or factual issues. When a pre-hearing conference is used, said conference may be conducted by the President of the Board, a designee of the President of the Board, or a hearing officer designated by the President of the Board. Said conference shall be conducted at least five (5) days prior to the hearing. Exhibits to be used at the hearing shall be marked and numbered. Exhibits will be exchanged at the pre-hearing conference. The admissibility or inadmissibility of exhibits to be used during the hearing will be determined by the individual presiding over the pre-hearing conference. Each exhibit used during the hearing must be produced in sufficient quantities for every Board Member to receive a copy at the time of hearing. Witnesses intended to be called at the hearing will be identified at the pre-hearing conference and the admissibility of their proposed testimony determined by the individual presiding over the pre-hearing conference. The issues to be determined at the hearing will be identified at the pre-hearing conference. A record of the pre-hearing conference may be made by tape recording.

(4) In such hearing, opportunity shall be afforded the party or parties requesting same to respond and present evidence and argument on all issues involved. The hearing shall be conducted in an orderly manner. The party or parties requesting the hearing shall be heard first; those, if any who oppose the relief sought by the requesting party shall then be heard.

(A) Unless precluded by law, informal disposition may be made of any individual proceedings by stipulation, agreed settlement, consent order or default.

(B) Any party shall at all times have the right to counsel, provided such counsel is duly licensed to practice law by the Supreme Court of Oklahoma. (5) Rulings on admissibility of evidence shall be made by the President of the Board or a hearing officer selected by the Board. The President of the Board or the hearing officer may recess and reconvene the hearing at his/her discretion.

(6) Should the party or parties contesting the Board’s actions desire a full verbatim record of the proceedings, it shall be the full responsibility of the contestant to employ and pay for the services of a competent court reporter to record the proceedings. If transcribed, the record shall be a part of the Board’s record of the hearing. Otherwise, the record will be taken by employees of the System as provided in Title 47, O.S. Section 2-309 as amended.

(7) The President of the Board or his/her designee shall have authority for purpose of the hearing to administer oaths; and with the approval of the Board, shall have the authority to issue subpoenas for witnesses or subpoenas duces tecum to compel the production of books, records, papers, and other objects, which subpoenas may be served, by any duly qualified officer of the law or any employee of the Board in any manner prescribed for the service of a subpoena in a civil action.

(8) Any request for continuance received five (5) days or more before the scheduled hearing date may be granted by the Executive Director. Reasons for granting a continuance may include one of the following reasons: illness of the party requesting the hearing, or illness of a material witness, or unavoidable conflict in the schedule of the legal counsel. If the request for continuance is received, the Executive Director will decide whether to grant such a continuance. Said request for continuance must be mailed to the Executive Director and must be simultaneously mailed to all other interested parties and so indicated on the request. If the continuance is granted, all parties will be notified by the Secretary of the Board, or the Secretary of the Board’s designee.

(9) All final orders in any hearing shall be made within thirty (30) days after the conclusion of the hearing. Parties shall be notified of such orders either in person or by registered mail. A final order shall include findings of fact and conclusion of law, separately stated.
member shall be required to return to duty and complete twenty (20) years of service.

(5) Retirement pursuant to Title 47 O.S. § 2-305, has at all times included reemployment of a member by a state agency in a position which is not covered by OLERS. Thus, in-service distributions from OLERS to such a member are permitted. Prior to September 19, 2002, if such member was reemployed by a state agency in a position which is covered by OLERS, such member will continue to receive in-service distributions from OLERS and will not accru cany any further credited service. On and after September 19, 2002, if a retired member is reemployed by a state agency in a position which is covered by OLERS, such member's monthly retirement payments shall be suspended until such member retires and is not reemployed by a state agency in a position which is covered by OLERS.

395:10-1-4.1. Refund of contributions
Any member who applies for a refund of his or her contributions and is eligible for a vested benefit shall be notified of the value of the benefit and when he or she would be eligible to begin receiving a benefit. The member must sign a written waiver of such benefit before such refund will be processed for payment.

395:10-1-4.2. Health insurance contribution
The Oklahoma Law Enforcement Retirement System shall contribute the amount required by law towards the cost of health insurance coverage under the State and Education Employees Group Insurance Plan only for retirees or survivors who actually receive a monthly retirement benefit for that month. This contribution shall not be made directly to the retiree. Title 74 O.S. § 1316:2; Title 47 O.S. § 2-301.

395:10-1-4.3. Qualified health insurance premiums
If the requirements of OKLA. ADMIN. CODE Section 395:10-1-16 Title 47 O.S. § 2-305:1C are satisfied, a member who, by reason of disability or attainment of normal retirement date or age, separates from service as a public safety officer with his or her participating employer, may elect to have payment made directly to the provider for qualified health insurance premiums by deduction from the member's monthly disability benefit or monthly retirement payment, after December 31, 2006.

395:10-1-5. Survivor benefits
All survivor benefits shall be paid in accordance with Title 47, O.S. Section 2-306 or OAC 395:10-1-11(b)(7).

395:10-1-7.1. Involuntary furlough
In computing the final average salary, a retiring member's monthly base salary including excess benefits, shift differential and skill-based pay will be used for each month the retiring member was placed on involuntary furlough under OPM Rule 530:10-15-48, Involuntary leave without pay (furlough).

395:10-1-9. Purchase of prior service credit
(a) A member may receive service credit not to exceed five (5) years of participating service accumulated by the member while an employee of a state agency, or as a commissioned officer with an in-state law enforcement agency. In addition, a member may purchase service credit as a commissioned officer with an out-of-state law enforcement agency, or with a federal law enforcement agency, either as a commissioned officer or in a scientific or technical field, if the member is not receiving or eligible to receive retirement credit or benefits for such service from any other public retirement System. The cost shall be computed in accordance with Title 47 O.S. § 2-307.5. Application for such prior service must be submitted to the administrative office of the system for computation of purchase cost and must be paid for in full within two (2) years of the member's effective date of membership in OLERS. Such service credit shall not be used in determining the eligibility of the member for retirement or vesting purposes.

(b) Effective January 1, 1991, all purchases of transferred credited service pursuant to Title 47 O.S. § 2-307.5, shall be based upon the actuarial cost of the incremental projected benefits to be purchased.

1) The actuarial cost and any tables formulated for the purpose of determining such cost during each fiscal year, shall be based on the actuarial assumptions utilized in the actuarial valuation report in effect at the time.

2) The actuarial value shall be based upon the member's age, salary and service at the time of purchase, together with the earliest age for retirement and actuarially projected salary at time of retirement. For purposes of this actuarial cost, it is assumed that all members are married at the time of retirement. If purchase is not made within (30) days of the Board's approval, the purchase must be recalculated and the actuarial cost may increase.

3) For purposes of this actuarial cost, the member's age shall be rounded up or down to the nearest birthday.

4) For purposes of this actuarial cost, the mortality tables shall be formulated as a unisex table assuming 1975 Group Annuity Mortality weighted 90% male.

5) In the event a member who chooses to purchase service has been employed less than twelve (12) months, his or her salary shall be annualized based upon the most current completed calendar months of payroll information.

(c) Military service may be granted in accordance with Title 47 O.S. § 2-307.4. To receive credit for such service, a DD214 or military discharge should be submitted along with the application for membership in OLERS, or any time prior to commencement of retirement benefits. Such service shall not be used in determining the eligibility of the member for retirement or vesting purposes.
395:10-1-10. Sick leave as credited service
(a) A member, upon retirement, electing a Deferred Option Plan or electing a vested benefit, shall be credited with not more than 1,040 hours of unused accumulated sick leave. For the purposes of this computation, 1,040 hours shall total six (6) months, fifteen (15) days, with 20 days totaling one month of credit.
(b) Effective July 1, 2008, a member, upon retirement, electing a Deferred Option Plan or electing a vested benefit, shall be credited with not more than 1,920 hours of unused accumulated sick leave. For the purposes of this computation, 1,920 hours shall total twelve (12) months, with 20 days totaling one month of credit.

395:10-1-11. Deferred Option Plan
(a) Forward DROP.
(1) Purpose. The Oklahoma Law Enforcement Deferred Option Plan allows an active participating member of OLERS who has not less than twenty (20) years of participating service, who is eligible to receive a service retirement pension, to make an election to participate in the OLERS Deferred Option Plan. In lieu of terminating employment and accepting a service retirement pension, the eligible member defers the receipt of benefits in accordance with Title 47 O.S., Section 2-305.2A, B, C, D, E and F and the provisions of this section.
(2) Definitions. RESERVED
(3) Application.
(A) The applicant must have twenty (20) years or more of participating service with OLERS to be eligible.
(B) The applicant must submit his/her completed application to OLERS on forms provided by OLERS.
(C) OLERS must receive the application a minimum of thirty (30) days prior to the effective date.
(D) The effective date of membership will be the first day of the month.
(E) Once the Board has approved a member's application and the member's option account has been credited with the first contribution or benefit, the member's participation in the OLERS Deferred Option Plan is irrevocable as long as the member remains employed.
(F) OLERS will provide the applicant a Plan Summary. In addition, the applicant will be asked to sign a statement acknowledging receipt and understanding of the Plan Summary.
(4) Contributions.
(A) The final member contribution made to OLERS shall be for the last pay period prior to the first of the month in which the member becomes a participant in the OLERS Deferred Option Plan.
(B) The employer's contribution will continue to OLERS.
(C) The employer's contribution shall be credited as follows:
(i) fifty percent (50%) to the member's option account. The credit to the member's option account shall be made the same day as the monthly retirement benefit credit is made;
(ii) fifty percent (50%) to OLERS.
(D) Neither the member nor any person on behalf may make any other contribution to the member's option account. Only the employer's contribution will be added to the member's option account.
(E) When a member has participated in the OLERS Deferred Option Plan for five (5) years, or if the member terminates employment prior to the end of five (5) years, contributions will no longer be credited to the member's option account.
(5) Benefits.
(A) The monthly retirement benefit that would have been payable had the member elected to cease employment and receive a service retirement shall be credited into the member's option account.
(B) The formula for calculating the pension benefit is two and one-half percent (2 1/2%) of the final average salary multiplied by the years of creditable service including partial years of service (based on completed months of service). Final average salary is the average paid base salary of the member for the highest salaried thirty (30) consecutive months, excluding pay for any accumulated leave or uniform allowance.
(C) The amount of the member's service retirement benefit is frozen at the inception of his/her participation in the OLERS Deferred Option Plan. No increase will be made to that benefit due to any changes in the member's salary whether for cost of living increases, promotions or otherwise, while still actively employed with the agency. The pension benefit may be increased, however, by cost of living increases as provided by the legislature for all retired members of OLERS.
(D) The monthly retirement benefit will be credited to the member's option account the last day of the month.
(6) Interest. (A) The member's option account shall earn interest at a rate of two percentage (2%) points below the rate of return of the total investment portfolio of OLERS, but no less than the actuarial assumed interest rate in accordance with Title 47 O.S., Section 2-305.2 (E)(2) at the beginning of the fiscal year. The fiscal year is July 1 through June 30.
(B) The Fund's rate of return shall be calculated monthly and certified by the Fund's Executive Director.
(i) For the purpose of calculating earnings for a member's account, deposits and withdrawals will be deemed to have occurred at the close of business on the last day of the month in which the transaction occurred in the system.
(ii) Earnings on a member's account will be calculated on a monthly basis using two methods.
(I) Method I Earnings I = Account balance at beginning of month times (the fund actual internal rate of return (less one twelfth (1/12) of 2%)).

(II) Method II Earnings II = Account balance at beginning of month times (Actuarial assumed earnings rate (divided by three hundred sixty-five days) times (the number of days in the month)).

(iii) Earnings credited to a member's account as of the fiscal year end shall be the greater of the sum of Method I or the sum of Method II calculated earnings.

(C) The interest shall be credited to the member's option account on an annual basis which is defined as fiscal year ending June 30. The amount of the interest credited shall be calculated at simple interest. The formula for calculating the interest shall be the amount of the deposit, times the applicable interest rate, less two percentage (2%) points, divided by 365 days, times the number of days the deposit was credited to the member's option account for the fiscal year.

(D) Each member shall receive an itemized statement on an annual basis each fiscal year. If a member terminates employment, interest calculated and certified by the Fund's Executive Director will be credited no later than the end of the following month to the member's option account for the partial year, provided the rate of return is greater than the actuarial assumed interest rate established in accordance with Title 47 O.S. §2-305.2(E)(2). If the rate of return is less than such actuarial assumed rate, then the member's option account will be credited at the assumed interest rate established in accordance with Title 47 O.S. §2-305.2(E)(2).

(E) When a member has participated in the OLERS Deferred Option Plan for five (5) years, or if the member terminates employment prior to the end of the five (5) years, the member's option account ceases to earn interest.

(F) At the conclusion of a member's participation in the OLERS Deferred Option Plan, the member must terminate employment and shall start receiving the member's accrued monthly retirement benefit from OLERS. A member who terminates employment pursuant to the Deferred Option Plan will not be eligible for active participation in OLERS; provided, however, that a member may be reemployed by a state agency in a position not covered under OLERS and receive in-service distributions of such member's accrued monthly retirement benefit from OLERS.

7 Payment.

(A) The member must make payment selection in writing a minimum of thirty (30) days prior to termination of employment.

(B) The member may select a lump sum payment, equal to the member's option account, which will be paid directly to the member by OLERS. This payment will be made no later than the end of the month following the month the last contribution has been received following termination of employment.

(C) The member may select a direct rollover of his or her distribution in accordance with Title 47 O.S. §2-305.1A.

(D) The member may select a true annuity to be provided by a third party selected by the participant.

(E) Once the member's option account has been paid to the member as a Direct Rollover or to the member's annuity provider, the member shall not have any recourse against OLERS, its Executive Director, staff, (and his/her staff) and/or the OLERS Board.

8 Beneficiaries. Upon the death of a participant, a lump sum payment equal to the member's option account balance shall be paid to the designated beneficiary of the participant or if there is no designated beneficiary or if the designated beneficiary predeceases the participant, the payment shall be paid to the estate of the participant. If the member's spouse is not designated as the sole primary beneficiary, the member's spouse must sign consent. A designated beneficiary who is a surviving spouse of a member may elect a Direct Rollover of the account balance in accordance with Title 47 O.S. §2-305.1A. A designated beneficiary who is not a surviving spouse may elect a Direct Rollover in accordance with Title 47 O.S. §2-305.1A and Title 47 O.S. §2-305.1B.

(b) Back DROP.

(1) Purpose. In lieu of participating in the Oklahoma Law Enforcement Deferred Option Plan pursuant to Title 47 O.S. §2-305.2 A, B, C, D and E, a member may elect to participate in the Oklahoma Law Enforcement Deferred Option Plan pursuant to Title 47 O.S. §2-305.2H ("Back DROP") and the provisions of this subsection.

(2) Definitions. For purposes of this subsection, the definitions as stated in Title 47 O.S. §2-305.2(H)(1) shall apply.

(3) Application for Back DROP / Conversion from Forward DROP.

(A) The applicant must have twenty (20) years or more of participating service with OLERS to be eligible.

(B) The applicant must submit his/her completed application to OLERS on forms provided by OLERS.

(C) OLERS must receive the application a minimum of thirty (30) days prior to the effective date.

(D) The effective date of membership will be the first day of the month.

(E) Once the Board has approved a member's application, the member's participation in the OLERS Back DROP is irrevocable.
(F) OLERS will provide the applicant a Plan Summary. In addition, the applicant will be asked to sign a statement acknowledging receipt and understanding of the Plan Summary.

(4) Contributions and Benefits.
(A) At the termination date, a member's monthly pension benefit will be determined based on the earlier attained participating service and on the final average salary as of the back drop date.
(B) The member's individual deferred option account will be credited with an amount equal to the deferred benefit balance; the member will terminate employment and will start receiving the member's accrued monthly retirement benefit from OLERS.
(C) The member will, upon application filed with the Board, be refunded from the fund an amount equal to the accumulated contributions the member made to the fund from the back drop date to the termination date, but excluding any interest.
(D) Such member will not be eligible for active participation in OLERS. Termination has at all times included reemployment of a member by a state agency but only in a position not covered under OLERS.
(E) The provisions of Title 47 O.S. §§ Section 2-305.2A, B, C, F and G apply to the Back DROP.

(5) Conversion to Back DROP from Deferred Option Plan.
(A) A member may participate in the Back DROP even if the member has elected to participate in the Oklahoma Law Enforcement Deferred Option Plan pursuant to Title 47 O.S. §§ Section 2-305.2A, B, C, D, E and F.
(B) Such a member may select a back drop date which is up to five (5) years prior to the termination date but not before the date at which the member completes 20 years of participating service. Such a member's participation in the Oklahoma Law Enforcement Deferred Option Plan may not exceed five (5) years when combined with such a member's prior period of participation in the Oklahoma Law Enforcement Deferred Option Plan.
(C) The provisions of Title 47 O.S. §§ Section 2-305.2B, C, E, F and G apply to a member who converts from the Oklahoma Law Enforcement Deferred Option Plan to Back DROP.

(6) Interest, Payment. The methodology for computing interest described in Chapter Interest and payments described in OAC 395:10-1-11(a)(6)(7) applies with regard to this subsection.

(7) Death. If a member dies and was eligible for Back DROP, the eligible spouse will be allowed to act as the member and may elect either Back DROP or Conversion from Front DROP. If the eligible spouse does not elect Back DROP or Conversion from Front DROP then Title 47 O.S. Section 2-306 applies.

395:10-1-12. Physical and psychological testing requirements
(a) Prior to hiring an applicant, the hiring agency will supply the essential job functions of the position and/or physical requirements along with the OLERS New Hire Forms Packet to the applicant.
(b) The applicant/hiring agency will take the essential job functions and the OLERS New Hire Forms Packet to the hiring agencies examining medical professional at the hiring agencies expense. (This medical professional should be different from the OLERS Boards medical professional.)
(c) The hiring agency will submit the completed OLERS New Hire Forms Packet to OLERS. Incomplete packets as determined by the Executive Director or their designee shall be returned and shall not be processed.
(d) The essential job functions and the physical and psychological tests will be evaluated by the OLERS Board reviewing medical professional who was selected and employed by the Board for approval or disapproval for membership into the System. The OLERS Board reviewing medical professional may request additional tests and/or information.
(e) The Executive Director shall have the authority to approve applications for membership on an interim status after reviewing the system physician reports until the Board has the opportunity to vote. The hiring agency is now approved to employ the applicant.
(f) The Board will vote to approve or disapprove membership at the Board meeting following receipt of completed physical or psychological examination results from the Board's reviewing medical professional. Upon approval of the OLERS Board, the applicant will become a member of OLERS starting the 1st of the month after the hire date and contributions will start being withheld. If the applicant qualifies for reinstatement, then they would start immediately contributing on their hire date.
(g) All medical and psychological records shall be sealed by the Board upon approval. These records are deemed confidential and shall not be made public by the Board. The Board may use these records for the defense of the System or as otherwise required by law.
(h) Failure of agencies and/or applicants to comply with the rules specified here shall result in denial of membership into the System.
(i) Any member that transfers from one OLERS covered position to another which involves a change in job functions may be required by the OLERS Board to complete new physical or psychological testing at the discretion of the Board and at the expense of the agency.
(a) The agency shall supply the essential job functions of the position along with physical or psychological forms required to the applicant for submittal to the examining medical or psychological professional.
(b) All applicants and agencies shall use only the forms approved by the Board for physical and psychological testing, when seeking to obtain or maintain membership in the Oklahoma Law Enforcement Retirement System.
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(e) All complete physical and psychological forms shall be provided to the Executive Director of the Board for submission to the Board’s reviewing physician or medical professional.

(f) The physical and psychological testing forms shall include a release for medical/psychological information on a form approved by the Board.

(g) Incomplete physical or psychological applications as determined by the Executive Director or their designee shall be returned and shall not be processed.

(h) The Agency shall supply the Board with the essential job functions and the OPM Notice of Personnel Actions of each position seeking to be filled. The Agency shall supply the Board with amendments or changes to essential job functions within 10 days of the changes being made. Any member that transfers from one covered position to another which involves a change in job functions may be required by the Board to complete new physical or psychological testing at the discretion and expense of the Board.

(i) The Board requires successful completion of physical and psychological testing as hereinafter specified. This section shall require passing of the tests.

(j) The Board will not assume responsibility for the cost of Post Offer Pre-Employment physical and psychological testing.

(k) The Board shall approve the process and procedure of the physical and psychological testing to be performed by the administering physician(s).

(l) The results of the physical and psychological tests will be evaluated by the physician or physicians or other professionals selected and employed by the Board for approval or disapproval for membership into the System prior to actual employment by the agency.

(m) The Executive Director or the designee shall review the completed medical or psychological forms for completeness.

(n) The Executive Director shall have the authority to approve applications for membership on an interim status after reviewing the system physician reports until the Board has the opportunity to vote.

(o) The Board will vote to approve or disapprove membership at the next regularly scheduled meeting upon receipt of completed physical or psychological examination results from the Board’s reviewing medical professional.

(p) All medical and psychological records shall be sealed by the Board upon approval for membership by the reviewing physician or medical professionals. These records are deemed confidential and shall not be made public by the Board except, the Board may use these records for the defense of the System or as otherwise required by law.

(q) Failure of agencies and/or applicants to comply with the rules specified here shall result in denial of membership into the System.

395:10-1-13. Application for disability retirement requirements

(a) Complete the System's Application for Disability Retirement questionnaire under oath.

(b) If the claim is for a service related disability, a copy of the collision, accident or incident report must be provided and the findings of the §2-310.1 & §2-310.2 Injury Review Board, if any.

(c) An executed authorization for release of medical information for all treating or evaluating physicians.

(d) An executed authorization for release of employment records.

(e) A letter from the Agency Head expressing the employer's opinion as to whether the injury did or did not occur within the scope of the applicant's employment.

(f) No application for service related disability retirement shall be placed on the Board's agenda until all documents required under this section have been received by the System.

(g) A statement from the applicant for disability describing the event or events which caused the purported disability together with a specific description of the disability.

(h) A specific declaration as to whether the disability claimed is non-service or service related.

(i) If the claim is for a service related disability, a copy of the collision, accident or incident report must be provided.

(j) A copy of all worker's compensation documents filed, including all medical evaluations.

(k) A copy of all medical records.

(l) An executed authorization for release of medical information for all treating or evaluating physicians.

(m) An executed authorization for release of employment records.

(n) A letter from the Agency Head expressing the employer's opinion as to whether the injury did or did not occur within the scope of the applicant's employment.

(o) Complete the System's Application For Disability Retirement questionnaire under oath providing information concerning the claim of the applicant and the following information:

1. Name
2. Age
3. Social Security Number
4. Name of employer
5. Length of employment
6. Date of injury
7. Cause of injury
8. Nature of injury
9. Witnesses to injury
10. Name and address of all physicians who have treated or evaluated the applicant
11. Period of time that you have been away from work as a result of the purported disability and the last date worked for your employer
12. Any additional information

(j) No application for service related disability retirement shall be placed on the Board's agenda until all documents required under this section have been received by the System.

(k) When an eligible member applies for retirement, the member may only apply for a single type of retirement, such as normal retirement, non-service disability retirement, or service related disability retirement. Once a member has been granted a specific retirement by the OLRIS Board, the member may not apply or obtain a different type of retirement under the System. This rule is not intended to distinguish
between temporary retirements which later become permanent retirements.

395:10-1-14. Gainful work [REVOKED]
(a) No member, who is receiving a disability retirement and who has not reached twenty (20) years of participating service, may engage in any employment wherein the member is performing similar essential job functions as were performed in the covered Olers position from which the member retired.
(b) The OLERS Board may inquire of the disabled member, at any time, as to whether the disabled member is currently or has been engaging in employment which might disqualify the member from remaining in a disability retirement status.
(c) The OLERS Board or its Executive Director is authorized to cause OLERS employees or its attorneys to make inquiries via oral and/or written communications to the member and/or beneficiary who is receiving or attempting to receive benefits. The communications may include depositions upon oral examinations or written questions, interrogatories, requests for admissions, requests for production of documents and things, and requests for the physical and mental examination of persons.
(d) The refusal or failure of any member to timely respond truthfully and fully to such inquiry may result in a suspension of the payment of benefits by OLERS until a determination can be made whether this rule has been violated. Suspension of benefit payments will not occur until the affected member is given notice and an opportunity to appear before the OLERS Board at its next regularly scheduled meeting and show cause why the benefit should not be suspended.
(e) Regarding injury of a catastrophic nature referenced in 47 O.S. § 2-300, para. 15, gainful work means work activity that involves doing physical or mental activities, even if the work is done on a part-time basis or with less activities, pay, or responsibilities than in past work. Gainful work activity means work activity done for pay or profit. Work activity is gainful if it is the kind of work that is usually performed for pay or profit, whether or not a profit is realized.
(f) In the event a member receives earnings from gainful work, as set forth in the Social Security Administration and included in the Federal Register, which exceed the monthly allowance for a twelve (12) month period, disability retirement benefits will be suspended. The current allowable earnings from gainful work is seven hundred eighty dollars ($780.00) per month and will be automatically adjusted annually based on increases in the national average wage index and published by the Social Security Administration.
(g) The System may request a signed and notarized affidavit related to gainful work. Failure to provide such verification of income from work activity may result in forfeiture of benefits.

395:10-1-16. Direct Payment of Qualified Health Insurance Premiums [REVOKED]
(a) Election. A member who is an eligible retired public safety officer and who wishes to have direct payments made toward his or her qualified health insurance premiums from his or her monthly disability benefit or monthly retirement payment, must make a written election, on the form provided by the System.
(1) The election must be made after he or she separates from service as a public safety officer with his or her participating employer.
(2) The election will only apply to distributions from the System after December 31, 2006, and to amounts not yet distributed to the eligible retired public safety officer.
(3) Direct payments for an eligible retired public safety officer’s qualified health insurance premiums can only be made from his or her monthly disability benefit or monthly retirement payment from OLERS and cannot be made from the Oklahoma Law Enforcement Deferred Option Plan.
(4) Amounts deducted from an eligible retired public safety officer’s monthly disability benefit or monthly pension payment, and paid toward his or her qualified health insurance premiums, may not exceed $3,000 per calendar year.
(b) Payments. Monthly payments toward qualified health insurance premiums will be sent by OLERS to the provider when the monthly disability benefit and monthly retirement payments are sent. Such monthly payments will continue month to month and year to year in the amount specified on the member’s most recent election form unless the System office receives at least thirty (30) days advance written notice to change or terminate such payments or the monthly disability benefit or monthly retirement payment terminations.
(c) Eligible Retired Public Safety Officer. A “public safety officer” is an individual serving a public agency in an official capacity, with or without compensation, as a law enforcement officer, firefighter, chaplain, or as a member of a rescue squad or ambulance crew. An “eligible retired public safety officer” is an individual who, by reason of disability or attainment of normal retirement date or age, is separated from
service as a public safety officer with his or her participating employer.

(d) **Qualified Health Insurance Premiums.** "Qualified health insurance premiums" are for coverage for the eligible retired public safety officer, his or her spouse, and dependents by an accident or health insurance plan (which may be a self-insured plan, in accordance with Notice 2007-99, Q&A 23, 2007-52, I.R.B. 1243) or a qualified long-term care insurance contract. The health plan does not have to be sponsored by the eligible retired public safety officer's former participating employer. Qualified health insurance premiums do not include amounts contributed pursuant to Chapter 395:10-1-1-2.

(e) **Miscellaneous.** A completed election form with all required information must be received by the System office at least thirty (30) days before:

(1) any deduction will be made from the eligible retired public safety officer's monthly disability benefit or monthly retirement payment and paid directly to the provider; and

(2) a change or termination of such monthly deductions and payments will be made.

[OAR Docket #21-467; filed 6-15-21]

TITLe 420. OKLAHOMA LIQUEFIED PETROLEUM GAS BOARD
CHAPTER 10. LIQUEFIED PETROLEUM GAS ADMINISTRATION

[OAR Docket #21-376]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
420:10-1-1. Purpose [AMENDED]
420:10-1-5. Permits [AMENDED]
420:10-1-8. Processing and handling of applications and examinations [AMENDED]
420:10-1-14. Standards for the storage and handling of liquefied petroleum gas [AMENDED]
420:10-1-16. Training schools [AMENDED]
420:10-1-18. Insurance requirements [AMENDED]
420:10-1-20. Suspension or revocation of registration permits and fines; appeals [AMENDED]

AUTHORITY:
Oklahoma Liquefied Petroleum Gas Board; 52 O.S. § 420.3

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Superseeded rules:
420:10-1-1. Purpose [AMENDED]
420:10-1-5. Permits [AMENDED]
420:10-1-8. Processing and handling of applications and examinations [AMENDED]
420:10-1-14. Standards for the storage and handling of liquefied petroleum gas [AMENDED]
420:10-1-16. Training schools [AMENDED]
420:10-1-18. Insurance requirements [AMENDED]

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INCORPORATIONS BY REFERENCE:
N/A

GIST/ANALYSIS:
The proposed revisions to the rules delete reference to LP gas appliances; reduces the renewal fee for Class I permits; amends the requirements for Class III DOT Transporter permit and provides for an endorsement for transport and an endorsement for bulk delivery; amends the requirements for Class IV permit display and training requirements and provides for an endorsement of Un-Odorized LP Gas End User; amends the requirements for Class IV-A permit; amends the language for Class VII permit to limit for odorized LP Gas only; deletes outdated examination language; adds language requiring the submital of plans for any facility using un-odorized LP Gas and requiring permit; cleans-up language regarding safety schools; increases insurance requirements for Class IV permits; sets forth administrative hearing procedure and appeal language.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

420:10-1-1. **Purpose**
The public policy of this State, as declared by the Legislature, requires that all persons, firms, corporations, associations and other legal entities that engage in the manufacture, fabrication and assembly, or sale of LP Gas appliances or in the sale of LP Gas or in the transportation of the same over the highways of the State of Oklahoma shall not engage in such business unless they have first secured a permit as required by the laws of the State of Oklahoma and the rules and regulations adopted pursuant to such laws. The rules of this chapter are intended to implement the policy and carry out the Board's statutory duty of regulation in the interest of public safety.

420:10-1-5. **Permits**
(a) **Permits required.** No person, firm, corporation, association or other entity shall engage in the manufacturing, assembling, fabrication, installing or selling of any system, container, or apparatus to be used in this State in or for the transportation, storing, dispensing, or utilization of LPG, nor shall any transporter, distributor, or retailer of LPG store, dispense and/or transport over the highways of this State any LPG for use in this State in any system, container, apparatus
or appliance without having first obtained a permit to do so as provided in this section.

(b) **Permit classifications.** The permits required for engaging in business shall be divided into the following classifications:

1. **Class I - Dealer permit.** The Class I Dealer Permit permits the holder to engage in any phase of the LP Gas business. A Class X Manager's permit must be secured for the person actually in charge of an LP Gas operation at each separate branch or base of operation of a Class I permit holder. The initial permit fee for a Class I is One Thousand Dollars ($1,000.00). The annual renewal fee required to be paid for the Class I permit is Nine Hundred Dollars ($900.00). The annual fee for a Class I permit is Four Hundred Dollars ($400.00).

   (A) Class I holder can go on inactive status, but will have to meet all the requirements of the permit, including paying the annual renewal fee, and having proper insurance requirements filed with the Administrator, before going back on active status. If requirements are not met the permit will then be revoked. The annual renewal fee required to be paid for a Class I permit holder on inactive status is Four Hundred Dollars ($400.00).

   (B) Applicant must furnish to the Board, evidence of the following insurance:

   (i) A minimum of $1,000,000.00 general liability insurance, as per 420:10-1-18;

   (ii) Worker's Compensation insurance shall be required as per state requirements;

   (iii) Motor vehicle insurance must meet State and Federal requirements.

   (C) Brokers/wholesalers selling LP Gas to anyone other than Class I permit holders or refinery/gas processing type facilities shall obtain a Class I permit and meet the requirements thereof, except for minimum storage and metering, when said sales are by transport bulkhead to bulkhead.

   (D) Before testing for a Class I permit, an applicant must meet the following requirements as approved by the Board:

   (i) Five (5) years experience as an active Class X Manager or equivalent; and

   (ii) Forty (40) hours of specified training.

2. **Class II - Truck Transporter permit.** The Class II Transporter Permit permits the holder to transport LP Gas as a common carrier or private carrier to another of the following: a person, firm, or corporation engaged in the production or manufacture of LP Gas and/or selling or reselling LP Gas to transporters, industrial consumers, processors, distributors, retailers, and/or to holders of Class I, III, or VI permits. A Class II permit shall not authorize the resale of LP Gas to an end-user. A Class II permit shall not be a substitute where a Class I is needed. A transport must meet all CFR 49 requirements. The initial permit fee for a Class II is One Thousand Dollars ($1,000.00). The annual fee for a Class II permit is Four Hundred Dollars ($400.00). All LP Gas transport drivers employed by a Class II permit holder are required to obtain a fuel handlers card. The annual filing fee for a fuel handlers card is Ten Dollars ($10.00).

3. **Class III - DOT Cylinder Transporter Permit.**

   (A) The Class III DOT Cylinder Transporter Permit permits the holder to operate a cylinder delivery service. The separate endorsement will be as follows: III-A, permits the holder to invoice the end-user for bulk deliveries only when the LP Gas is delivered by a Class I permit holder. The holder to operate a LP Gas cylinder sale or delivery service for LP Gas in accordance with all other rules and regulations and NFPA Pamphlets 54 and 58.

   (B) The annual fee for a Class III permit is One Hundred Fifty Dollars ($150.00). The annual fee for the separate endorsement is Three Hundred Dollars ($300.00). Class III DOT Cylinder Transporter Permit for Un-Odorized LP Gas Endorsement. A separate endorsement to a Class III permit is required, if applicable, and in addition to the Class III DOT Cylinder Transporter Permit, and allows the holder to operate a DOT cylinder sale or delivery service for un-odorized LP Gas in accordance with all other rules and regulations, NFPA Pamphlets 54 and 58, and the following:

   (i) Pursuant to this Endorsement, un-odorized LP Gas shall be sold or delivered in approved DOT cylinders only.

   (ii) All deliveries shall be made in appropriately marked and placarded vehicles.

   (iii) Delivery vehicles shall be operated by licensed personnel holding appropriate certificates and qualifications for the safe handling of LP Gas.

   (iv) Prior to application or renewal of any Class III DOT Cylinder Transporter Permit for Un-Odorized LP Gas Endorsement the applicant or holder shall provide the Administration as part of this application or renewal a complete list of facilities and each delivery location, including name of facility, street address of facility, name of contact person and contact information of said facility and the name and location of the Class I permit dealer supplying the Un-Odorized LP Gas to the permit holder.

   (v) Sales or deliveries of un-odorized LP Gas made pursuant to this Endorsement shall be made to facilities properly permitted by this Administration only.

(C) The Bulk Delivery Class III A Endorsement. The separate Class III A Bulk Delivery Endorsement to the Class III permit is required if applicable and shall permit the holder to invoice the end user for bulk delivery of odorized LP Gas to the facility of the end user only when the LP Gas is delivered to that location by a Class I permit holder.

(D) The annual fee for a Class III permit is $300. The annual fee for the Un-odorized LP Gas Endorsement is $300. The annual fee for the Bulk Delivery Endorsement is $300.
(E) All DOT cylinder transport drivers employed by a Class III permit holder are required to obtain a fuel handlers card. The annual filing fee for a fuel handlers card is Ten Dollars ($10.00).

(4) **Class IV - Installer Permit.**

(A) The Class IV Installer Permit permits the holder to install and service LP Gas systems, appliances, and other LP Gas equipment. The applicant is required to have immediate supervision for two (2) weeks with a Class IV, IV-D, Class X, or a person licensed by Oklahoma Construction Industries Board with a Mechanical License, and then shall be required to pass a written examination for each separate endorsement. The endorsements will be as follows:

(i) LP, Low Pressure systems covered by NFPA 54;
(ii) HP, High Pressure systems covered by NFPA 58;
(iii) RV, Recreational Vehicle systems covered by NFPA 1192;
(iv) MC, Meter Calibration systems covered by NIST Handbook 44;
(v) TI, Truck Inspections and Piping covered by NFPA 58 and CFR 49;
(vi) DO, Dispenser Operator for Class IV permit holders that also dispense propane.

(B) Exception from two (2) week training period would be anyone already licensed by Oklahoma Construction Industries Board with a Mechanical License. If the supervising person determines that the new applicant is properly trained, proper documentation of the training is on file, and a Class IV application has been forwarded to the LP Gas Administration, the applicant at that time may begin performing the duties of a Class IV-D permit holder until such time as the test is administered and the permit issued. This time shall not exceed thirty (30) days or the applicant shall cease to perform these duties. Current Class IV permit holders, as of September 1, 1994, properly trained in delivery of LP Gas will not be required to take the test and will be issued a IV-D permit. The annual fee for a Class IV-D is Fifty Dollars ($50.00).

(B) Class IV-D permit does not permit the holder to install or service LP Gas carburetion systems.

(C) Any installer not under the personal and direct supervision of a Class X holder at the immediate time and location of installation shall be required to have a Class IV or IV-D permit.

(6) **Class VI - DOT Cylinder &/or LP Gas Motor Fuel Station Operator Permit.**

(A) The Class VI DOT Cylinder and/or LP Gas Motor Fuel Station Operator Permit permits the holder to operate DOT cylinder dispensing station and/or a motor fuel dispenser for public resale. Said Permit must be prominently displayed for public and official inspection at all times. A permit is required for each DOT cylinder dispensing station and/or motor fuel station. The endorsements will be as follows:

(i) AAG, This Attended Autogas "AAG" endorsement permits the holder to operate LP Gas dispenser stations that fill DOT cylinders and/or Attended LP Gas motor fuel refueling dispensers for resale.

(ii) UAG, This Unattended Autogas "UAG" endorsement permits the holder to operate Unattended self-service LP Gas motor fuel dispenser stations; however, these installations require more stringent regulations than those that are attended. In addition to the requirements in this section, the permit holder shall be required to install equipment that meets or exceeds the minimum installation and performance standards described in OAC Section 420:10-1-14(28). For the purpose of defraying the cost and expenses of administering and enforcing this rule, persons, firms and corporations shall pay at the time of initial inspection a fee of Three Hundred Dollars ($300.00) for each unattended LP Gas motor fuel dispenser station. Thereafter, the annual inspection fee is One Hundred Fifty Dollars ($150.00) for each unattended LP Gas motor fuel dispenser station.

(B) Permit holder is responsible for the safety of the dispensing operation and training and safety.
employees dispensing LP Gas Permit holder must comply with reasonable training requirements of the Class I and Class 10 manager of the LP Gas provider insure all employees dispensing LP Gas at each location of permit holder are trained and permitted by this agency including notification to the Class 10 manager whenever training is necessary for new and/or unpermitted employees. Class VI locations may not become operational until a permit has been issued. A Class VI-A LP Gas Dispensing permit must be secured for the person actually in charge of an LP Gas dispensing operation of a Class VI permit holder. A permit will not be issued until the proper fee has been paid and certificate of insurance is received by the LP Gas Administration. The annual fee for a Class VI permit is One Hundred Fifty Dollars ($150.00).

(C) Un-Odorized LP Gas End User Endorsement. Facilities obtaining un-odorized LP Gas in approved DOT cylinders or otherwise for use must obtain an Un-Odorized LP Gas End User Endorsement. To obtain such an endorsement, detailed plans describing such use and location of cylinder storage, and any and all LP Gas plumbing in said facility must be submitted in writing and approved for any facility using un-odorized LP Gas in any manner. These plans must be submitted to the Administration Office along with the proper fee, and an on-site inspection must be performed by a Safety Code Enforcement Officer prior to final approval and before the introduction of LP Gas into the system. A $100.00 plan review fee must accompany all plans submitted. The fee for the inspection is $100.00. The annual fee for the Un-Odorized LP Gas End User Endorsement is $500. This endorsement must be prominently displayed for official inspection at any time.

(7) Class VI-A - LP Gas Dispensing Permit. All employees involved in dispensing LP Gas must acquire a Class VI-A permit, except a Class IV, Class IV-D, and Class X. A Class VI-A LP Gas Dispensing permit is required for a person actively in charge of or engaged in LP Gas dispensing operations for the holder of a Class VI permit. All Class VI-A permit holders must be an employee of said Class VI permit holder. Class VI-A applicants must be properly trained by a Class VI or Class X or at a Board-approved training class on proper filling of ASME tanks and DOT cylinders, and inspection thereof per NFPA 58. Applicants shall be required to pass an approved written examination. Test shall be administered by a Safety Code Enforcement Officer, or by Class X manager. In either case, the test fee for the Class VI-A permit is Ten Dollars ($10.00). Holder must post permit at the facility they are employed by carry permit and attend the Board-approved annual safety school once every year. This does not prohibit any person, firm or corporation from filling his own equipment from his own supply line, or dispensing motor fuel from an approved limited access self-service dispenser. The annual fee for a Class VI-A permit is Thirty Five Dollars ($35.00).

(8) Class VII - Cylinder Exchange Program Permit. The Class VII Cylinder Exchange Program Permit permits the holder to participate in the cylinder exchange program for odorized LP Gas only. A permit is required for each cylinder exchange location. Class VII locations may not become operational until a permit has been issued. Permits will not be issued until the proper fee has been paid and certificate of insurance is received by the LP Gas Administration. The annual fee for a Class VII permit is Fifty Dollars ($50.00).

(9) Class IX - LP Gas Container Sales Permit. The Class IX Gas Container Sales Permit permits the holder to manufacture and/or sell LP Gas containers. This permit is required by both wholesalers and retailer. The annual fee for a Class IX permit is Seventy Dollars ($70.00).

(10) Class IX-A - Manufactured Homes and Recreation Sales Permit.

(A) The Class IX-A Manufactured Homes and Recreation Sales Permit permits the holder to manufacture, fabricate and sell all LP Gas facilities or systems used in manufactured homes, campers, recreational vehicles and portable buildings whether such LP Gas system is manufactured, fabricated or sold separately or as an integral part of such trailer, camper, recreational vehicle or portable building. The annual fee for a Class IX-A is Seventy Dollars ($70.00).

(B) This shall not be construed to require a permit for a sale by the owner of a manufactured home or recreational vehicle who is not engaged in such business on a commercial basis and does not make over two such sales in one year.

(11) Class X - Manager's Permit.

(A) A Class X Manager's permit is required for a person actively in charge of LP Gas operation for holder of Class I permit and at each separate branch or base of operation of a Class I permit. All Class X holders must be a full-time employee of said Class I holder. The annual fee for a Class X permit is One Hundred Fifty Dollars ($150.00).

(B) Before testing for a Class X permit, an applicant must meet the following requirements as approved by the Board:

(i) Hold an active Class IV or Class IV-D permit and employed under an active Class I Dealer for a minimum of three (3) years or equivalent; and
(ii) One (1) year of the minimum three (3) years required experience can be satisfied with forty (40) hours of specified training.

(C) Temporary exemptions for emergency conditions can be granted by the Administrator.

(12) Additional permits required for employees of Class I dealers. Class IV, IV-D, VI-A, and X permits are the only additional permits that may be required for the employees of a Class I dealer, or as may be required by future Board action.
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(13) **LP Gas Trailer, Bobtail or Cargo Tank inspections.** For the purpose of defraying the cost and expenses of administering and enforcing this act, persons, firms and corporations shall also pay at the time of inspection an annual inspection fee of One Hundred Fifty Dollars ($150.00) for each LP Gas bobtail, MC 330 or MC 331 trailer or cargo tank that transports LP Gas in this State. All requirements imposed subsequent to these inspections must be met within thirty (30) days of the initial inspection. Failure to comply will necessitate a re-inspection at a charge of One Hundred Fifty Dollars ($150.00) for each inspection. The inspection fee shall increase to Three Hundred Dollars ($300.00) for each LP Gas bobtail, MC 330 or MC 331 trailer or cargo tank that transports LP Gas in this State if said LP Gas bobtail, MC 330 or MC 331 trailer or cargo tank is not initially inspected within sixty (60) days following the current permit expiration date, or if requirements imposed subsequent to the initial inspection are not completed within sixty (60) days of the initial inspection, whichever is later, or at the discretion of the Administrator.

(14) **Containers or cylinders.** There is hereby levied the following fee, to be paid to the Administrator, upon all first sales, purchases, rentals or uses in this state of liquefied petroleum gas containers or cylinders; on all Department of Transportation (DOT) cylinders, vehicle fuel containers, a fee of Three Dollars ($3.00) each, and on all other containers, a fee of Ten Dollars ($10.00) each.

420:10-1-8. Processing and handling of applications and examinations

(a) **Scheduling.** Upon the receipt of an application for a permit for Class I or Class X the Board or Administrator shall schedule the applicant provided therein for examination at the next periodic written examination, unless the application be filed less than 30 days prior to the next scheduled written examination.

(b) **Passing score.** A score of 80% correct shall be a passing grade for all examinations.

(c) **Examinations.**

(1) **Class I examination.** Questions for a Class I examination shall be selected at random from a reservoir of questions consisting of no less than 500 questions but no more than 1000 questions. Questions shall be of four-part, multiple choice. Prior to being placed in the reservoir the questions shall be reviewed by the Administrator and approved by the Board. For each examination a total of 100 questions shall be drawn from the reservoir. All applicants sitting at one time shall receive identical examinations. Questions shall be from NFPA pamphlets 58 and 54 and rules and regulations promulgated by the Board. All exams shall be coded in such a manner that identity of the applicant shall be unknown to the grading authority.

(2) **Qualified Managers examination.** Questions for a Class X Qualified Managers Examination shall be selected at random from a reservoir of questions consisting of no less than 500 questions but no more than 1000 questions. Questions shall be of four-part, multiple choice. Prior to being placed in the reservoir the questions shall be reviewed by the Administrator and approved by the Board. For each examination a total of 100 questions shall be drawn from the reservoir. All applicants sitting at one time shall receive identical examinations. Questions shall be from NFPA pamphlets 58 and 54 and rules and regulations promulgated by the Board. All exams shall be coded in such a manner that identity of the applicant shall be unknown to the grading authority.

(3) **Class IV and IV-D examinations.** Class IV and IV-D examinations consist of standardized examinations. Class IV examinations will consist of 50 questions and Class IV-D exam will consist of 75 questions, each to be prepared by the Administrator.

(4) **Class II, III, VI-A—VII examinations.** Class II, III, VI-A and VII examinations shall be standard concerning basics of safety and handling of LP Gas. The examination to be prepared by the Administrator.

(d) **Applicant information.**

(1) All applicants for the same type permit sitting at any one time shall receive identical examinations.

(2) All applications and examinations except Class I and Class X shall be scheduled by the Administrator at such times as he may deem appropriate.

(3) Applicants may review their examination papers at the Administration Office within 30 days after examination date.

420:10-1-14. Standards for the storage and handling of liquefied petroleum gas

(a) **NFPA standards.** The standards for the storage and handling of liquefied petroleum gases adopted by the National Fire Protection Association and published in its pamphlets No. 58, and the standards for the installation of gas appliances and gas piping adopted by said National Fire Protection Association published in its pamphlet No. 54 have been adopted by the Legislature in 52 O.S. 1991, Section 402.3 (e) and shall be accepted standards for the State of Oklahoma. All Class I permit holders must have a current copy of NFPA 58 and 54 on file at each separate branch.

(b) **Supplemental standards.** The following standards are supplemental to NFPA pamphlet No. 58 and shall be part of the rules and regulations of the Oklahoma Liquefied Petroleum Gas Board:

(1) **Definitions.**

(A) The word "approved" as used in this section means acceptable to the State Liquefied Petroleum Gas Administrator. A device or system having materials or forms different from those detailed in this section may be examined and tested according to the intent of the regulations and if found equivalent, may be approved.

(B) In this section those provisions which are considered essential for adequate protection of life and property from fire are indicated by the words "shall" and "must". The words "should" or "preferably" indicate advisory provisions concerning which the State
Liquefied Petroleum Gas Administrator of Oklahoma should be consulted.

(C) In each place mentioned in NFPA No. 54 and NFPA No. 58 where it refers to "the authority having jurisdiction" this would mean the Liquefied Petroleum Gas Administrator.

(D) An "important building" shall be any building, open to the public, or inhabited by people, in which any LP Gas system or any type is installed

(2) **Submital of plans.**

(A) Prior to the installation of new, or the modification of liquefied petroleum gas plumbing systems, excluding tank change outs, in school buildings, churches, courthouses, office buildings and other buildings to which the public is invited, such as cafés, dance halls, tourist courts and parks, plans and specifications for such installation in duplicate, shall be submitted to, and approved, by the State Liquefied Petroleum Gas Administrator, and before such systems are filled with liquefied petroleum gas, they shall be physically inspected and approved by a licensed installer and a report made by him to the State Liquefied Petroleum Gas Administrator on LPG Form 4, or its revision, furnished by the LP Gas Administrator's office.

(B) Plans must be submitted and approved on any release date for fuel storage and vaporizing capacity, a bulkhead approved by the LP Gas Administrator shall be required on each liquid line of one and one-quarter (1-1/4) inch or larger.

(C) All installations, installed after July 1, 2002, of storage containers, with more than 4,000 gallon water capacity, shall have internal valves installed as per NFPA 58.

(D) On installations of stationary or portable storage, with an aggregate of more than 4,000 gallons water capacity, a bulkhead approved by the LP Gas Administrator shall be required on each liquid line of one and one-half (1-1/2) inch or larger and each vapor line of one and one-quarter (1-1/4) inch or larger.

(4) **Piping - including pipe, tubing and fittings.**

(A) No person, firm, or corporation shall connect a liquefied petroleum gas tank to any piping without having first determined that such piping complies with the laws of the State of Oklahoma and the rules and regulations of the State Liquefied Petroleum Gas Administrator relative to liquefied petroleum gas piping.

(B) All installations, installed after July 1, 2002, of storage containers, with more than 4,000 gallon water capacity, shall have internal valves installed as per NFPA 58.

(C) On installations of stationary or portable storage, with an aggregate of more than 4,000 gallons water capacity, a bulkhead approved by the LP Gas Administrator shall be required on each liquid line of one and one-half (1-1/2) inch or larger and each vapor line of one and one-quarter (1-1/4) inch or larger.

(5) **Vaporizers and housings.**

(A) The minimum capacity of the storage container feeding the vaporizer shall not be less than ten (10) times the hourly capacity of the vaporizer in gallons.

(B) The minimum capacity of a storage container being heated by a direct fired tank heater shall be less than ten (10) times the hourly vaporizing capacity of the tank heater in gallons.

(6) **Liquid metering systems.** Each bulk retail delivery of liquid LP Gas shall be measured by a suitable LP Gas liquid meter system, except those deliveries of liquid LP Gas in cylinders which are filled by weight, deliveries of LP Gas vapor through vapor meters and a delivery of a full transport load from the terminal to the end-user with a bill of lading, are exempt from the requirements of this paragraph.

(A) LP Gas Liquid meters shall indicate deliveries in terms of gallons and to the nearest tenth of a gallon.

(B) The LP Gas liquid meter shall meet, in addition to the requirements of this paragraph, the following requirements:

(i) The system shall include a device (such as a differential back-pressure regulator) so designed
and installed that the product being measured will remain in a liquid state during passage through the meter.

(ii) No means shall be provided by which any measured liquid can be diverted from the measuring chamber, differential valve equipment or the discharge line therefrom.

(iii) Effective January 1, 1994, in accordance with the National Institute of Standards and Technology (NIST) Handbook 44, all LP Gas Liquid meters used for bulk delivery shall be designed with the necessary equipment for mechanically printing gallons on a delivery ticket and the customer served thereby shall be given a ticket mechanically imprinted by the printing device. The customer's name and Class I Dealer's name must be included on the metered ticket. Meters used for stationary dispensing of motor fuel will not be required to be equipped with such printing device.

(iv) All bulk metered sales of propane, via bobtail or transport, shall be made by temperature compensated measure. Except, any truck now operating without a temperature compensation meter shall be retrofitted by no later than July 1, 2003.

(C) All meters where product is sold to the public must be proved annually by an approved meter tester/inspector and have written certification on file at permit holders place of business. All meters and temperature compensators must be accurate within the manufacturers tolerance not to exceed + or -1% at any time. The LP Gas liquid meter system shall be designed and constructed to provide for applying lead-and-wire seals in such a manner that no modifications or adjustments which would affect the accuracy of deliveries, can be made without mutilating the seal or seals. If a seal is broken, notification must be made to the Administrator and resaled by a Safety Code Enforcement Officer, an approved meter tester, or a person approved by the Administrator. In addition, the Administrator at his discretion may require proving of metering system to determine the accuracy.

(D) No dealer or firm controlled or affiliated with a dealer may calibrate or certify its own meters. All meters must be tested with a volumetric meter prover.

(7) Qualified personnel. Each holder of an LP Gas permit shall be responsible for having qualified personnel operating and installing LP Gas equipment.

(8) Filling unsafe or unapproved dispensing or storage tanks prohibited. No person, firm, or corporation shall introduce liquefied petroleum gas into a dispensing or storage tank in the State with knowledge that such dispensing or storage tank or piping is known to be in an unsafe operating condition.

(9) Basement installations. No appliance shall be installed in any basement or semi-basement unless it is fully automatically controlled and properly vented and must have the approval of the State Liquefied Petroleum Gas Administrator.

(10) Standards for containers.

(A) In accordance with 52 O.S. Sec. 420.5, all first sales, rentals, purchases or uses of DOT cylinders and ASME tanks in this State, must have Oklahoma Identification tags attached to such cylinders or tanks. However, all DOT cylinders and ASME tanks in Oklahoma, with a manufacturers date prior to September 1, 1993, are not required to have Oklahoma Identification tags. These Oklahoma Identification tags are not transferable from one cylinder or tank to another.

(B) Any new container sold or installed in Oklahoma for use in this State shall carry a five year warranty covering workmanship and material. This warranty shall provide that any container not in compliance with this regulation must be repaired or replaced by the fabricator at no expense to the dealer or customer. This provision is to take care of "pin-hole" leaks in the weld that were not detected at the time of fabrication and does not apply to fittings.

(C) Containers shall be filled or used only upon authorization of the fee simple owner. The name of the fee simple owner, if other than the consumer, shall be conspicuously shown on the container.

(D) Any stationary storage container converted from anhydrous ammonia to propane shall be converted as follows:

(i) The container shall be purged of anhydrous ammonia by water flooding, steam or other methods described by the National Propane Gas Association's (NPGA) Recommendation for Prevention of Ammonia Contamination; and

(ii) It shall then be properly purged with propane vapor and tested with the red litmus paper as described in NFPA 58 or by any other test approved by the Board; and

(iii) The test shall be completed by the permit holder that performs the conversion; and

(iv) The results shall be documented and shall contain the container manufacturer, water capacity, serial number, the results of the test, the capacity of the relief valve, the date of the test, and the signature of the permit holder conducting the test. A copy of the results shall be provided to the owner of the container; and

(v) Any dealer filling a converted anhydrous ammonia container for the first time shall either be provided a copy of the test or complete the test as described above; and

(vi) The container shall meet all requirements of NFPA 58.

(11) Underground containers.

(A) Underground containers before being installed must be inspected by the State Liquefied Petroleum Gas Administrator, and a fee of One Hundred Dollars ($100.00) paid to the State Liquefied
Petroleum Gas Administrator’s office, and reinstalled by a licensed LP Gas installer.

(B) Underground containers shall be dug up at the expense of the owner at any time at the discretion of the State Liquefied Petroleum Gas Administrator.

(C) Prior to performing an installation of an underground container a person must complete Board approved Cathodic Protection training.

(12) Minimum storage. All new Class I permit holders must provide bulk propane storage capacity of not less than an aggregate of 18,000 water gallons. The minimum storage must be maintained and operational, with installation approved by the authority having jurisdiction, and within a fifty (50) mile radius of the corporate office or branch location. The minimum storage shall be considered maintained if the area meets the requirements of NFPA 58, the rules and regulations established by the Board and is kept reasonably clear of long, dry grass, weeds, debris, and any other combustible material. Any exceptions to the minimum storage requirement may be granted by the Board. Current active Class I permit holders, as of September 1, 1994, are not required to meet this minimum storage requirement. After a change of ownership the new Class I permit holder must secure the minimum storage requirement within one year.

(13) Painting. All bulk storage containers of a capacity 120 gallons water capacity or greater shall be painted a heat reflection color.

(14) Lettering bulk storage and dispensers.

(A) All bulk storage 2,000 gallons and above shall be lettered with the name of the contents, such as LP Gas, butane, propane, and a "No Smoking" sign in letters not less than six (6) inches high.

(B) In addition to subparagraph (A) of this paragraph, all bulk storage used for loading and unloading facilities, and all container filling storage (dispensers) shall include the name of the person, firm, or corporation operating the bulk storage or dispenser and their phone number in letters not less than two (2) inches high. This information shall be placed so as to be readily visible to the public.

(C) For all size bulk storage containers the name of the fee simple owners, if other than the consumer, shall be conspicuously shown on the container.

(15) Extinguishers required. Extinguishers of the dry chemical type, with a B:C or A:B:C rating, are required. Extinguishers shall have a net content of not less than the current NFPA 58 requirements and shall be inspected at least once each year by an authorized inspector such as Fire Departments or Fire Appliance Company representatives. Current weatherproof inspection tags shall be attached to the extinguisher.

(16) Marking cargo vehicles. Every tank vehicle used for transportation of liquefied petroleum gas shall be marked and placarded according to current DOT requirements. Each tank vehicle must also have the name of the person, firm or corporation on each side of the cargo tank in letters a minimum of two (2) inches in height. This information shall be placed so as to be readily visible to the public. This name shall be the same as permit holder has designated on the Class I or Class II permit.

(17) Parking and garaging LP gas tank vehicles. Any tank vehicle used for transportation of liquefied petroleum gas shall not be parked beneath or adjacent to any electric transmission line in such position that there is a possibility of a conductor contacting the tank in event of breakage.

(18) Filling unapproved truck, trailer or cargo tanks prohibited.

(A) An inspection form, when properly completed, and a LPG registration decal (the serial number of which is shown on the inspection form), shall be evidence that the liquefied petroleum gas truck, trailer or cargo tank described on the inspection form by its serial number has been approved by the Liquefied Petroleum Gas Administrator for use in the transportation of liquefied petroleum gas. Such LPG registration decal and inspection form also shall authorize the person, firm or corporation whose name appears on the inspection form or its bona fide employees to operate the truck or trailer tank described on the inspection form, and further shall authorize the filling of such truck, trailer or cargo tank with liquefied petroleum gas.

(B) The LPG registration decal shall be displayed at all times in an easily visible location on the left front of the cargo tank, which is on the driver’s side. A copy of the inspection form shall be retained, until the expiration date, in the office of the person, firm or corporation whose name appears thereon. It will not be necessary to keep or display a copy of the inspection form on the truck, trailer or cargo tank.

(C) No person, firm or corporation shall operate a truck, trailer or cargo tank in the transportation of liquefied petroleum gas in this State unless such person, firm or corporation has been issued a LPG registration decal and an inspection form certifying that such tank has been registered with and approved by the State Liquefied Petroleum Gas Administrator, or unless its operation has been specifically approved by a communication from the State Liquefied Petroleum Gas Administrator.

(D) The LPG registration decal and the inspection form required in this paragraph are not transferable by the person, firm or corporation to whom they are issued or from one truck, trailer or cargo tank to another, and they are not to be used after the expiration date of the fiscal year for which they were issued, or in the event the Class I permit becomes inactive.

(19) Vaporizers. Exhaust gases shall not be used as a direct means of heat supply for the vaporization of fuel.

(20) Stationary engines in building.

(A) All engine rooms shall be well ventilated at the floor level.

(B) When engines are installed below grade level, suitable floor level mechanical exhaust ventilation...
shall be provided and operated continuously or adequate means shall be provided to purge the room before the engine is started. In any case the mechanical ventilation shall be in operation when the engine is running. Before and during any repairs to the engine the room shall be ventilated.

(C) Automatic fire doors shall be provided at openings in the engine room that open into other sections of the building.

(D) Exhaust gases shall be discharged outside the building in a manner that will not create a fire or any other hazard.

(E) Regulators and pressure relief valves installed in buildings and engine rooms shall be vented to the outside and discharge at least five feet away from any building opening. Such venting will not be required for combination engine fuel vaporizing - fuel reducing - fuel metering devices providing an acceptable automatic shut-off valve is installed immediately ahead of such devices.

(21) Storage outside of buildings. Valves and safety relief devices shall be protected against accumulations of ice and snow. Protective caps shall be deemed adequate.

(22) Appliances. Any mobile home, travel trailer, camper or recreational vehicle shall be delivered to the buying public by the permit holder with the system prospective.

(23) Maximum vapor pressure and container working pressure.

(A) The maximum vapor pressure of the product at 100 degree Fahrenheit which may be transferred to a container shall not exceed the design working pressure of the container. Exception: 200 psig ASME working pressure vessels in LP Gas service in Oklahoma prior to January 1, 1994, may be continued in service for commercial propane, provided that they are fitted with relief valves and meet the start-to-leak setting in relation to the design pressure of the container, shall be in accordance with NFPA 58. For the purpose of this exception, "commercial propane" is defined as having a vapor pressure not in excess of 210 psig at 100 degree Fahrenheit. This exception does not apply to LP Gas motor fuel and mobile fuel containers.

(B) Any stationary 200 psig ASME containers brought into Oklahoma from out of state and intended for stationary LP Gas installation in Oklahoma at any facility requiring submission of plans and specifications must be tested by at least two (2) of the following nondestructive test methods recognized by ASME to determine if the container or assembly is safe for LP Gas use in Oklahoma. The following test results must be submitted to the Oklahoma LP Gas Administration for approval.

(i) Hydrostatic Test;
(ii) Ultrasonic thickness test;
(iii) Wet particle fluorescent or magnaflux.

(24) Testing, leakage and visual inspection, and meter calibration.

(A) Hydrostatic testers operating in Oklahoma that are hydrostatic testing cargo containers for LP Gas use in Oklahoma must be approved by the Oklahoma LP Gas Board and shall:

(i) Hold a Federal C.T. number;
(ii) Include in their testing the use of a calibrated pressure chart recorder;
(iii) Hold a Class IV installer permit.

(B) Leakage and visual inspectors operating in Oklahoma and performing this inspection on cargo containers and their systems for LP Gas use in Oklahoma must be approved by the Oklahoma LP Gas Board and meet the following requirements:

(i) Inspectors shall hold a Federal C.T. number;
(ii) If the inspection includes repairs that require the LP Gas system to be re-plumbed, a Class IV permit is required.

(C) Meter calibrators operating in Oklahoma that are meter calibrators for LP Gas use in Oklahoma must be approved by the Oklahoma LP Gas Board and meet the following requirements:

(i) Meters shall be tested in accordance to Oklahoma Rules and Regulations, Section 420:10-1-14(7);
(ii) Meter calibrators shall furnish the meter owner a copy of the calibration showing the correct gear numbers and temperature compensator settings;
(iii) Meter calibration results shall be on a form approved by the LP Gas Administrator and a copy of the completed form shall be furnished to the meter owner;
(iv) Meter calibrators shall hold a Class IV permit.
(v) Meter calibration testers shall test meters according to National Institute of Standards and Technology (NIST) standards.

(25) Cylinder exchange stations.

(A) Cylinder exchange cabinets shall be constructed as per NFPA 58.

(B) The cabinet shall have the following signs affixed to it and readily visible to the public:

(i) "Propane" or "Flammable Gas" and "No Smoking" in letters not less than two (2) inches high;
(ii) "Net Weight ____ lbs." with the net weight of the cylinders to be specified, all of which shall be displayed on the front of the cabinet in letters not less than two (2) inches high;
(iii) Name of Class I permit holder who supplies the cylinders;
(iv) 24-hour Emergency telephone number.

(C) The cabinet shall be located for distance and number of cylinders as per NFPA 58.
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(D) The cylinder storage area shall be kept free of wood, debris and other combustible/flammable material not necessary to the storage for a distance of ten (10) feet, not to include the construction materials of the building itself.

(E) Protection against vehicle impact shall be provided in accordance with good engineering practice where vehicle traffic normally is expected at the location as per NFPA 58.

(F) A fire extinguisher shall be provided as per NFPA 58

(G) A warning sign shall be posted at or near any entrance doorway stating the "LP GAS EXCHANGE CYLINDERS EMPTY OR FULL SHALL NOT BE TAKEN INDOORS FOR ANY REASON."

(H) The Class I permit holder shall provide safety training materials to the Class VII permit holder. The Class VII permit holder is responsible for providing appropriate safety information to the individual exchanging the cylinder. This documentation of training will be kept by the Class VII permit holder at the Class VII location.

(I) Automated cylinder exchange cabinets that include an automated vending system for exchanging cylinders shall comply with the following additional requirements:

(i) Electrical equipment installed in cylinder storage compartments shall comply with the requirements for Class I, Division 2 equipment in accordance with NFPA 70, National Electrical Code;
(ii) Cabinets shall be designed such that cylinders can be placed inside only in the upright position;
(iii) Door releases for access to stored cylinders shall be permitted to be pneumatic, mechanical or electrically powered;
(iv) A manual override control shall be permitted for use by authorized personnel;
(v) The vending system shall not be capable of returning to automatic operation after a manual override until the system has been inspected and reset by authorized personnel.

(J) A Class I permit shall be required in order to supply exchange cylinders for the cylinder exchange permit holder.

(K) A busy sidewalk and thoroughfare, as referenced in NFPA 58, shall be further defined as not being located on private property. A busy sidewalk is alongside a public road and a thoroughfare is a public road.

(26) Recreational vehicles. Installations or repairs on LP Gas systems on recreational vehicles shall be performed as per NFPA 1192, Standard on Recreational Vehicles.


(A) Unattended self-service LP Gas motor fuel dispenser stations shall meet the applicable sections of the rules and regulations of the Oklahoma Liquefied Petroleum Gas Board and NFPA 58.

(B) Any unattended self-service LP Gas motor fuel dispenser shall also meet all Alternative Provisions for Installations of ASME containers found in NFPA 58 regardless of tank size. This includes Redundant Fail Safe Product Control and Low Emission Transfer requirements.

(C) The delivery valve and nozzle combination shall be designed, installed, and operated, so that LP Gas will not be released unless the valve is correctly attached to the filler coupling on the receiving valve of the LP Gas motor fuel container.

(D) To maintain minimum performance standards, the following shall be considered minimum system performance requirements:

(i) Dispensing rate minimum of eight (8) gallons per minute (GPM) per manufacturer's specifications;
(ii) Vehicle fueling area, ground where vehicle is parked, shall be reasonably level to allow for complete fuel fills.

(E) The dispenser shall have the following signs affixed to the dispenser and readily visible to the public:

(i) Step by step operating instructions, approved in advance by the Administrator;
(ii) A warning sign(s) stating, "WARNING, STATE LAW PROHIBITS FILLING ANY PORTABLE DOT CONTAINERS AT THIS DISPENSER" and "All vehicles refueling at this dispenser must have an appropriate ASME container fitted with an operational OPD valve" in letters not less than two (2) inches high;
(iii) Proper name of LP Gas being dispensed, as specified by federal regulations at CFR-Title 49, in letters not less than two (2) inches high;
(iv) "No Smoking" in letters not less than two (2) inches high;
(v) 24-hour emergency telephone number in letters not less than two (2) inches high;
(vi) Name of the Class I permit holder that services the dispenser, in letters not less than two (2) inches high.

420:10-1-16. Training schools

(a) Safety schools for Class I dealers and X managers. It shall be the continuing responsibility of all Class I holders, including Sole Proprietorships and Class X permit holders to attend a Board sanctioned management safety seminar at least once every two years. Seminars shall be available at least annually, with biennial attendance a requisite for license renewals.

(b) Safety school for fuel handling personnel. Class IV, IV-D, VI, and VI-A, and X permit holders must attend a Board sponsored or sanctioned safety school at least once a year.
The Administrator is authorized to suspend the State of Oklahoma insurance requirements for LP Gas permit holders licensed by the State of Oklahoma. No insurance coverage shall be canceled or terminated without otherwise provided for in this section, no registration permit shall be maintained in full force and effect during the operation of the business for which the coverage was issued. Except as otherwise provided for in this section, no registration permit shall be issued until said certificate is filed with the Administrator. No insurance coverage shall be canceled or terminated without thirty (30) days prior written notice of cancellation or termination to the Administrator. The following are the minimum insurance requirements for LP Gas permit holders licensed by the State of Oklahoma:

1. **Class I - Dealer Permit.**
   - (A) General liability, Bodily Injury, Property Damage, including products and completed operations liability coverage shall be obtained as follows: $1,000,000 per occurrence; $1,000,000 aggregate.
   - (B) Motor vehicle insurance must meet State and Federal requirements.
   - (C) Workers' compensation insurance shall be obtained as required by Oklahoma State statutes.

2. **Class II - Truck Transporter Permit.**
   - (A) General liability, Bodily Injury, Property Damage, including products and completed operations liability coverage shall be obtained as follows: $1,000,000 per occurrence; $1,000,000 aggregate.
   - (B) Motor vehicle insurance must meet State and Federal requirements.
   - (C) Workers' compensation insurance shall be obtained as required by Oklahoma State statutes.

3. **Class III - DOT Cylinder Transporter Permit.**
   - (A) General liability, Bodily Injury, Property Damage, including products and completed operations liability coverage shall be obtained as follows: $1,000,000 per occurrence; $1,000,000 aggregate.
   - (B) Motor vehicle insurance must meet State and Federal requirements.
   - (C) Workers' compensation insurance shall be obtained as required by Oklahoma State statutes.

4. **Class IV - Installer Permit.**
   - (A) General liability, Bodily Injury, Property Damage, including products and completed operations liability coverage shall be obtained as follows: $25,000 per occurrence; $50,000 aggregate.
   - (B) Workers' compensation insurance shall be obtained as required by Oklahoma State statutes.

5. **Class IV - Driver/Installer Permit.** The Class IV-D permit is only issued in conjunction with the Class I permit; therefore, the insurance coverage of the Class I permit holder will cover the Class IV-D permit holder.

6. **Class VI - DOT Cylinder &/or LP Gas Motor Fuel Station Operation Permit.**
   - (A) General liability, Bodily Injury, Property Damage, including products and completed operations liability coverage shall be obtained as follows: $100,000 per occurrence; $100,000 aggregate.
   - (B) Workers' compensation insurance shall be obtained as required by Oklahoma State statutes.

7. **Class VI-A - LP Gas Dispensing Permit.** The Class VI-A permit is only issued in conjunction with the Class I, II, III, VI and/or VII permit; therefore, the insurance coverage of the Class I, II, III, VI and/or VII permit holder will cover the Class VI-A permit holder.

8. **Class VII - Cylinder Exchange Program Permit.**
   - (A) General liability, Bodily Injury, Property Damage, including products and completed operations liability coverage shall be obtained as follows: $25,000 per occurrence; $25,000 aggregate. This insurance coverage is only necessary when the permit holder engages in manufacturing and/or installing LP Gas containers.
   - (B) Workers' compensation insurance shall be obtained as required by Oklahoma State statutes.

9. **Class IX - LP Gas Container Sales Permit.**
   - (A) General liability, Bodily Injury, Property Damage, including products and completed operations liability coverage shall be obtained as follows: $25,000 per occurrence; $25,000 aggregate. This insurance coverage is only necessary when the permit holder engages in manufacturing and/or installing LP Gas containers.
   - (B) Workers' compensation insurance shall be obtained as required by Oklahoma State statutes.

10. **Class IX-A - Manufactured Homes and Recreation Sales Permit.**
    - (A) General liability, Bodily Injury, Property Damage, including products and completed operations liability coverage shall be obtained as follows: $25,000 per occurrence; $25,000 aggregate. This insurance coverage is only necessary when the permit holder engages in manufacturing, fabrication or installation of LP Gas systems.
    - (B) Workers' compensation insurance shall be obtained as required by Oklahoma State statutes.

11. **Class X - Manager's Permit.** The Class X permit is only issued in conjunction with the Class I permit; therefore, the insurance coverage of the Class I permit holder will cover the Class X permit holder.

420:10-1-20. Suspension or revocation of registration permits and fines; appeals

(a) **Authority.** The Administrator is authorized to suspend or revoke any registration permit issued by the Board, if it is found at a hearing on the matter, that the registrant has violated...
or is violating or has failed or is failing to comply with any provisions of Title 52, O.S., Section 420.1 and following, or these rules or specifications, or has delivered a lesser quantity of gas than the registrant bills the customer for with intent to defraud.

(b) **Individual Proceeding.** Administrative actions presented to the Administrator shall be an individual proceeding governed by the provisions of Article II of the Oklahoma Administrative Procedures Act.

(c) **Notice of Hearing on Citation.** The administrative process shall be initiated upon the filing of a Notice of Hearing on Citation which will provide notice of the proposed administrative action, including a statement of the time, place and nature of the hearing, the legal authority and jurisdiction under which the hearing is to be held, a reference to the sections of statutes and rules involved and a statement of the matters asserted. The Notice of Hearing on Citation shall be served by personal service or any other method of service provided by law.

(1) Upon his or her own motion, or upon the receipt of written complaint from any member of the Board, or from any Deputy Administrator or Inspector, that a registrant has violated or is violating or has failed or is failing to comply with any of the provisions of Section 420.1 and following, or these safety rules, regulations and/or specifications, the Administrator is authorized and it shall be his or her duty to hold a public hearing to consider such complaint. The Administrator shall have the power to conduct investigations; to summon and compel the attendance at such hearing of Witnesses; to require the production of any records or documents pertinent to the subject matter of any investigation or hearing, and to provide for the taking of depositions of witnesses in accordance with the rules of the district courts of this state. Notice of the date, time and place of any such hearing shall be given by registered mail not less than ten (10) days, exclusive of the date of mailing, before the date thereof, addressed to the registrant complained against and to any other parties involved, each of whom shall have the right to file answer, to appear and be heard in person and by counsel, and to present evidence at such hearing. The registrant complained against and any other parties involved may appear in person or present their case, including any evidence supporting their case, in writing to the Administrator in lieu of their making a physical appearance, and the Administrator will consider any such written evidence at the hearing.

(d) **Burden of Proof.** At any hearing conducted pursuant to this section, the LP Gas Administration shall have the burden of proving by clear and convincing evidence that the registrant has violated the statutes or rules stated in the Notice.

(e) **Hearing Officer.** The Administrator shall act as hearing officer and shall preside over the hearings. The Administrator shall have the duty to conduct a fair hearing, to take all necessary action to avoid delay, and to maintain order. The Administrator shall have all powers necessary, including, but not limited to:

1. Examine witnesses and direct witnesses to testify.
2. Receive, rule on, exclude or limit evidence.
3. Rule on procedural issues.

(f) **Recording.** Testimony given at a hearing shall be audio recorded. All parties to the hearing may receive a copy of the audio upon request of the LP Gas Administration and payment of the costs thereof. Any party desiring a stenographic record of the testimony, at their own expense, may provide the services of a licensed or certified shorthand reported to obtain an official record of the hearing.

(g) **Proposed Findings of Fact and Conclusions of Law.** Any party to the hearing may file proposed findings of fact and conclusions of law within the time fixed by the hearing officer. Any party so filing shall also serve one copy of their proposed findings and conclusions upon each other party to the hearing.

(h) **Order.** If the Administrator finds at a hearing that the registrant has violated or is violating or has failed or is failing to comply with any provision of Section 420.1 and following, or these rules or specifications, the Administrator, if the findings justify such action, shall issue an order suspending the registrant's registration permit for a period not to exceed ninety (90) days, revoking the registration permit, or imposing a fine of not more than Five Hundred Thousand Dollars ($500,000) ($1,000,000) for each separate offense. Any fine imposed pursuant to this section shall be deposited into the Liquefied Petroleum Gas Fund. The amount of the fine and the type of penalty imposed for an offense or violation shall be within the Administrator's discretion, provided that the following fines shall be imposed for the following offenses or violations, in addition to any other fines and penalties the Administrator may impose additional fines for repeated or aggravated offenses or violations:

1. **Container Law.** (filing container owned conspicuously by another person) — [Title 52, O.S. §§420.9(F)]; $500.00 maximum fine.
2. **Unauthorized removal of red tag.** [OAC 420:10-14(b)(9)]; $500.00 maximum fine.
3. **Failing to carry or use check blocks.** [NFPA 58, Ch.6.3.8]; $500.00 maximum fine.
4. **Failing to complete or late filing of LPG Form 4.** [OAC 420:10-1.15]; $500.00 maximum fine per occurrence.
5. **Inaccurate meters or meter calibration.** [OAC 420:10-1.14(b)(1) ]; $500.00 maximum fine.
6. **Meter gears do not match calibration report; Failing to report unsealed meter; Failing to give printed ticket.** [OAC 420:10-1.14(b)(7)]; $500.00 maximum fine.
7. **Failing to obtain a proper permit to operate in LPG Industry.** [OAC 420:10-1.15]; $500.00 maximum fine.
8. **Failing to notify existing permit before expiration.** [OAC 420:10-1.16]; 25% of permit cost maximum fine.
9. **Failing to attend safety school.** [OAC 420:10-1.16]; $500.00 maximum fine.
10. **Failing to comply with inspection requirements.** [OAC 420:10-1.14]; $500.00 maximum fine.
11. **Leaving Internal Safety Valve (ISV) open or manual liquid outlet valve open during transportation.** [NFPA 58, Ch.6.3.1.2]; $500.00 maximum fine.
12. **ESV's not operating.** [NFPA 58, Ch.6.3.1.2]; $500.00 maximum fine.
13. **Other violations.** [OAC 420:10-1.14]; $500.00 maximum fine.
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(14) Failing to list all storage sites—[various]: $500.00 maximum fine.
(15) Failing to pay invoice from Administrator within 35 days from issued date—[various]: 25% of invoice maximum fine.
(16) No insurance—[OAC 420:10-1-18]: $500.00 maximum fine.
(17) Failing to report accident—[OAC 420:10-1-14(b)(3)]: $500.00 maximum fine.
(18) Failing to attend management safety seminar—[OAC 420:10-1-16]: $500.00 maximum fine.

(d) The Administrator's findings, judgment and order shall be reduced to writing and be recorded in a permanent public record to be retained in the office of the Administrator. Order shall be in writing and include findings of fact and conclusions of law. Copies shall be furnished to the registrant complained against and to the board.

(i) Reconsideration. Within ten (10) days after a final order is issued by the Administrator, the aggrieved party may ask the Board for reconsideration of the order if there are adequate grounds set forth in section 317 of Article II of the Oklahoma Administrative Procedures Act. Any registrant who has been fined, or whose registration permit is suspended or revoked by the Administrator may, within thirty (30) days after such fine, suspension or revocation, file an appeal with the Board shall review the order of the Administrator de novo at the next scheduled meeting of the Board, and the Board shall affirm the Administrator's order if supported by substantial evidence.

(ii) Appeal to District Court. In the event the Board affirms in whole or in part the action of the Administrator, the registrant may, within thirty (30) days after the Board's action, file an appeal with the district court of Oklahoma County or in the county wherein the registrant resides or has its principal place of business in this state, pursuant to Article II of the Administrative Procedures Act. Upon filing of an appeal, enforcement of the Administrator's order shall be stayed pending final disposition of such appeal. Upon affirmance, the order shall become final and conclusive and the stay of enforcement shall be vacated.

[OAR Docket #21-376; filed 6-14-21]

TITLE 429. OKLAHOMA LOTTERY COMMISSION
CHAPTER 1. GENERAL ADMINISTRATION

[OAR Docket #21-461]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
429:1-1-3 [AMENDED]
429:1-1-4 [REVOKED]
429:1-1-5 [AMENDED]

AUTHORITY
Oklahoma Lottery Commission; 3A O.S., Section 709 and Section 710

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
September 23, 2020

COMMENT PERIOD:
October 15 through November 18, 2020
PUBLIC HEARING:
November 16 and 18, 2020
ADOPTION:
January 25, 2021
SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:
January 25, 2021
LEGISLATIVE APPROVAL:
Approved June 11, 2021 by HJR 1046
FINAL ADOPTION:
June 11, 2021
EFFECTIVE:
September 6, 2021
SUPERSEDED EMERGENCY ACTIONS:
N/A
INCORPORATIONS BY REFERENCE:
N/A

GIST/ANALYSIS:
The proposed changes to Chapter 1 in Title 429 relate to general administration of the Lottery. The rule changes are in response to the Governor's request in Executive Order 2020-03 for agencies to review agency rules to identify costly, ineffective, duplicative, and outdated regulations. The rule changes proposed in this action will eliminate duplicative and unnecessary agency rules. More specifically, the changes to 1-1-3 remove definitions that do not apply to this Chapter or that are already included in the Oklahoma Lottery Act. The revoking of 1-1-4 is because these requirements are included in Title 3A, Section 702 and Section 709. The stricken language in 1-1-5 removes the requirement for an unnecessary statement from a retailer appeal letter.

CONTACT PERSON:
Jay Finks, Executive Director, Oklahoma Lottery Commission, 123 Robert S. Kerr, Oklahoma City, OK 73102, 405-522-7721, jay.finks@lottery.ok.gov

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 6, 2021:

429:1-1-3. Definitions
In addition to terms defined in the Oklahoma Education Lottery Act, the following words or terms, when used in this Chapter, shall have the following meaning unless the context clearly indicates otherwise:

"Act" means the Oklahoma Education Lottery Act.
"Active Game" means a lottery game currently available for sale from the Oklahoma Lottery Commission.
"Activated Pack" means the status of a pack of tickets which indicates to the OLC that tickets are being sold from that pack.
"Altered Ticket" means any ticket intentionally changed by a player or by other persons or means in an attempt to make the ticket appear as a winning ticket.
"Authorized Location" means a business authorized by a contract with OLC to sell OLC Lottery products. "Authorized Location" and "Authorized Retailer" are synonymous terms.
"Automatic Win Symbol" means any symbol that, when revealed under the removable covering on an instant ticket, automatically wins a prize for the player.
"Breaks" means a gap of one or more numbered instant tickets in a pack number sequence.
"Cancelled Ticket" means any OLC ticket for which the ticket sale and/or validation information has been deleted from OLC records.

"Caption" means the letters appearing near the play symbols in the instant ticket play area that verify the correctness of play symbols.

"Certified Drawing" means a drawing in which the lottery and an independent accountant attests that the drawing equipment functioned properly and that a random selection of a winning combination has occurred.

"Claim Center" means an OLC authorized location available to pay claims for prizes of more than $600. A "Claim Center" may also be a retailer authorized by the Board to pay prizes up to five thousand dollars ($5,000.00) without regard to where the ticket or share was purchased, after performing validation procedures appropriate to the game and as specified by the Board.

"Claim Form" means the printed form authorized by OLC that a player shall complete and submit to OLC along with a ticket to determine eligibility for prize payment, in the event that such prize has not been validated and paid by an OLC retailer.

"Claimant" means a player who has submitted a claim for prize payment.

"Claim Period" means the period of time prescribed by the Act during which players must claim cash prizes. For instant games, the claim period is ninety (90) days after the announced end of the game. For online games, the claim period is one hundred eighty (180) days after the drawing date.

"Computer Selected Items" means numbers or groups of numbers selected for a player by the computer in online games. Also known as auto picks, quick picks, or computer picks.

"Counterfeit Ticket" means any ticket not produced by an OLC authorized ticket printer or an OLC online games sales terminal.

"Defective Printed Tickets" means the same as misregistered ticket.

"Display Printing" means the printing on the ticket not associated with the ticket game play.

"District Office" means an OLC claim center, if any, in various cities in Oklahoma.

"Disputed Ticket" means a ticket which the claimant believes is a prize winning ticket, but which fails OLC validation procedures.

"Doubling" means any method used on a ticket to double a prize amount.

"Draw Procedures" means the written document approved by OLC that specifies the process for selecting winners for a particular instant game or instant game promotion, if a drawing is designed as part of the game or promotion, and for each online game or online game promotion.

"Drawing" means the process by which the lottery randomly selects numbers or items in accordance with the specific game rules or game promotion rules for those games or game promotions requiring random selection of numbers or items.

"Duplicate Ticket" means a ticket produced by photography, xerography or any other duplication method other than an authorized instant ticket printed for OLC or generated by an authorized online terminal.

"Electronic Funds Transfer" or "EFT" means the process by which the OLC transfers funds from a retailer authorized bank account to pay amounts due the OLC or by which OLC provides funds to a retailer for payment of prizes.

"Entry" means a lottery ticket or other OLC authorized document submitted to OLC or any OLC authorized party for participation in an OLC drawing.

"Executive Director" means the chief executive officer and administrator of the Oklahoma Lottery Commission.

"Finalist" means a person selected through a preliminary drawing for participation in a grand prize drawing.

"Floating Image Play Area" means the play area of each instant ticket which may print in a slightly different position on game tickets as a security measure.

"Game Board" means a pre-printed OLC form for use by players in selecting numbers for online games (see "Play Slip").

"Game Name" means the name of the Instant or Online game, as specified in the game procedures.

"Game Number" means the preprinted number on an instant ticket which identifies a particular game.

"Game Report" means a report prepared after a game end showing, at a minimum, the number of tickets sold and the number of prizes awarded in the game.

"Game Specifications Document" means the same as working papers.

"Grand Prize Drawing" means an event in which qualified players/contestants are awarded prizes in a random manner and as provided in OLC approved procedures.

"High-Tier Prize" means a prize of $601 or more.

"Instant Game" means an instant ticket lottery game offered by OLC for sale to the public that is played by revealing a hidden play area on a ticket to display the play symbols.

"Instant Game Procedures" means the document summarizing the game specifications as provided in the working papers for each Instant Game.

"Instant Game Promotion Procedures" means the OLC approved procedures for player participation in any Instant Game Promotion.

"Jackpot" means a large prize; often the top prize in an online game.

"Lottery Retailer" or "Retailer" means a business entity contracted to OLC to sell lottery tickets.

"Low-Tier Prize" means a prize of twenty-five dollars ($25) or less.

"Mid-Tier Prize" means a prize of $25.01-$600.

"Minor" means an individual younger than 18 years of age.

"Misused Ticket" means a ticket cut during production such that the ticket is not whole and able to be validated.

"Misregistered Ticket" means any ticket on which printed data has been misprinted in such a manner as to prevent reading during the validation process.

"Mutilated Ticket" means any lottery ticket accidentally or intentionally damaged such that completion of OLC validation procedures is not possible.
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"Non-Cash Prize" means merchandise prizes offered in lottery games or lottery promotions.

"Oklahoma Lottery Retailer Contract" means Parts 1 through 8 of the Lottery Retailer Sales Contract Application, Title 3A, Section 701 ff of the Oklahoma Statutes as amended, Emergency and Permanent Rules approved by the OLC Board. As used in these Rules the terms, "Retailer Contract," "Oklahoma Ticket Sales Contract," "Lottery Retail Sales Contract," and "Lottery Retail Sales Contract" all mean "Oklahoma Lottery Retailer Contract".

"OLC" means the Oklahoma Lottery Commission.

"Online Game" means a game where tickets or shares are purchased through a network of sales terminals located at OLC authorized retail outlets through use of an OLC authorized play slip or manual retailer input of player requested numbers. "Online Game" does not include a game played via the Internet.

"Online Game Procedures" means the document summarizing game specifications for each online game offered for sale by OLC.

"Online Game Promotion Procedures" means the document summarizing promotion specifications for each online game promotion offered by OLC.

"Pack" or "Pack Size" means a package of instant tickets, each ticket with a different number. The number of tickets in a pack is generally from 60 to 500.

"Pack Number" means the unique number on the ticket that designates each pack of instant tickets in the game. Each pack number is unique within each instant game.

"Play Area" means the covered area of an instant ticket that contains the ticket-play symbols.

"Play Central® Lottery Kiosk" means a self-service ticket vending machine that allows the player to purchase instant tickets and/or online game tickets without any clerk assistance.

"Play Panel" means an area on an online game play slip or game board used by a player to select numbers for a single online game play.

"Play Slip" means a pre-printed OLC form for use by players in selecting numbers for online games (see game board).

"Play Spot" means an authorized area on an instant ticket containing one play symbol and one caption.

"Play Station" means a stand-alone unit provided by OLC for the display of lottery game brochures, play slips, etc.

"Play Style" means the method of play to determine a winner for an individual game or game promotion.

"Play Symbol" means the printed data under the removable covering on the front of an instant ticket that is used to determine eligibility for a prize. The symbols for individual games will be specified in individual instant game procedures.

"Player Selected Item" means a number or item or group of numbers or items selected by a player in connection with an online game.

"Point of Sale Material" or "POS" means flyers, brochures, posters and signage used within at lottery retail locations to identify the products and games available for sale, as well as to provide general information (i.e., odds, jackpot amounts, prize levels and beneficiaries).

"Point of Purchase Material" or "POP" is synonymous with POS.

"Preliminary Drawing" means an event for the selection of contestees for a grand prize drawing.

"Price Point" means the retail selling price of an individual game ticket.

"Printer Omitted Tickets" means any tickets designated by OLC's instant ticket printer as having been omitted from the ticket order quantity for reasons stated by the ticket printer.

"Price" means a cash amount or product (merchandise) that can be won in a lottery game or game promotion.

"Price Drawing" means a method for determining game or game promotion winners, as defined in OLC procedures.

"Price Structure" means the number, value, and odds of winning prizes for an individual game as approved by OLC in individual game procedures.

"Retailer" means a business which sells lottery tickets or shares on behalf of OLC pursuant to a retailer contract.

"Retailer Commission" means the amount of money paid to retailers for selling lottery products.

"Retailer Paid Prizes" means prizes which may be paid by retailers subject to OLC validation procedures.

"Retail Sales Price" means the OLC designated price OLC retailers must charge for a ticket when sold.

"Retailer Ticket Order Quantity" means the number of tickets or packs of tickets ordered by the retailer from OLC or its authorized distributor.

"Retailer Validation Code" means the code found under the covered area over the play symbols on the front of the instant ticket which the OLC retailer may use to verify and validate low-tier winners.

"Seasonal Retailer" means a business which sells Lottery tickets or shares on behalf of OLC pursuant to a retailer contract and whose business may be closed for some portion of the year and/or whose business hours may be significantly reduced for some portion of the year due to the seasonal nature of the business. Businesses that are closed temporarily for remodeling, change of ownership, or similar temporary closings will not be deemed to be seasonal retailers.

"Settled Pack" means the status of an activated pack of instant tickets when the OLC has invoiced the retailer based upon a pre-determined formula or schedule and the retailer has paid for the pack.

"Share" means any intangible evidence of participation in a lottery game.

"Ticket" means any tangible evidence issued by the lottery to provide participation in a lottery game or drawing authorized by the Act.

"Ticket Number" means the number on the ticket that refers to the ticket sequence within the pack.

"Ticket Order Quantity" means the number of tickets or packs of tickets ordered by OLC from the instant ticket printer.

"Unreadable Ticket" means any ticket on which any play data or other ticket validation information cannot be read as part of the prize validation procedure.
"Validation Number" means the unique data printed on a ticket that enables verification of the ticket as a valid winner.

"Validation Procedures" means the procedures utilized by OLC and/or its authorized vendors to determine if a claimed ticket is a valid winner.

"Valid Ticket" means a ticket which meets all OLC game specifications and OLC validation requirements.

"Variant" means a symbol used in conjunction with certain play styles and may include a symbol that serves as a "wild card" to complete a winning combination of play symbols.

"VIRN (Void If Removed Numbers)" means a series of numbers under the removable covering on an instant ticket to be used in the validation process.

"Wild" means a symbol or word, different from all the others in an instant game, used to complete a match on a winning ticket.

"Working Papers" means the written document approved by the OLC for instant game production that includes, among other things, the game name, the art work for the front and back of the ticket, how a prize is won, game prize structure, play style, ticket delivery schedule to OLC, and eligibility for drawing, if any.

429:1-1-4. Public accountability [REVOKED] (a) The OLC and Board will operate pursuant to the Oklahoma Open Records Act and the Oklahoma Open Meeting Act. (b) In the promulgation of rules, the Board shall be subject to the Administrative Procedures Act (75 O.S. §250 et seq.).

429:1-1-5. Procedures for retailer appeal to Board (a) The provisions of this rule are provided to retailers who wish to appeal the cancellation, denial, revocation, temporary suspension, suspension or rejection of renewal of a lottery retailer contract by the executive director or designee. (b) These rules shall be given the most reasonable meaning, taken in their total context, and will be construed to secure due process in the resolution of retailer appeals. They shall not be construed to limit legal rights or obligations of any party. (c) The executive director shall designate a member of the Oklahoma Lottery Commission (OLC) staff to evaluate lottery retailer contracts. That designee may:

(1) Temporarily suspend a lottery retailer contract without prior notice pending any prosecution, hearing, or investigation, whether by a third party or by the OLC; or
(2) Cancel, suspend, deny, revoke, terminate, or reject renewal of a lottery retailer contract when it is in the best interest of the lottery, the public welfare, or the State of Oklahoma, and shall promptly notify the retailer of such action. (d) Retailers will be notified by certified mail at the last retailer address known to the OLC. The notification will outline the reasons for OLC's action and advise retailers of their right to appeal to the executive director. (e) Retailers shall have twenty (20) days from the date of the notice of the (1) temporary suspension or (2) cancellation, suspension, denial, revocation, termination, or rejection of renewal of a lottery retailer contract to appeal to the executive director. Appeals shall be filed and signed by the retailer and shall set out therein:

(1) The name, address and retailer's certificate number; (2) The argument and/or legal authority upon which each assignment of error is made; and (3) A statement of relief sought by the retailer; and (4) A verification by the retailer that the statements and facts contained therein are true. (f) The executive director will consider the appeal of the (1) temporary suspension or (2) cancellation, suspension, denial, revocation, or termination or rejection of renewal of a lottery retailer contract by the OLC designee and shall fix a date for a hearing.

(1) The hearing date shall be set within thirty (30) days of the date the appeal is received. (2) Notice of the time, date and location of the hearing will be sent to the parties. (3) The executive director shall issue a written order after the hearing which shall be sent by certified mail to the retailer within thirty (30) days of the hearing date. (g) Any aggrieved party to the contract may appeal the order of the executive director to the Board of Trustees of the OLC by filing a notice of such appeal with the executive director within twenty (20) days of the mailing of the written order by the executive director. Such appeal must specify the grounds upon which the party alleges the executive directors order to be erroneous. (h) The Board of Trustees will hear the appeal of the order of the executive director's and shall fix a date of hearing, at which time the Board shall be authorized and empowered to hear evidence pertinent to the appeal.

(1) Notice of the time, date and location of the hearing will be sent to the parties. (2) The Board may, in its discretion, vacate, modify, or affirm, in part or whole, the order of the executive director. (3) The Board shall issue a written order in each case within sixty days of the hearing date. (i) Orders of the Board shall be subject to judicial review (3A O.S., §730).

[OAR Docket #21-461; filed 6-15-21]
"Altered Ticket" means any ticket intentionally changed by a player or by other persons or means in an attempt to make the ticket appear as a winning ticket.

"Authorized Location" means a business authorized by a contract with OLC to sell OLC Lottery products. "Authorized Location" and "Authorized Retailer" are synonymous terms.

"Automatic Win Symbol" means any symbol that, when revealed under the removable covering on an instant ticket, automatically wins a prize for the player.

"Breaks" means a gap of one or more numbered instant tickets in a pack number sequence.

"Cancelled Ticket" means any OLC ticket for which the ticket sale and/or validation information has been deleted from OLC records.

"Caption" means the letters appearing near the play symbols in the instant ticket play area that verify the correctness of play symbols.

"Certified Drawing" means a drawing in which the lottery and an independent accountant attests that the drawing equipment functioned properly and that a random selection of a winning combination has occurred.

"Claim Center" means an OLC authorized location available to pay claims for prizes of more than $600. A "Claim Center" may also be a retailer authorized by the Board to pay prizes up to five thousand dollars ($5,000.00) without regard to where the ticket or share was purchased, after performing validation procedures appropriate to the game and as specified by the Board.

"Claim Form" means the printed form authorized by OLC that a player shall complete and submit to OLC along with a ticket to determine eligibility for prize payment, in the event that such prize has not been validated and paid by an OLC retailer.

"Claimant" means a player who has submitted a claim for prize payment.

"Claim Period" means the period of time prescribed by the Act during which players must claim cash prizes. For instant games, the claim period is ninety (90) days after the announced end of the game. For online games, the claim period is one hundred eighty (180) days after the drawing date.

"Computer Selected Items" means numbers or groups of numbers selected for a player by the computer in online games. Also known as auto picks, quick picks, or computer picks.

"Counterfeit Ticket" means any ticket not produced by an OLC authorized ticket printer or an OLC online games sales terminal.

"Defectively Printed Tickets" means the same as mis-registered ticket.

"Display Printing" means the printing on the ticket not associated with the ticket game play.

"District Office" means an OLC claim center, if any, in various cities in Oklahoma.

"Disputed Ticket" means a ticket which the claimant believes is a prize winning ticket, but which fails OLC validation procedures.

"Doubler" means any method used on a ticket to double a prize amount.
"Draw Procedures" means the written document approved by OLC that specifies the process for selecting winners for a particular instant game or instant game promotion, if a drawing is designed as part of the game or promotion, and for each online game or online game promotion.

"Drawing" means the process by which the lottery randomly selects numbers or items in accordance with the specific game rules or game promotion rules for those games or game promotions requiring random selection of numbers or items.

"Duplicate Ticket" means a ticket produced by photography, xerography or any other duplication method other than an authorized instant ticket printed for OLC or generated by an authorized online terminal.

"Electronic Funds Transfer" or "EFT" means the process by which the OLC transfers funds from a retailer authorized bank account to pay amounts due the OLC or by which OLC provides funds to a retailer for payment of prizes.

"Entry" means a lottery ticket or other OLC authorized document submitted to OLC or any OLC authorized party for participation in an OLC drawing.

"Executive Director" means the chief executive officer and administrator of the Oklahoma Lottery Commission.

"Finalist" means a person selected through a preliminary drawing for participation in a grand prize drawing.

"Floating Image Play Area" means the play area of each instant ticket which may print in a slightly different position on game tickets as a security measure.

"Game Board" means a pre-printed OLC form for use by players in selecting numbers for online games (see "Play Slip").

"Game Name" means the name of the Instant or Online game, as specified in the game procedures.

"Game Number" means the preprinted number on an instant ticket which identifies a particular game.

"Game Report" means a report prepared after a game ending, at a minimum, the number of tickets sold and the number of prizes awarded in the game.

"Game Specifications Document" means the same as working papers.

"Grand Prize Drawing" means an event in which qualified players/contestants are awarded prizes in a random manner and as provided in OLC approved procedures.

"High-Tier Prize" means a prize of $601 or more.

"Instant Game" means an instant lottery game offered by OLC for sale to the public that is played by revealing a hidden play area on a ticket to display the play symbols.

"Instant Game Procedures" means the document summarizing the game specifications as provided in the working papers for each Instant Game.

"Instant Game Promotion Procedures" means the OLC approved procedures for player participation in any Instant Game Promotion.

"Jackpot" means a large prize; often the top prize in an online game.

"Lottery Retailer" or "Retailer" means a business entity contracted to OLC to sell lottery tickets.

"Low-Tier Prize" means a prize of twenty-five dollars ($25) or less.

"Mid-Tier Prize" means a prize of $25.01-$600.

"Minor" means an individual younger than 18 years of age.

"Miscut Ticket" means a ticket cut during production such that the ticket is not whole and able to be validated.

"Misregistered Ticket" means any ticket on which printed data has been misprinted in such a manner as to prevent reading during the validation process.

"Mutilated Ticket" means any lottery ticket accidentally or intentionally damaged such that completion of OLC validation procedures is not possible.

"Non-Cash Prize" means merchandise prizes offered in lottery games or lottery promotions.

"Oklahoma Lottery Retailer Contract" means Parts I through 8 of the Lottery Retailer Sales Contract Application, Title 3A, Section 701 ff of the Oklahoma Statutes as amended, Emergency and Permanent Rules approved by the OLC Board. As used in these Rules the terms, "Retailer Contract", "Oklahoma Lottery Sales Contract," "Retailer Game Sales Contract," and "Lottery Retailer Sales Contract" all mean "Oklahoma Lottery Retailer Contract".

"OLC" means the Oklahoma Lottery Commission.

"Online Game" means a game where tickets or shares are purchased through a network of sales terminals located at OLC authorized retail outlets through use of an OLC authorized play slip or manual retailer input of player requested numbers. "Online Game" does not include a game played via the Internet.

"Online Game Procedures" means the document summarizing game specifications for each online game offered for sale by OLC.

"Online Game Promotion Procedures" means the document summarizing promotion specifications for each online game promotion offered by OLC.

"Online Terminal" means the OLC authorized sales terminal used to sell various online lottery number games.

"Pack" or "Pack Size" means a package of instant tickets, each ticket with a different number. The number of tickets in a pack is generally from 60 to 500.

"Pack Number" means the unique number on the ticket that designates each pack of instant tickets in the game. Each pack number is unique within each instant game.

"Play Area" means the covered area of an instant ticket that contains the ticket play symbols.

"Play Central ® - Lottery Kiosk" means a self-service ticket vending machine that allows the player to purchase instant tickets and/or online game tickets without any clerk assistance.

"Play Panel" means an area on an online game play slip or game board used by a player to select numbers for a single online game play.

"Play Slip" means a pre-printed OLC form for use by players in selecting numbers for online games (see game board).

"Play Spot" means an authorized area on an instant ticket containing one play symbol and one caption.

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"Play Station" means a stand-alone unit provided by OLC for the display of lottery game brochures play slips, etc.

"Play Style" means the method of play to determine a winner for an individual game or game promotion.

"Play Symbol" means the printed data under the removable covering on the front of an instant ticket that is used to determine eligibility for a prize. The symbols for individual games will be specified in individual instant game procedures.

"Player-Selected Item" means a number or item of group of numbers or items selected by a player in connection with an online game.

"Point-of-Sale Material" or "POS" means flyers, brochures, posters and signage used within/at lottery retail locations to identify the products and games available for sale, as well as to provide general information (i.e., odds, jackpot amounts, prize levels and beneficiaries). "Point of Purchase Material" or "POP" is synonymous with POS.

"Preliminary Drawing" means an event for the selection of contest entries for a grand prize drawing.

"Price Point" means the retail selling price of an individual game ticket.

"Printer Omitted Tickets" means any tickets designated by OLC's instant ticket printer as having been omitted from the ticket order quantity for reasons stated by the ticket printer.

"Prize" means a cash amount or product (merchandise) that can be won in a lottery game or game promotion.

"Prize Drawing" means a method for determining game or game promotion winners, as defined in OLC procedures.

"Prize Structure" means the number, value, and odds of winning prizes for an individual game as approved by OLC in individual game procedures.

"Retailer" means a business which sells lottery tickets or shares on behalf of OLC pursuant to a retailer contract.

"Retailer Commission" means the amount of money paid to retailers for selling lottery products.

"Retailer-Paid Prizes" means prizes which may be paid by retailers subject to OLC validation procedures.

"Retail Sales Price" means the OLC designated price OLC retailers must charge for a ticket when sold.

"Retailer Ticket Order Quantity" means the number of tickets or packs of tickets ordered by the retailer from OLC or its authorized distributor.

"Retailer Validation Code" means the code found under the covered area over the play symbols on the front of the instant ticket which the OLC retailer may use to verify and validate low-tier winners.

"Seasonal Retailer" means a business which sells lottery tickets or shares on behalf of OLC pursuant to a retailer contract and whose business may be closed for some portion of the year and/or whose business hours may be significantly reduced for some portion of the year due to the seasonal nature of the business. Businesses that are closed temporarily for remodeling, change of ownership, or similar temporary closings will not be deemed to be seasonal retailers.

"Settled Pack" means the status of an activated pack of instant tickets when the OLC has invoiced the retailer based upon a pre-determined formula or schedule and the retailer has paid for the pack.

"Share" means any intangible evidence of participation in a lottery game.

"Ticket" means any tangible evidence issued by the lottery to provide participation in a lottery game or drawing authorized by the Act.

"Ticket Number" means the number on the ticket that refers to the ticket sequence within the pack.

"Ticket Order Quantity" means the number of tickets or packs of tickets ordered by OLC from the instant ticket printer.

"Unreadable Ticket" means any ticket on which any play data or other ticket validation information cannot be read as part of the prize validation procedure.

"Validation Number" means the unique data printed on a ticket that enables verification of the ticket as a valid winner.

"Validation Procedures" means the procedures utilized by OLC and/or its authorized vendors to determine if a claimed ticket is a valid winner.

"Valid Ticket" means a ticket which meets all OLC game specifications and OLC validation requirements.

"Variant" means a symbol used in conjunction with certain play styles and may include a symbol that serves as a "wild card" to complete a winning combination of play symbols.

"VIRN (Void If Removed Numbers)" means a series of numbers under the removable covering on an instant ticket to be used in the validation process.

"Wild" means a symbol or word, different from all the others, in an instant game, used to complete a match on a winning ticket.

"Working Papers" means the written document approved by the OLC for instant game production that includes, among other things, the game name, the art work for the front and back of the ticket, how a prize is won, game prize structure, play style, ticket delivery schedule to OLC, and eligibility for a drawing, if any.

429:10-1-3. Retailer compensation
(a) Retailers will earn six percent (6%) for each dollar of ticket sales plus three-quarters of one percent (.75%) for each dollar of prizes $600.00 or less paid by the retailer.
(b) In the event OLC designates certain retailers to pay prizes of up to $5,000, pursuant to the Act and 429:10-1-7(b) (relating to payment of prizes), retailers so designated shall earn six percent (6%) for each dollar of ticket sales plus three-quarters of one percent (.75%) for each dollar of prizes $5,000 or less paid by the retailer; retailers so designated will receive $10 for each prize claim processed and forwarded to OLC for payment.
(c) Retailers may earn a bonus payment for selling a winning PowerBall or Hot Lotto America ticket as provided herein:
(1) Powerball Jackpot prize ticket (6 of 6), not more than $25,000;
(2) PowerBall second level prize ticket (5 of 5 white balls with no PowerBall), not more than $5,000;
(3) Hot Lotto America Jackpot prize ticket (6 of 6), not more than $5,000;
(4) Hot Lotto America second level prize ticket (5 of 5 white balls with no Hot Ball All Star Bonus), not more than $1,000;

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(5) Mega Millions Jackpot prize ticket (6 of 6), not more than $25,000;
(6) Mega Millions second level prize ticket (5 of 5 white balls with no MegaBall), not more than $5,000;

(d) This bonus payment will be paid to the retailer in a manner as determined by the Oklahoma Lottery Commission regardless of whether the winning prize ticket is claimed by the apparent winner or not. All bonus payment programs shall be approved by the Board of Trustees of the Oklahoma Lottery Commission prior to implementation.

429:10-1-4. Retailer selection criteria and application fee

In addition to the retailer selection criteria in the Act, OLC will consider the criteria enumerated herein:

(1) It is the intent of OLC that all retailers sell both instant and online (computerized or pick-your-numbers) games, thus retailer selection criteria for retailers of instant tickets and retailers of online (computerized or pick-your-numbers) games are identical.

(2) Retailer applicants shall, at the time of application, consent to the requirements of the Act and the requirements enumerated herein, which may be revised or amended by the OLC subject to Board approval and notification to retailers.

(3) Persons applying to become lottery retailers shall be charged a uniform application fee of $95. The OLC may designate a portion of this fee as a non-refundable application fee and the remaining portion to cover the retailer bonding requirements.

(4) All lottery retailer contracts may be renewable annually from the date of issuance at the discretion of the OLC, unless sooner canceled or terminated.

(5) No certificate of authority to act as a lottery retailer shall be issued to any applicant doing business or who holds a license to do business as a pawnbroker, supervised lender, or deferred deposit lender, also known as a payday lender, or whose primary business is categorized as a check casher.

429:10-1-5. Acceptance and return of instant lottery tickets

(a) All instant lottery tickets ordered by retailer and accepted from OLC or its authorized distributor are deemed to be purchased by retailer at the price established by OLC, less appropriate retailer commissions and/or OLC approved adjustments.

(b) Retailers will accept only complete ticket orders and will not be allowed to accept a part of the ticket order delivered to them.

(c) Retailers shall be responsible for lost, stolen, missing, damaged or destroyed active packs of instant tickets and will be charged the full price of the tickets minus any applicable commissions, unless the tickets are recovered by OLC. If a retailer notifies the OLC within 24 hours of any active pack of tickets becoming lost, stolen, missing, damaged or destroyed and files a police report, in instances when packs are stolen, and cooperates in the investigation by the OLC, the OLC may reduce the retailer's costs to $25.00 for each active pack.

(d) Retailers are responsible for lost, stolen, missing, damaged or destroyed instant tickets. If a retailer notifies the OLC within 24 hours of any inactive pack of tickets becoming lost, stolen, missing, damaged or destroyed and files a police report, in instances when packs are stolen, and cooperates with OLC in the investigation by OLC, the OLC may waive any retailer cost for each inactive pack.

(e) The OLC will accept full inactive pack returns only as follows:

(1) after the official notification to retailers announcing an end of game, retailers shall have six (6) weeks after the official end date to return all full and inactivated packs of tickets to a lottery representative; or,

(2) within ten (10) days of termination, suspension, cancellation, revocation or non-renewal of the retailer's contract with the OLC.

(f) The OLC will accept partial pack returns only as follows:

(1) within six (6) weeks of the termination, suspension, cancellation, revocation or non-renewal of the retailer's contract with the OLC.

(2) within the specific time frames established by OLC as a part of an official game ending procedure.

(3) A maximum of four (4) breaks in ticket number sequence per pack will be allowed.

(4) The tickets must be returned to a designated OLC representative.

(g) The OLC will accept the return of all instant tickets damaged prior to delivery acceptance by the retailer. These tickets must be returned to a designated OLC representative within one week of receipt of the tickets. The OLC may, at its sole discretion, elect to accept the return of tickets damaged after delivery.

(h) Retailers shall keep sufficient inventory to support all sales during a two week delivery cycle. Retailers who frequently require emergency or special orders may be assessed a delivery charge at the discretion of the OLC.

429:10-1-7. Payment of prizes

(a) During the retailer's normal business hours, retailers are required to pay prizes $600.00 or under. Retailers are encouraged to pay in cash, but they may pay mid-tier prizes ($25.01 to $600) with a business check or money order if this is disclosed in advance to the claimant. Consistent reported failure to pay prizes to claimants or the issuance of a non-sufficient funds (NSF) check to claimants may be sufficient grounds to suspend or terminate the retailer contract.

(b) OLC may authorize designated retailers to pay prizes up to five-thousand dollars ($5,000.00), without regard to where the ticket or share was purchased, after performing validation procedures appropriate to the game and as specified by the Board.

(c) Before attempting to validate a ticket, the Retailer should instruct the Claimant to print their name on the back of the ticket and sign their name in the space provided.

(d) Retailer must establish that the ticket is a winning ticket by using the OLC validation procedures/system. If the retailer...
(a) The accounting period for purposes of preparing retailer invoices shall be weekly from Saturday at 12:00 midnight through the following Saturday at 11:59:59 p.m.

(b) All packs of instant tickets activated in an accounting period and for which the prize validation requirements specified in (c) of this Section have occurred, and all sales of online game tickets occurring within the accounting period will be invoiced to the retailer, less any retailer commissions and/or OLC authorized adjustments. The retailer invoice will be available through the OLC lottery sales terminal after 4:00:00 a.m. on Monday, immediately following the end of the accounting period.

(c) For instant games, retailers may select one of the following three (3) settlement options. Retailers may select a settlement option during the initial contract process and may change the option only on their annual renewal date and only if they advise the OLC of their desire to change the option no later than two (2) weeks prior to their annual renewal date.

(1) Settlement Option 1: all ticket packs activated by the retailer or by the OLC on behalf of the retailer for which eighty percent (80%) of the winning low-tier tickets contained in the pack have been validated by the end of the previous accounting period will be included in the current retailer weekly invoice. Any pack which has been activated for a period of thirty (30) days will be invoiced to the retailer, even if eighty percent (80%) of the pack’s winning low-tier tickets have not been validated. In the event a retailer activates concurrently two or more instant game packs from the same game, the first pack activated will be included in the current retailer weekly invoice regardless of how many low-tier tickets have been validated from the first, except in situations where the retailer has two or more selling locations within the same retail business in which case the first pack activated will be included in the current retailer weekly invoice when the third or subsequent pack of that game is activated, regardless of how many low-tier tickets have been validated from the first pack.

(2) Settlement Option 2: all ticket packs will be settled 21 days after activation, at which time such settled packs will be included on the weekly invoice for the week in which they were settled. In the event a retailer activates concurrently two or more instant game packs from the same game, the first pack activated will be included in the current retailer weekly invoice, except in situations where the retailer has two or more selling locations within the same retail business, in which case the first pack activated will be included in the current retailer weekly invoice when the third or subsequent pack of that game is activated.

(3) Settlement Option 3: all ticket packs will be settled immediately on activation, at which time such settled packs will be included on the weekly invoice for the week in which they were settled.

(d) The retailer invoice will provide a calculation of the proceeds due the OLC. The proceeds will be equal to the retail value of instant game ticket packs, plus the retail value of on-line ticket sales, less applicable sales or cashing commissions, less any winning tickets paid by the retailer during the accounting period, plus or minus any adjustments to the retailer account authorized by OLC.

429:10-1-8. Minimum sales requirement [REVOKED]

(a) The OLC will establish minimum weekly instant and/or online sales requirements which will be communicated to retailers. Failure to achieve these minimum weekly sales levels may result in suspension or cancellation of the retailer’s contract at the sole discretion of OLC.

(b) In order to promote and maintain the availability of lottery retailers in remote and/or sparsely populated areas of the state, and to provide for the continuing operation of seasonal retailers, OLC may waive these minimum sales requirements at OLC’s sole discretion.

429:10-1-9. Merchandising [REVOKED]

(a) Each retailer shall offer all available instant games for sale to the public.

(b) The retailer shall use ticket dispensers provided by OLC for the sale of lottery tickets, and shall place the dispenser and online game lottery sales terminal(s) in a prominent location in the retail establishment near the cash register or check-out area.

(c) The retailer shall prominently display point-of-sale materials supplied by the OLC, which may include door decals, game posters, display tickets, danglers, change mats, lighted interior signs, banners, odds of winning, or any other items provided by the OLC unless the OLC agrees otherwise in writing.

(d) Retailer must agree to make available to potential lottery customers player information supplied by OLC, to explain game rules, to provide adequate supplies of claim forms, game or game promotion entry envelopes, play selection slips, and to provide adequate space for a play station.

429:10-1-10. Settlement and retailer invoicing

(a) The accounting period for purposes of preparing retailer invoices shall be weekly from Saturday at 12:00 midnight through the following Saturday at 11:59:59 p.m.

(b) After validating and paying a winning instant game ticket, the retailer should deface the ticket in a manner sufficient to prevent subsequent attempts to claim the ticket prize amount.

(f) For prizes greater than $600, retailers will provide claimants with OLC claim forms, if available, or direct them to an authorized claim center, the OLC office, or the OLC website.

(g) A retailer shall not charge any player or claimant a fee for selling a ticket, validating a winning ticket, paying a winning ticket, verifying a non-winning ticket, providing a claim form, or for any other assistance not authorized by OLC.

(h) If a claimant of a winning ticket is less than 18 years of age, retailers must instruct the claimant that the Act prohibits prize payment to any person under the age of 18 years or under the age of 18 years and return the ticket to the claimant.
(e) For purposes of calculating the retailer invoice, free ticket prizes validated by the retailer shall have the same value as the applicable retail value of free ticket(s) provided to the claimant.

[OAR Docket #21-462; filed 6-15-21]

**TITLE 429. OKLAHOMA LOTTERY COMMISSION**

**CHAPTER 15. INSTANT LOTTERY GAMES**

[OAR Docket #21-463]

**RULEMAKING ACTION:**
PERMANENT final adoption

**RULES:**
429:15-1-2 [AMENDED]
429:15-1-4 [AMENDED]
429:15-1-5 [AMENDED]
429:15-1-6 [AMENDED]
429:15-1-8 [AMENDED]
429:15-1-8.1 [NEW]
429:15-1-11 [REVOKED]
429:15-1-12 [REVOKED]
429:15-1-13 [AMENDED]
429:15-1-13.1 [NEW]
429:15-1-13.2 [NEW]
429:15-1-14 [AMENDED]
429:15-1-15 [NEW]
APPENDIX A [REVOKED]
APPENDIX B [REVOKED]

**AUTHORITY**
Oklahoma Lottery Commission; 3A O.S., Section 709 and Section 710

**SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:**
September 23, 2020

**COMMENT PERIOD:**
October 15 through November 18, 2020

**PUBLIC HEARING:**
November 16 and 18, 2020

**ADOPTION:**
January 25, 2021

**SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:**
January 25, 2021

**LEGISLATIVE APPROVAL:**
Approved June 11, 2021 by HJR 1046

**FINAL ADOPTION:**
June 11, 2021

**EFFECTIVE:**
September 6, 2021

**SUPERSEDED EMERGENCY ACTIONS:**
n/a

**INCORPORATIONS BY REFERENCE:**
n/a

**GIST/ANALYSIS:**
The proposed changes to Chapter 15 in Title 429 relate to the conduct of lottery games. The rule changes are in response to the Governor's request in Executive Order 2020-03 for agencies to review agency rules to identify costly, ineffective, duplicative, and outdated regulations. The rule changes proposed in this action will eliminate duplicative and unnecessary agency rules. The rule as it currently exists addresses Instant Tickets / Games conducted by the Lottery. As changed, the rule will combine the provisions of current Chapter 20 dealing with Online Games into this one, creating one chapter to address all lottery games rather than two separate chapters.

The change to rule 429:15-1-2 eliminates definitions that are not used in this Chapter and adds one rule for Lottery Game Promotion Procedures to replace separate rules for Instant games and Online games. The changes to rule 429:15-1-4, 5, 6, 7 and 8 remove unnecessary language and combine language from Chapter 20 regarding online games. The addition of rule 429:1-8.1 combines existing language from Chapter 20 into Chapter 15. Rule 429:15-1-11 is revoked as unnecessary as this is industry standard and OLC practice. Rule 429:15-1-12 is revoked to remove unnecessary language from rules as these actions are also part of best-practices conducted by the Lottery, and games offering grand prizes are conducted in accordance with the rules mandated by the game governing organizations. The changes in Rule 429:15-1-13 clear up the process for making Instant Game information available to the public on the Lottery website. Rules 429:15-1-13.1 and 13.2 are rules combined into chapter 15 from existing rules in chapter 20. The change in rule 429:15-1-14 combines instant and online promotion procedures previously included in Chapter 15 and Chapter 20. Rule 15-1-15 combines a rule previously in Chapter 20, prohibiting the sell-out of a game. Appendix A and Appendix B are both revoked as they do not need to be in agency rules as procedures are required for all games.

**CONTACT PERSON:**
Jay Finks, Executive Director, Oklahoma Lottery Commission, 123 Robert S. Kerr, Oklahoma City, OK 73102, 405-522-7721, jay.finks@lottery.ok.gov.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 6, 2021:**

429:15-1-2. Definitions
In addition to terms defined in the Oklahoma Education Lottery Act, the following words or terms, when used in this Chapter, shall have the following meaning unless the context clearly indicates otherwise:

"Act" means the Oklahoma Education Lottery Act.

"Active Game" means a lottery game currently available for sale from the Oklahoma Lottery Commission.

"Activated Pack" means the status of a pack of tickets which indicates to the OLC that tickets are being sold from that pack.

"Altered Ticket" means any ticket intentionally changed by a player or by other persons or means in an attempt to make the ticket appear as a winning ticket.

"Authorized Location" means a business authorized by a contract with OLC to sell OLC Lottery products. "Authorized Location" and "Authorized Retailer" are synonymous terms.

"Automatic Win Symbol" means any symbol that, when revealed under the removable covering on an instant ticket, automatically wins a prize for the player.

"Breaks" means a gap of one or more numbered instant tickets in a pack number sequence.

"Cancelled Ticket" means any OLC ticket for which the ticket sale and/or validation information has been deleted from OLC records.

"Caption" means the letters appearing near the play symbols in the instant ticket play area that verify the correctness of play symbols.

"Certified Drawing" means a drawing in which the lottery and an independent accountant attest that the drawing equipment functioned properly and that a random selection of a winning combination has occurred.

"Claim Center" means an OLC authorized location available to pay claims for prizes of more than $600. A "Claim Center" may also be a retailer authorized by the Board to pay prizes up to five thousand dollars ($5,000.00) without regard
to where the ticket or share was purchased, after performing validation procedures appropriate to the game and as specified by the Board.

"Claim Form" means the printed form authorized by OLC that a player shall complete and submit to OLC along with a ticket to determine eligibility for prize payment, in the event that such prize has not been validated and paid by an OLC retailer.

"Claimant" means a player who has submitted a claim for prize payment.

"Claim Period" means the period of time prescribed by the Act during which players must claim cash prizes. For instant games, the claim period is ninety (90) days after the announced end of the game. For online games, the claim period is one hundred eighty (180) days after the drawing date.

"Computer Selected Items" means numbers or groups of numbers selected for a player by the computer in online games. Also known as auto picks, quick picks, or computer picks.

"Counterfeit Ticket" means any ticket not produced by an OLC authorized ticket printer or an OLC online games sales terminal.

"Defective Print Tickets" means the same as misregistered ticket.

"Display Printing" means the printing on the ticket not associated with the ticket game play.

"District Office" means an OLC claim center, if any, in various cities in Oklahoma.

"Disputed Ticket" means a ticket which the claimant believes is a prize winning ticket, but which fails OLC validation procedures.

"Doubler" means any method used on a ticket to double a prize amount.

"Draw Procedures" means the written document approved by OLC that specifies the process for selecting winners for a particular instant game or instant game promotion, if a drawing is designed as part of the game or promotion, and for each online game or online game promotion.

"Drawing" means the process by which the lottery randomly selects numbers or items in accordance with the specific game rules or game promotion rules for those games or game promotions requiring random selection of numbers or items.

"Duplicate Ticket" means a ticket produced by photograph, xerography or any other duplication method other than an authorized instant ticket printed for OLC or generated by an authorized online terminal.

"Electronic Funds Transfer" or "EFT" means the process by which the OLC transfers funds from a retailer authorized bank account to pay amounts due the OLC or by which OLC provides funds to a retailer for payment of prizes.

"Entry" means a lottery ticket or other OLC authorized document submitted to OLC or any OLC authorized party for participation in an OLC drawing.

"Executive Director" means the chief executive officer and administrator of the Oklahoma Lottery Commission.

"Finalist" means a person selected through a preliminary drawing for participation in a grand prize drawing.

"Floating Image Play Area" means the play area of each instant ticket which may print in a slightly different position on game tickets as a security measure.

"Game Board" means a pre-printed OLC form for use by players in selecting numbers for online games (see "Play Slip").

"Game Name" means the name of the Instant or Online game, as specified in the game procedures.

"Game Number" means the preprinted number on an instant ticket which identifies a particular game.

"Game Report" means a report prepared after a game end showing, at a minimum, the number of tickets sold and the number of prizes awarded in the game.

"Game Specifications Document" means the same as working paper.

"Grand Prize Drawing" means an event in which qualified players/contestants are awarded prizes in a random manner and as provided in OLC approved procedures.

"High-Tier Prize" means a prize of $601 or more.

"Instant Game" means an instant ticket lottery game offered by OLC for sale to the public that is played by revealing a hidden play area on a ticket to display the play symbols.

"Instant Game Procedures" means the document summarizing the game specifications as provided in the working papers for each Instant Game.

"Instant Game Promotion Procedures" means the OLC approved procedures for player participation in any Instant Game Promotion.

"Jackpot" means a large prize, often the top prize in an online game.

"Lottery Game Promotion Procedures" means the document summarizing promotion specifications for each lottery game promotion offered by OLC.

"Lottery Retailer" or "Retailer" means a business entity contracted to OLC to sell lottery tickets.

"Low-Tier Prize" means a prize of twenty-five dollars ($25) or less.

"Mid-Tier Prize" means a prize of $25.01 - $600.

"Minor" means an individual younger than 18 years of age.

"Miscut Ticket" means a ticket cut during production such that the ticket is not whole and able to be validated.

"Misregistered Ticket" means any ticket on which printed data has been misprinted in such a manner as to prevent reading during the validation process.

"Mutilated Ticket" means any lottery ticket accidentally or intentionally damaged such that completion of OLC validation procedures is not possible.

"Non-Cash Prize" means merchandise prizes offered in lottery games or lottery promotions.

"Oklahoma Lottery Retailer Contract" means Parts 1 through 8 of the Lottery Retailer Sales Contract Application, Title 3A, Section 701 ff. of the Oklahoma Statutes as amended, Emergency and Permanent Rules approved by the OLC Board. As used in these Rules the terms, "Retailer Contract," "Oklahoma Ticket Sales Contract," "Lottery Retail Sales Contract," and "Lottery Retailer Sales Contract" all mean "Oklahoma Lottery Retailer Contract,"
"OLC" means the Oklahoma Lottery Commission.
"Online Game" means a game where tickets or shares are purchased through a network of sales terminals located at OLC authorized retail outlets through use of an OLC authorized play slip or manual retailer input of player requested numbers. "Online Game" does not include a game played via the Internet.
"Online Game Procedures" means the document summarizing game specifications for each online game offered for sale by OLC.
"Online Game Promotion Procedures" means the document summarizing promotion specifications for each online game promotion offered by OLC.
"Online Terminal" means the OLC authorized sales terminal used to sell various online lottery number games.
"Pack" or "Pack Size" means a package of instant tickets, each ticket with a different number. The number of tickets in a pack is generally from 60 to 500.
"Pack Number" means the unique number on the ticket that designates each pack of instant tickets in the game. Each pack number is unique within each instant game.
"Play Area" means the covered area of an instant ticket that contains the ticket play symbols.
"Play-Central® Lottery Kiosk" means a self-service ticket vending machine that allows the player to purchase instant tickets and/or online game tickets without any clerk assistance.
"Play Panel" means an area on an online game play slip or game board used by a player to select numbers for a single online game play.
"Play Slip" means a pre-printed OLC form for use by players in selecting numbers for online games (see game board).
"Play Spot" means an authorized area on an instant ticket containing one play symbol and one caption.
"Play Station" means a stand-alone unit provided by OLC for the display of lottery game brochures play slips, etc.
"Play Style" means the method of play to determine a winner for an individual game or game promotion.
"Play Symbol" means the printed data under the removable covering on the front of an instant ticket that is used to determine eligibility for a prize. The symbols for individual games will be specified in individual instant game procedures.
"Player-Selected Item" means a number or item or group of numbers or items selected by a player in connection with an online game.
"Point-of-Sale Material" or "POS" means flyers, brochures, posters and signage used within/ at lottery retail locations to identify the products and games available for sale, as well as to provide general information (i.e., odds, jackpot amounts, prize levels and beneficiaries).
"Point-of-Purchase Material" or "POP" is synonymous with POS.
"Preliminary Drawing" means an event for the selection of contestents for a grand prize drawing.
"Price Point" means the retail selling price of an individual game ticket.

"Printer Omitted Tickets" means any tickets designated by OLC’s instant ticket printer as having been omitted from the ticket order quantity for reasons stated by the ticket printer.
"Price" means a cash amount or product (merchandise) that can be won in a lottery game or game promotion.
"Price Drawing" means a method for determining game or game promotion winners, as defined in OLC procedures.
"Price Structure" means the number, value, and odds of winning prizes for an individual game as approved by OLC in individual game procedures.
"Retailer" means a business which sells lottery tickets or shares on behalf of OLC pursuant to a retailer contract.
"Retailer Commission" means the amount of money paid to retailers for selling lottery products.
"Retailer Paid Prizes" means prizes which may be paid by retailers subject to OLC validation procedures.
"Retail Sales Price" means the OLC designated price OLC retailers must charge for a ticket when sold.
"Retailer Ticket Order Quantity" means the number of tickets or packs of tickets ordered by the retailer from OLC or its authorized distributor.
"Retailer Validation Code" means the code found under the covered area over the play symbols on the front of the instant ticket which the OLC retailer may use to verify and validate low-tier winners.
"Seasonal Retailer" means a business which sells Lottery tickets or shares on behalf of OLC pursuant to a retailer contract and whose business may be closed for some portion of the year and/or whose business hours may be significantly reduced for some portion of the year due to the seasonal nature of the business. Businesses that are closed temporarily for remodeling, change of ownership, or similar temporary closings will not be deemed to be seasonal retailers.
"Settled Pack" means the status of an activated pack of instant tickets when the OLC has invoiced the retailer based upon a pre-determined formula or schedule and the retailer has paid for the pack.
"Share" means any intangible evidence of participation in a lottery game.
"Ticket" means any tangible evidence issued by the lottery to provide participation in a lottery game or drawing authorized by the Act.
"Ticket Number" means the number on the ticket that refers to the ticket sequence within the pack.
"Ticket Order Quantity" means the number of tickets or packs of tickets ordered by OLC from the instant ticket printer.
"Unreadable Ticket" means any ticket on which any play data or other ticket validation information cannot be read as part of the prize validation procedure.
"Validation Number" means the unique data printed on a ticket that enables verification of the ticket as a valid winner.
"Validation Procedures" means the procedures utilized by OLC and/or its authorized vendors to determine if a claimed ticket is a valid winner.
"Valid Ticket" means a ticket which meets all OLC game specifications and OLC validation requirements.
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"Variant!" means a symbol used in conjunction with certain play styles and may include a symbol that serves as a "wild card" to complete a winning combination of play symbols.

"VIRN (Void If Removed Numbers)" means a series of numbers under the removable covering on an instant ticket to be used in the validation process.

"Wild!" means a symbol or word, different from all the others in an instant game, used to complete a match on a winning ticket.

"Working Papers" means the written document approved by the OLC for instant game production that includes, among other things, the game name, the art work for the front and back of the ticket, how a prize is won, game prize structure, play style, ticket delivery schedule to OLC, and eligibility for a drawing, if any.

429:15-1-4. Sale of instant-game lottery tickets
(a) Only retailers who have a current contract with OLC are authorized to sell Instant Game lottery tickets and tickets may be sold only at the authorized location.
(b) Each Instant Game lottery ticket shall be sold for the retail sales price authorized by OLC and stated in the Instant Game Procedures on the OLC website.

429:15-1-5. Determination of lottery prize winner
(a) The play symbols shall be used by a player to determine eligibility for instant game prizes. The numbers appearing on an online ticket shall be used by the player to determine eligibility for online game prizes.
(b) A player's eligibility to win a prize is subject to OLC ticket validation requirements.
(c) For each individual game, the player shall uncover the play area on the front of the ticket to reveal the play symbols. Eligibility to win a prize is based on the approved play style provided in the OLC Instant Game Procedures, and which may include programmed in the Lottery's central gaming system.

   (1) Match Three—If three identical play symbols are revealed on the ticket, the player shall win the prize indicated.
   (2) Match Three with Specific Match Variant—The player shall win the prize indicated in either of the following ways:
      (A) The player matches three identical play symbols; or
      (B) The player matches two identical play symbols and the variant as specified in the Instant Game Procedures.
   (3) Three Match Three—If three identical play symbols or numbers are revealed across one of the three lines, the player shall win the prize indicated.
   (4) Add Up—If the player adds up all of the play numbers printed on the ticket and the amount is greater than or equal to the required total amount printed on the ticket, the player shall win the prize indicated.

   (5) Three in Line—If the player finds three identical play symbols, either diagonally, vertically, or horizontally, on the same ticket, the player shall win the prize indicated.
   (6) Key Number Match—If the player finds a play number or symbol that matches the designated key number play numbers or symbols, the player shall win the prize indicated.
   (7) Your Number(s) Beat Their Number(s)—If the player finds a play number(s) designated as "yours" that is greater than the play number(s) designated as "theirs," the player shall win the prize indicated.
   (8) Three Consecutive Numbers or Symbols in Sequence—If the player finds three play numbers or symbols in a specified consecutive order among the play numbers or symbols, the player shall win the prize indicated.
   (9) Doubler—If the player finds a play symbol designated as a doubler, the player prize won shall double in amount.
   (10) Any other play style developed by OLC.

(d) The numbers appearing on an Online ticket shall be used by the player to determine eligibility for Online Game prizes.
(e) A player's eligibility to win a prize is subject to the OLC ticket validation requirements.
(f) Eligibility to win a prize is based on the approved play style provided in the Online Game Procedures.
(g) An online game play may only be claimed for the highest prize category won.
(h) For purposes of calculation of any prize to be paid in any Online game, the winning prize amount shall be rounded down to the nearest dollar.

429:15-1-6. Ticket lottery ticket validation requirements
(a) Each Instant Game lottery ticket shall be validated according to OLC validation procedures prior to payment of any prize.
(b) An Instant Game ticket shall comply with all of the following:
   (1) The ticket shall not be stolen or appear on any list of printer omitted tickets on file with the OLC;
   (2) The ticket shall not be counterfeit or forged, in whole or in part;
   (3) The ticket shall not be mutilated, altered, or unreadable;
   (4) The ticket shall have been issued by the OLC in an authorized manner;
   (5) The ticket shall pass the confidential OLC validation and security tests appropriate to the applicable play style;
   (6) The validation number of an apparent winning ticket shall appear on the OLC's official file of validation numbers of winning tickets. A ticket with that validation number shall not have been paid previously;
   (7) The ticket shall be intact, and not miscut, and have exactly one play symbol and exactly one caption in each of the play spots, exactly one pack number, exactly one ticket number, exactly one retailer validation code, and exactly one validation number on the ticket;
(8) The game, pack, ticket, and validation numbers must be present in their entirety and be fully legible. The validation numbers shall correspond, using the OLC’s files, to the play symbols on the ticket;
(9) The play symbols, captions, validation number, retailer validation code, pack number, and ticket number must be right side up and not reversed in any manner;
(10) The ticket must not be blank or partially blank, misregistered, defective, or printed or produced in error;
(11) Each of the play symbols must be exactly one of those described in the Instant Games—Game Procedures Working Papers, and each of the captions must be exactly one of those described in the Instant Game—Procedures Working Papers;
(12) Each of the play symbols on the ticket must be printed in the correct symbol font and correspond precisely to the artwork on file at the OLC. Each of the captions must be printed in the caption font and must correspond precisely to the artwork on file at the OLC. The retailer validation code must be printed in the retailer validation code font and must correspond precisely to the artwork on file at the OLC. The validation number must be printed in the validation number font and must correspond precisely to the artwork on file at the OLC;
(13) The display printing must be regular in every respect and correspond precisely with the artwork on file at the OLC.

(c) An Online game ticket shall comply with all of the following:
(1) The ticket validation number shall be present in its entirety and shall correspond to the prize validation file and with the data printed on the ticket;
(2) The ticket shall not be mutilated, altered, unreadable, or tampered with in any manner;
(3) The ticket shall not be counterfeit or a duplicate of another winning ticket;
(4) The ticket shall have been issued by the lottery through an authorized Online game sales terminal in an authorized manner;
(5) The ticket shall be validated in accordance with confidential OLC procedures for claiming, validating and payment of prizes;
(6) The ticket shall have been recorded in the OLC central computer system or recording media before the drawing and the ticket shall match this OLC record in every aspect;
(7) The validation number data and the drawing date of an apparent winning ticket shall appear on the official file of winning tickets and a single play grid with the exact data and the ticket may not have been previously paid;
(8) The ticket may not be misregistered or defectively printed to an extent that it cannot be validated by the lottery;
(9) The ticket shall pass all other confidential security tests of OLC.

Any ticket not passing all of the validation tests and requirements is void and ineligible for any prize and shall not be paid. The OLC may, in its sole discretion, reimburse the player for the cost of the void ticket. This shall be the claimant’s only remedy.

(d) If a defective ticket is purchased by a player, the only OLC liability shall be reimbursement for the cost of the defective ticket.

429:15-1-8. Game end date or game promotion end date and prize claim period
(a) The OLC, at any time, may announce the game end date for an individual game or game promotion.
(b) No tickets shall be sold past the game end date.
(c) Instant Game prizes shall be claimed no later than 90 days after the game end date of the individual game. Online draw games shall be claimed no later than 180 days after the drawing date of the individual game.
(d) Instant and Online Game Promotion end dates and related promotion entry dates will be provided in the Instant Game and Online Game Promotion Procedures for each Instant Game Promotion.

429:15-1-8.1. Draw procedures
Drawings procedures for online games and Online Game promotions will be defined in an OLC approved and secure draw procedures document.

429:15-1-11. Game report [REVOKED]
Following the time period in which prizes may be claimed after termination of a game, the OLC shall prepare a report that shows, at a minimum, the total number of tickets sold and the number of prizes awarded in the game. Such report shall be completed within forty five (45) days of the expiration date of the game’s prize claim period and shall be posted on the OLC website.

429:15-1-12. Grand prize drawing [REVOKED]
(a) This section shall apply to individual games that provide for a grand prize drawing, if any.
(b) Game drawing procedures shall be provided to retailers and the public.
(c) Eligibility for a grand prize drawing shall be determined by, but not limited to, a direct entry to a grand prize drawing or an entry into a preliminary draw as provided in Instant Game Procedures or Instant Game Promotion procedures. The OLC shall determine any prizes to be awarded and the method of payment which shall be stated in the Instant Game Procedures or Instant Game Promotion Procedures.
(d) Preliminary draws and grand prize drawings shall be conducted at times and places and pursuant to the methods stated in the OLC Instant Game Procedures or Instant Game Promotion Procedures.
(e) An entry to a preliminary or grand prize drawing submitted by a player in accordance with the applicable procedures is eligible to be included in a drawing.
(f) Entries to a preliminary or grand prize drawing shall be delivered to the address or location designated by OLC no later than the last day of the time frame specified.
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429:15-1-13. Instant Game Procedures overview
(a) The OLC shall make available to retailers and the public Instant Game Procedures detailed information for each Instant Game prior to it being introduced for sale to the public via the Lottery website, to include:
(b) The Instant Game Procedures for each game shall contain, at a minimum, the following:
   (1) game number;
   (2) game name;
   (3) retail sales price;
   (4) play style/overall odds;
   (5) pack size/top prize and number of top prizes in the game;
   (6) play symbols/total number of tickets printed;
   (7) captions or play symbol captions specific prizes levels and their corresponding odds of winning;
   (8) number and value of prizes;
   (9) retailer paid prizes;
   (10) prize drawings, if any.
(e) The play style for an individual game shall be fully described in the Instant Game Procedures and may take the form of one or more of the following methods of play:
   (1) Match Three like amounts or symbols;
   (2) Match Three with Specific Match Variant;
   (3) Three Match Three;
   (4) Add Up;
   (5) Three In Line;
   (6) Key Number Match;
   (7) Your Number(s) Beats Their Number(s);
   (8) Three Consecutive Numbers or Symbols in Sequence;
   (9) Doubler, or
   (10) Any other play style developed by OLC.
(d) Instant game procedures will follow the format provided as an example only in Appendix A.

429:15-1-13.1. Entry of plays
(a) Online Game plays may only be entered manually using the authorized lottery sales terminal or by means of a playslip provided by the OLC and hand-marked by the player or by other means approved by the OLC.
(b) Retailers shall not permit facsimile playslips, copies of playslips, or other materials not printed or approved by the OLC to be inserted into the sales terminal's playslip reader.
(c) Retailers shall not permit any device to be connected to a lottery sales terminal to enter plays, except as approved by OLC.

429:15-1-13.2. Online Game detail
(a) OLC shall make available to retailers and the public game information for each Online Game prior to the game being introduced to the public for sale via the Lottery website to include:
   (1) The game name;
   (2) The retail sales price;
   (3) How to Play;
   (4) The game odds;
   (5) The game prize structure.

(a) OLC shall make available to retailers and the public specifications/promotional procedures for each Instant Lottery Game Promotion prior to the promotion being introduced to the public for participation via the Lottery website.
(b) The Instant Game Promotion Promotional Procedures shall contain, at a minimum, the following:
   (1) Game promotion name;
   (2) Retail sales price, if any;
   (3) Play style/Number of winners to be drawn;
   (4) Odds/Eligibility requirements;
   (5) Prize levels/Number of prizes by prize level;
   (6) Method of player entry/Submission requirements;
   (7) Prize drawings or winner selection method; and
   (8) Deadline for player entry.
(e) Instant Game Promotion Procedures will follow the format provided as an example only in Appendix B.

429:15-1-15. Game sell-out prohibited
No OLC office or OLC retailer shall directly and knowingly sell a ticket or combination of tickets to any person or entity which would guarantee such a purchaser a prize in an online game or online game promotion.
APPENDIX A. INSTANT GAME PROCEDURES [REVOKED]

The following information is provided as an example only.

Oklahoma Lottery Commission

INSTANT GAME PROCEDURES
INSTANT GAME NO. 01 "GAME NAME"

Date

1. Instant Game Number:

2. Game Name:

3. Retail Sales Price:

4. Overall Odds:

5. Play Style:

6. Pack Size:

7. Play Symbols:

8. Captions or Play Symbol Captions:

<table>
<thead>
<tr>
<th>PLAY SYMBOL</th>
<th>CAPTION</th>
</tr>
</thead>
</table>

9. Prize Levels:

   Prize Levels

10. Retailer Paid Prizes:

11. Prize Drawings (if any):

   Approved

James R. Scroggins
EXECUTIVE DIRECTOR

Date
APPENDIX B. INSTANT GAME PROMOTION PROCEDURES [REVOKED]

The following information is provided as an example only.

Oklahoma Lottery Commission

INSTANT GAME PROMOTION PROCEDURES
INSTANT GAME NO. 01 "GAME NAME"

Date

1. Game Promotion Name:

2. Retail Sales Price, if any:

3. Play Style:

4. Odds:

5. Prize Levels:

6. Method of Player Entry:

7. Prize drawings or winner selection method:

8. Deadline for player entry:

Approved

James R. Scroggins
EXECUTIVE DIRECTOR

[OAR Docket #21-463; filed 6-15-21]
TITLE 429. OKLAHOMA LOTTERY COMMISSION
CHAPTER 20. ONLINE GAMES [REVOKED]

[OAR Docket #21-464]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
429:20-1-2 [REVOKED]
429:20-1-3 [REVOKED]
429:20-1-4 [REVOKED]
429:20-1-5 [REVOKED]
429:20-1-6 [REVOKED]
429:20-1-7 [REVOKED]
429:20-1-8 [REVOKED]
429:20-1-9 [REVOKED]
429:20-1-10 [REVOKED]
429:20-1-11 [REVOKED]
429:20-1-12 [REVOKED]
429:20-1-13 [REVOKED]
429:20-1-14 [REVOKED]
429:20-1-15 [REVOKED]
429:20-1-16 [REVOKED]
429:20-1-17 [REVOKED]
APPENDIX A [REVOKED]
APPENDIX B [REVOKED]

AUTHORITY:
Oklahoma Lottery Commission; 3A O.S., Section 709 and Section 710

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND
CABINET SECRETARY:
September 23, 2020

COMMENT PERIOD:
October 15 through November 18, 2020

PUBLIC HEARING:
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ADOPTION:
January 25, 2021

SUBMISSION OF ADOPTED RULES TO GOVERNOR AND
LEGISLATURE:
January 25, 2021

LEGISLATIVE APPROVAL:
Approved June 11, 2021 by HJR 1046

FINAL ADOPTION:
June 11, 2021

EFFECTIVE:
September 6, 2021

SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
The proposed changes to Chapter 20 in Title 429 relate to the conduct of online lottery games. The rule changes are in response to the Governor's request in Executive Order 2020-03 for agencies to review agency rules to identify costly, ineffective, duplicative, and outdated regulations. The rule changes proposed in this action will eliminate duplicative and unnecessary agency rules. The rule as it currently exists addresses Online Tickets / Games conducted by the Lottery. As changed, this Chapter 20 is revoked and its provisions are combined into Chapter 15, previously only dealing with Instant Games, thus making one remaining chapter to address all lottery games rather than two separate chapters with duplicative provisions.

CONTACT PERSON:
Jay Finks, Executive Director, Oklahoma Lottery Commission, 123 Robert S. Kerr, Oklahoma City, OK 73102, 405-522-7721, jay.finks@lottery.ok.gov.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 6, 2021:

429:20-1-2. Definitions [REVOKED]
In addition to terms defined in the Oklahoma Education Lottery Act, the following words or terms, when used in this Chapter, shall have the following meaning unless the context clearly indicates otherwise:

"Act" means the Oklahoma Education Lottery Act.
"Active Game" means a lottery game currently available for sale from the Oklahoma Lottery Commission.
"Activated Pack" means the status of a pack of tickets which indicates to the OLC that tickets are being sold from that pack.
"Altered Ticket" means any ticket intentionally changed by a player or by other persons or means in an attempt to make the ticket appear as a winning ticket.
"Authorized Location" means a business authorized by a contract with OLC to sell OLC Lottery products.
"Authorized Location" and "Authorized Retailer" are synonymous terms.
"Automatic Win Symbol" means any symbol that, when revealed under the removable covering on an instant ticket, automatically wins a prize for the player.
"Breaks" means a gap of one or more numbered instant tickets in a pack number sequence.
"Cancelled Ticket" means any OLC ticket for which the ticket sale and/or validation information has been deleted from OLC records.
"Caption" means the letters appearing near the play symbols in the instant ticket play area that verify the correctness of play symbols.
"Certified Drawing" means a drawing in which the lottery and an independent accountant attests that the drawing equipment functioned properly and that a random selection of a winning combination has occurred.
"Claim Center" means an OLC authorized location available to pay claims for prizes of more than $600. A "Claim Center" may also be a retailer authorized by the Board to pay prizes up to five thousand dollars ($5,000.00) without regard to where the ticket or share was purchased, after performing validation procedures appropriate to the game and as specified by the Board.
"Claim Form" means the printed form authorized by OLC that a player shall complete and submit to OLC along with a ticket to determine eligibility for prize payment, in the event that such prize has not been validated and paid by an OLC retailer.
"Claimant" means a player who has submitted a claim for prize payment.
"Claim Period" means the period of time prescribed by the Act during which players must claim cash prizes. For instant games, the claim period is ninety (90) days after the announced end of the game. For online games, the claim period is one hundred eighty (180) days after the drawing date.
"Computer Selected Items" means numbers or groups of numbers selected for a player by the computer in online games. Also known as auto picks, quick picks, or computer picks.
"Counterfeit Ticket" means any ticket not produced by an OLC authorized ticket printer or an OLC online games sales terminal.
Permanent Final Adoptions

"Defective-Printed-Tickets" means the same as mis-registered ticket.

"Display-Printing" means the printing on the ticket not associated with the ticket game play.

"District-Office" means an OLC claim center, if any, in various cities in Oklahoma.

"Disputed-Ticket" means a ticket which the claimant believes is a prize-winning ticket, but which fails OLC validation procedures.

"Doubler" means any method used on a ticket to double a prize amount.

"Draw-Procedures" means the written document approved by OLC that specifies the process for selecting winners for a particular instant game or instant-game promotion, if a drawing is designed as part of the game or promotion, and for each online game or online game promotion.

"Drawing" means the process by which the lottery randomly selects numbers or items in accordance with the specific game rules or game-promotion rules for those games or game promotions requiring random selection of numbers or items.

"Duplicate-Ticket" means a ticket produced by photograph, xerography or any other duplication method other than an authorized instant ticket printed for OLC or generated by an authorized online terminal.

"Electronic-Funds-Transfer" or "EFT" means the process by which the OLC transfers funds from a retailer authorized bank account to pay amounts due the OLC or by which OLC provides funds to a retailer for payment of prizes.

"Entry" means a lottery ticket or other OLC authorized document submitted to OLC or any OLC authorized party for participation in an OLC drawing.

"Executive-Director" means the chief executive officer and administrator of the Oklahoma Lottery Commission.

"Finalist" means a person selected through a preliminary drawing for participation in a grand-prize drawing.

"Floating Image Play-Area" means the play area of each instant ticket which may print in a slightly different position on game tickets as a security measure.

"Game Board" means a pre-printed OLC form for use by players in selecting numbers for online games (see "Play Slip").

"Game Name" means the name of the Instant or Online game, as specified in the game procedures.

"Game Number" means the preprinted number on an instant ticket which identifies a particular game.

"Game Report" means a report prepared after a game end showing, at a minimum, the number of tickets sold and the number of prizes awarded in the game.

"Game Specifications Document" means the same as working papers.

"Grand Prize Drawing" means an event in which qualified players/contestants are awarded prizes in a random manner and as provided in OLC approved procedures.

"High-Tier Prize" means a prize of $601 or more.

"Instant Game" means an instant ticket lottery game offered by OLC for sale to the public that is played by revealing a hidden play area on a ticket to display the play symbols.

"Instant Game Procedures" means the document summarizing the game specifications as provided in the working papers for each Instant Game.

"Instant Game Promotion Procedures" means the OLC-approved procedures for player participation in any Instant Game Promotion.

"Jackpot" means a large prize; often the top prize in an online game.

"Lottery Retailer" or "Retailer" means a business entity contracted to OLC to sell lottery tickets.

"Low-Tier Prize" means a prize of twenty-five dollars ($25) or less.

"Mid-Tier Prize" means a prize of $25.01-$600.

"Minor" means an individual younger than 18 years of age.

"Mismatch Ticket" means a ticket cut during production such that the ticket is not whole and able to be validated.

"Misregistered-Ticket" means any ticket on which printed data has been misprinted in such a manner as to prevent reading during the validation process.

"Mutilated-Ticket" means any lottery ticket accidentally or intentionally damaged such that completion of OLC validation procedures is not possible.

"Non-Cash Prize" means merchandise prizes offered in lottery games or lottery promotions.

"Oklahoma Lottery Retailer Contract" means Parts I through 8 of the Lottery Retailer Sales Contract Application. Title 3A, Section 701 ff. of the Oklahoma Statutes as amended, Emergency and Permanent Rules approved by the OLC Board. As used in these Rules the terms, "Retailer Contract," "Oklahoma Ticket Sales Contract," "Lottery Retail Sales Contract," and "Lottery Retailer Sales Contract" all mean "Oklahoma Lottery Retailer Contract".

"OLC" means the Oklahoma Lottery Commission.

"Online Game" means a game where tickets or shares are purchased through a network of sales terminals located at OLC authorized retail outlets through use of an OLC authorized play slip or manual retailer input of player requested numbers. "Online Game" does not include a game played via the Internet.

"Online Game Procedures" means the document summarizing game specifications for each online game offered for sale by OLC.

"Online Game Promotion Procedures" means the document summarizing promotion specifications for each online game promotion offered by OLC.

"Online Terminal" means the OLC authorized sales terminal used to sell various online lottery number games.

"Pack" or "Pack Size" means a package of instant tickets, each ticket with a different number. The number of tickets in a pack is generally from 60 to 500.

"Pack Number" means the unique number on the ticket that designates each pack of instant tickets in the game. Each pack number is unique within each instant game.

"Play Area" means the covered area of an instant ticket that contains the ticket play symbols.
Permanent Final Adoptions

"Play Central® - Lottery Kiosk" means a self service ticket vending machine that allows the player to purchase instant tickets and/or online game tickets without any clerk assistance.

"Play-Panel" means an area on an online game play slip or game board used by a player to select numbers for a single online game play.

"Play Slip" means a pre-printed OLC form for use by players in selecting numbers for online games (see game board).

"Play Spot" means an authorized area on an instant ticket containing one play symbol and one caption.

"Play Station" means a stand-alone unit provided by OLC for the display of lottery game brochures play slips, etc.

"Play Style" means the method of play to determine a winner for an individual game or game promotion.

"Play Symbol" means the printed data under the removable covering on the front of an instant ticket that is used to determine eligibility for a prize. The symbols for individual games will be specified in individual game instant game procedures.

"Player-Selected Item" means a number or item or group of numbers or items selected by a player in connection with an online game.

"Point-of-Sale Material" or "POS" means flyers, brochures, posters and signage used within/at lottery retail locations to identify the products and games available for sale, as well as to provide general information (i.e., odds; jackpot amounts; prize levels; and beneficiaries).

"Point of Purchase Material" or "POP" is synonymous with POS.

"Preliminary Drawing" means an event for the selection of contestants for a grand prize drawing.

"Price Point" means the retail selling price of an individual game ticket.

"Printer Omitted Tickets" means any tickets designated by OLC’s instant ticket printer as having been omitted from the ticket order quantity for reasons stated by the ticket printer.

"Prize" means a cash amount or product (merchandise) that can be won in a lottery game or game promotion.

"Prize Drawing" means a method for determining game or game promotion winners, as defined in OLC procedures.

"Prize Structure" means the number, value, and odds of winning prizes for an individual game as approved by OLC in individual game procedures.

"Retailer" means a business which sells lottery tickets or shares on behalf of OLC pursuant to a retailer contract.

"Retailer Commission" means the amount of money paid to retailers for selling lottery products.

"Retailer Paid Prizes" means prizes which may be paid by retailers subject to OLC validation procedures.

"Retail Sales Price" means the OLC designated price OLC retailers must charge for a ticket when sold.

"Retailer Ticket Order Quantity" means the number of tickets or packs of tickets ordered by the retailer from OLC or its authorized distributor.

"Retailer Validation Code" means the code found under the covered area over the play symbols on the front of the instant ticket which the OLC retailer may use to verify and validate low-tier winners.

"Seasonal Retailer" means a business which sells Lottery tickets or shares on behalf of OLC pursuant to a retailer contract and whose business may be closed for some portion of the year and/or whose business hours may be significantly reduced for some portion of the year due to the seasonal nature of the business. Businesses that are closed temporarily for remodeling, change of ownership, or similar temporary closings will not be deemed to be seasonal retailers.

"Settled Pack" means the status of an activated pack of instant tickets when the OLC has invoiced the retailer based upon a pre-determined formula or schedule and the retailer has paid for the pack.

"Share" means any intangible evidence of participation in a lottery game.

"Ticket" means any tangible evidence issued by the lottery to provide participation in a lottery game or drawing authorized by the Act.

"Ticket Number" means the number on the ticket that refers to the ticket sequence within the pack.

"Ticket Order Quantity" means the number of tickets or packs of tickets ordered by OLC from the instant ticket printer.

"Unreadable Ticket" means any ticket on which any play data or other ticket validation information cannot be read as part of the prize validation procedure.

"Validation Number" means the unique data printed on a ticket that enables verification of the ticket as a valid winner.

"Validation Procedures" means the procedures utilized by OLC and/or its authorized vendors to determine if a claimed ticket is a valid winner.

"Valid Ticket" means a ticket which meets all OLC game specifications and OLC validation requirements.

"Variant" means a symbol used in conjunction with certain play styles and may include a symbol that serves as a "wild card" to complete a winning combination of play symbols.

"VIRN (Void If Removed Numbers)" means a series of numbers under the removable covering on an instant ticket to be used in the validation process.

"Wild" means a symbol or word, different from all the others in an instant game, used to complete a match on a winning ticket.

"Working Papers" means the written documentation approved by the OLC for instant game production that includes, among other things, the game name, the art work for the front and back of the ticket, how a prize is won, game prize structure, play style, ticket delivery schedule to OLC, and eligibility for a drawing, if any.

429:20-1-3. Ticket responsibility [REVOKED]
(a) A ticket is a bearer instrument until signed on the back by the ticket holder.
(b) The OLC will not be responsible for lost, stolen, or destroyed tickets.
(c) The OLC will not be responsible for mutilated, altered, unreadable tickets, or tickets tampered with in any manner.
(d) The OLC will not be responsible for tickets claimed by a player in error for a lower prize at a retailer.

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429:20-1-4. Sale of Online Game tickets [REVOKED]
(a) Only retailers who have a current contract with OLC are authorized to sell Online Game tickets, and tickets may be sold only at the authorized location.
(b) Each Online Game ticket shall be sold for the retail sales price authorized by OLC and stated in the Online Game Procedures.

429:20-1-5. Determination of prize winner [REVOKED]
(a) The numbers appearing on an Online ticket shall be used by the player to determine eligibility for Online Game prizes.
(b) A player’s eligibility to win a prize is subject to the OLC ticket validation requirements.
(c) Eligibility to win a prize is based on the approved play style provided in the Online Game Procedures.
(d) An online game play may only be claimed for the highest prize category won.
(e) For purposes of calculation of any prize to be paid in any Online game, the winning prize amount shall be rounded down to the nearest dollar.

429:20-1-6. Ticket validation requirements [REVOKED]
(a) Each Online game ticket shall be validated according to OLC validation procedures prior to payment of a prize.
(b) An Online game ticket shall comply with all of the following:
(1) The ticket validation number shall be present in its entirety and shall correspond to the prize validation file and with the data printed on the ticket;
(2) The ticket shall not be mutilated, altered, unreadable, or tampered with in any manner;
(3) The ticket shall not be counterfeit or a duplicate of another winning ticket;
(4) The ticket shall have been issued by the lottery through an authorized Online game sales terminal in an authorized manner;
(5) The ticket shall be validated in accordance with confidential OLC procedures for claiming, validating and payment of prizes;
(6) The ticket shall have been recorded in the OLC central computer system or recording media before the drawing and the ticket shall match this OLC record in every aspect;
(7) The validation number data and the drawing date of an apparent winning ticket shall appear on the official file of winning tickets and a single play grid with the exact data and the ticket may not have been previously paid;
(8) The ticket may not be misregistered or defectively printed to an extent that it cannot be validated by the lottery;
(9) The ticket shall pass all other confidential security tests of OLC.
(c) Any ticket not passing all of the validation tests and requirements is void and ineligible for any prize and shall not be paid. The OLC may, in its sole discretion, reimburse the player for the cost of the void ticket. This shall be the claimant’s only remedy.
(d) If a defective ticket is purchased by a player, the only OLC liability shall be reimbursement for the cost of the defective ticket.

429:20-1-7. Disputed ticket [REVOKED]
If a dispute arises between OLC and a ticket claimant concerning whether the ticket is a winning ticket and if the ticket prize has not been paid, the OLC may, exclusively at OLC’s determination, reimburse the claimant for the cost of the disputed ticket. This shall be the claimant’s only remedy.

429:20-1-8. Game end date or game promotion end date and prize claim period [REVOKED]
(a) The OLC, at any time, may announce the end date for an individual game.
(b) No tickets shall be sold past the game end.
(c) Online game prizes shall be claimed no later than 180 days after the drawing date of the individual game.
(d) Online Game Promotion end dates and related promotion entry dates will be provided in the Online Game Promotion Procedures for each online game promotion.

Drawings procedures for online games and Online Game promotions will be defined in an OLC approved and secure draw procedures document.

429:20-1-10. Governing law [REVOKED]
In purchasing a ticket, the player agrees to comply with, and abide by, the Act, and all rules and final decisions of the OLC, and all procedures and instructions established by the OLC for the conduct of the game or game promotion.

429:20-1-11. Prize withholdings [REVOKED]
All prizes are subject to applicable federal tax withholdings, state income tax, and other required state withholdings, or delinquent state debt.

429:20-1-12. Game report [REVOKED]
Following the time period in which prizes may be claimed after termination of a game, the OLC shall prepare a report that shows, at a minimum, the total number of tickets sold and the number of prizes awarded in the game. Such report shall be completed within forty-five (45) days of the expiration date of the game’s prize claim period and shall be posted on the OLC website.
429:20-1-13. Prize amounts for online games [REVOKED]
(a) The total amount of prize money allocated to the winnings pool for online games shall be a minimum of forty-five percent (45%) of the total gross Online Game sales.
(b) The allocation of the Online Game winnings to the prize pool categories shall be provided in the Online Game Procedures.
(c) All online game prizes shall be paid in a lump sum cash payment, except prizes of one million dollars ($1,000,000) or more which may be paid as provided in (d) and (e) of this section.
(d) First prize.
(1) The amount allocated to the first prize prize pool in an online large jackpot game may be used to purchase securities or an annuity for each winning ticket.
(2) The first prize will be payable to winning ticket holders by an initial cash payment plus equal payments as established by OLC.
(3) Any winning ticket owned by multiple owners shall be funded as outlined in Paragraph 1 and 2 of this section to the owners as declared on the claim form for claiming the online prize.
(4) The first prize may be payable to winning ticket holder(s) in a lump sum cash payment equal to the cash value of the first prize prize pool. The decision to accept a lump sum payment must be unanimously agreed to by all owners of the winning ticket.
(e) In the event that a prize of one million dollars ($1,000,000) or more is owned by multiple owners and the resulting prize amount payable to each owner is less than one million dollars ($1,000,000), each owner of the prize amount will be paid in a lump sum cash amount.

429:20-1-14. Game sell-out prohibited [REVOKED]
No OLC office or OLC retailer shall directly and knowingly sell a ticket or combination of tickets to any person or entity which would guarantee such a purchaser a prize in an online game or online game promotion.

(a) Online Game plays may only be entered manually using the authorized lottery sales terminal or by means of a play slip provided by the OLC and hand marked by the player or by other means approved by the OLC.
(b) Retailers shall not permit facsimile play slips, copies of play slips, or other materials not printed or approved by the OLC to be inserted into the sales terminal’s play slip reader.
(c) Retailers shall not permit any device to be connected to a lottery sales terminal to enter plays, except as approved by OLC.

429:20-1-16. Online Game Procedures [REVOKED]
(a) OLC shall make available to retailers and the public specifies for each Online Game prior to the game being introduced to the public for sale.
(b) The Online Game Procedures shall contain at a minimum the following:
(1) The game name;
(2) The retail sales price;
(3) The game play style;
(4) The game odds;
(5) The game prize levels;
(6) The retailer paid prize levels; and
(2) The method of prize drawings.
(c) This section shall also apply to any multi-state game offered for sale by OLC.
(d) Online Game Procedures will follow the format provided as an example only in Appendix C.

429:20-1-17. Online Game Promotion Procedures [REVOKED]
(a) OLC shall make available to retailers and the public specifies for each Online Game Promotion prior to the promotion being introduced to the public for participation.
(b) The Online Game Promotion Procedures shall contain, at a minimum, the following:
(1) The game promotion name;
(2) Retail sales price, if any;
(3) Play style;
(4) Odds;
(5) Prize levels;
(6) Method of player entry;
(7) Method of prize drawings; and
(8) Promotion entry deadlines.
(c) This section shall also apply to any multi-state game promotion offered by OLC.
(d) Online Game Promotion Procedures will follow the format provided as an example only in Appendix D.
The following information is provided as an example only.

Oklahoma Lottery Commission

ONLINE GAME PROCEDURES

Date

1. Game Name:
2. Retail Sales Price:
3. Play Style:
4. Odds:
5. Prize Levels:
6. Retailer Paid Prize Levels:
7. The Method of Prize Drawings:

Approved

______________________________
James R. Scroggins Date
EXECUTIVE DIRECTOR
APPENDIX B. ONLINE GAME PROMOTION PROCEDURES [REVOKED]

The following information is provided as an example only.

Oklahoma Lottery Commission
ONLINE GAME PROMOTION PROCEDURES

Date

1. Game Promotion Name:
2. Retail Sales Price (if any):
3. Play Style:
4. Odds:
5. Prize Levels:
6. Method of Player Entry:
7. Prize Drawings or Winner Selection Method:
8. Promotion Entry Deadlines:

Approved

James R. Scroggins  Date
EXECUTIVE DIRECTOR

[OAR Docket #21-464; filed 6-15-21]
Permanent Final Adoptions

TITLE 435. STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
CHAPTER 7. ADMINISTRATIVE REMEDIES

[OAR Docket #21-375]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
435:7-1-1. Administrative remedy, notice of intention to impose administrative remedy, and service of notice [NEW]
435:7-1-2. Response and contest in writing to notice of intent to impose administrative remedy [NEW]
435:7-1-3. Compliance with notice of imposition of administrative remedy [NEW]
435:7-1-4. Notice and hearing before the Board [NEW]
435:7-1-5. Allowed administrative remedies [NEW]
435:7-1-6. Confidentiality of patient information in notice and/or final administrative remedy order [NEW]
435:7-1-7. Reports of imposition of notice and/or final administrative remedy orders [NEW]
435:7-1-8. Failure to comply with final administrative remedy order [NEW]

AUTHORITY:
59 O.S. § 503.2, 59 O.S. §§ 519 et seq; Oklahoma Board of Medical Licensure and Supervision

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
November 24, 2020

COMMENT PERIOD:
December 15, 2020 - January 15, 2021

PUBLIC HEARING:
January 19, 2021

ADOPTION:
March 11, 2021

SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:
March 17, 2021

LEGISLATIVE APPROVAL:
Approved June 11, 2021 by HJR 1046

FINAL ADOPTION:
June 11, 2021

EFFECTIVE:
August 26, 2021

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

GIST/ANALYSIS:
The adopted rules allow the Medical Board to dispose of cases outside of its traditional disciplinary action process. In addition to setting forth infractions or violations that may be resolved through the issuance of an administrative remedy order, the adopted rules also provide for a process and procedures for the issuance of such administrative remedies. Additionally, the adopted rules include provisions related to the protection of confidential patient information, public disclosure of the orders, and enforcement of administrative remedy orders.

CONTACT PERSON:
Barbara J. Smith, Executive Secretary, Oklahoma State Board of Medical Licensure and Supervision, 101 NE 51st Street, Oklahoma City, Oklahoma 73105, (405) 962-1422, bsmith@okmedicalboard.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

435:7-1-1. Administrative remedy, notice of intention to impose administrative remedy, and service of notice
(a) Pursuant to 59 O.S.Supp. 2019, §503.2, the State Board of Medical Licensure and Supervision ("Board"), or the Board Secretary ("Board Secretary") acting for the Board, may issue a Notice against a licensee for statutory or regulatory prescribed unprofessional conduct.
(b) For the purposes of this section, "unprofessional conduct" includes but is not limited to:
   (1) Practicing without timely renewing a license;
   (2) Failure to provide required or accurate information on an initial licensure application;
   (3) Failure to provide required or accurate information on a renewal application;
   (4) Failure to timely obtain required continuing education hours;
   (5) Failure to notify Board of current practice location and mailing address;
   (6) Failure to cooperate with a lawful investigation conducted by the Board; or
   (7) Failure to register with the prescription monitoring program (PMP) in compliance with state law.
(c) Before an administrative remedy is imposed, the licensee shall be provided with a Notice of Intention to Impose Administrative Remedy ("Notice"). The Notice shall include:
   (1) Sufficient information regarding the allegations to allow the licensee to prepare a response;
   (2) The proposed administrative remedy;
   (3) Statement of the time, place, and nature of hearing consistent with Article II of the Administrative Procedures Act;
   (4) Deadlines for a written response and the consequences of failing to meet such deadlines;
   (5) The licensee's right to submit a written response right to appear at the hearing;
   (6) The consequences of the imposition of an administrative remedy, including the fact that the remedy will constitute a public record but that it will not be considered a limitation and restriction on the license and not reportable to the National Practitioner Databank;
   (7) A description of the procedural process for consideration of a written response and request for a personal appearance; and
   (8) The name and contact information for a Board staff member who can provide further information.
(d) A copy of the Notice shall be mailed to the licensee by certified mail, return receipt requested and delivery restricted to the addressee, to the address on file with the Board, or by personal service. A licensee may consent in writing to service via electronic mail message.

435:7-1-2. Response and contest in writing to notice of intention to impose administrative remedy
(a) The licensee must respond in writing to the Notice within twenty (20) days of service as follows:
435:7-1-3. Compliance with notice of imposition of administrative remedy

If the licensee consents and complies with the Notice within twenty (20) days after service of the Notice, it shall be so acknowledged by the Board Secretary on a copy of the Notice, which shall constitute an agreed imposition of the administrative remedy. A report of the same shall be made by the Board Secretary to the Board at the next regularly scheduled Board meeting for ratification and Final Administrative Order.

435:7-1-4. Notice and hearing before the Board

(a) A hearing on a contest of the Notice will be governed by the requirements of Article II of the Administrative Procedures Act. The Board's Rules for Individual Proceedings shall also govern.

(b) Following a hearing on the contest of the Notice, the Board may affirm, lessen, or reject the administrative remedy set forth in the Notice.

(c) Within ten (10) days of the Final Administrative Order, a licensee may request a rehearing, reconsideration, or reopening pursuant to 75 O.S. §317 and Okla. Admin. Code §435:3-3-21. Otherwise, the Board's decision shall constitute a Final Administrative Order.

(d) The Board's Final Administrative Order shall include the following separately stated information:

(1) Findings of Fact; and

(2) Conclusions of Law.

(e) A copy of the Final Administrative Order shall be mailed to the licensee by certified mail, return receipt requested to the addressee, to the address on file with the Board or personally delivered. A copy of the Order shall be delivered or mailed forthwith and to his or her attorney of record.

435:7-1-5. Allowed administrative remedies

(a) The Notice and/or the Board's Final Administrative Order may assess a monetary fine of up to $1,500.00 per violation of unprofessional conduct but in no event shall a fine exceed any amount otherwise set forth in statute or rules and/or

(b) The Board may impose continuing education requirements that must be pre-approved by the Board Secretary or the Board. The Notice will specify the amount of continuing education credit hours required and the time in which the licensee has to complete the credit hours.

435:7-1-6. Confidentiality of patient information in notice and/or final administrative remedy order

(a) To the extent required by law, any patient information must be redacted from any Notice and/or Final Administrative Order or any document filed in a contest of such a Notice of Final Administrative Order.

(b) To the extent that a patient must be identified, the initials of the patient's first and last names shall be used.

(c) Under no circumstance may the Board, the Board Secretary, Board staff, the licensee, or any person representing the licensee disclose any information confidential by law in any Notice and/or Final Administrative Order or any document filed in a contest of such Notice and/or Final Administrative Order.

(d) "Document," includes but is not limited to, originals or copies, whether tangible or electronically stored, of any letters, notes, pleadings, exhibits, photographs, videos, sound recordings, or demonstrative exhibits.

435:7-1-7. Reports of imposition of notice and/or final administrative remedy orders

(a) Any Notice or Final Administrative Order issued under this Chapter shall be a public record.

(b) The issuance of a Notice or Final Administrative Order under this Chapter may not be considered a restriction or limitation on the license, nor shall the issuance either one be considered an action connected with the delivery of health care services. Further, the imposition of any order under this Chapter shall not be reported to the National Practitioner Data Bank.

435:7-1-8. Failure to comply with final administrative remedy order

(a) A licensee shall not be issued a renewal license until licensee has complied with all the provisions of the Final Administrative Order.

(b) In the event that the licensee has not timely complied with a Final Administrative Order, the Board Secretary may file a motion to enforce or initiate disciplinary action against a licensee.

[OAR Docket #21-375; filed 6-14-21]

TITLE 435. STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
CHAPTER 35. LICENSED DIETITIANS AND PROVISIONAL DIETITIANS

[OAR Docket #21-374]
SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
November 24, 2020
COMMENT PERIOD:
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PUBLIC HEARING:
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ADOPTION:
March 11, 2021
SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:
March 17, 2021
LEGISLATIVE APPROVAL:
Approved June 11, 2021 by HJR 1046
FINAL ADOPTION:
June 11, 2021
EFFECTIVE:
August 26, 2021
SUPERSEDED EMERGENCY ACTIONS:
n/a
INCORPORATIONS BY REFERENCE:
n/a
GIST/ANALYSIS:
The proposed revisions will bring the amended definitions into compliance with formatting requirements set forth in Okla. Admin. Code 655:10-5-10.(c).
CONTACT PERSON:
Barbara J. Smith, Executive Secretary, Oklahoma State Board of Medical Licensure and Supervision, 101 NE 51st Street, Oklahoma City, Oklahoma 73105, (405) 962-1422, bsmith@okmedicalboard.org.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALY ADOPTED AS SET FORTH IN 75 O.S. SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

435:35-1-2. Definitions
The following words and terms, when used in this Chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Academy" means the Academy of Nutrition and Dietetics and is the national professional association for registered dietitians.

"ACEND" means the Accreditation Council for Education in Nutrition and Dietetics which accredits educational and pre-professional training programs in dietetics.

"Act" means the Licensed Dietitian Act, 59 O.S. Supp. 1984, Section 1721 et seq.

"Autonomy" means ensures a patient, client, or professional has the capacity and self-determination to engage in individual decision-making specific to personal health or practice.

"Beneficence" means encompasses taking positive steps to benefit others, which includes balancing benefit and risk.

"Board" means the Oklahoma State Board of Medical Licensure and Supervision.

"Competence" means a principle of professional practice, identifying the ability of the provider to administer safe and reliable services on a consistent basis.

"Conflict(s) of Interest(s)" means defined as a personal or financial interest or a duty to another party which may prevent a person from acting in the best interests of the intended beneficiary, including simultaneous membership on boards with potentially conflicting interests related to the profession, members or the public.

"Commission" means the Commission on Dietetic Registration and is the agency which evaluates credentials, administers proficiency examinations and issues certificates of registration to qualifying dietitians and is a member of the National Commission on Health Certifying Agencies.

"Customer" means any client, patient, resident, participant, student, consumer, individual/person, group, population, or organization to which the nutrition and dietetics practitioner provides service.

"Diversity" means actively identifying and offering opportunities to individuals with varied skills, talents, abilities, disabilities, backgrounds and practice expertise. The Academy values and respects the diverse viewpoints and individual differences of all people. The Academy’s mission and vision are most effectively realized through the promotion of a diverse membership that reflects cultural, ethnic, gender, racial, religious, sexual orientation, socioeconomic, geographical, political, educational, experiential and philosophical characteristics of the public it serves. The Academy actively identifies and offers opportunities to individuals with varied skills, talents, abilities, ideas, disabilities, backgrounds and practice expertise.

"Evidence-based Practice" means Evidence-based practice is an approach to health care wherein health practitioners use the best evidence possible, i.e., the most appropriate information available, to make decisions for individuals, groups and populations. Evidence-based practice values, enhances and builds on clinical expertise, knowledge of disease mechanisms, and pathophysiology. It involves complex and conscientious decision-making based not only on the available evidence but also on client characteristics, situations, and preferences. It recognizes that health care is individualized and ever changing and involves uncertainties and probabilities. Evidence-based practice incorporates successful strategies that improve client outcomes and are derived from various sources of evidence including research, national guidelines, policies, consensus statements, systematic analysis of clinical experience, quality improvement data, specialized knowledge and skills of experts.

"Justice" means (social justice): supporting fair, equitable, and appropriate treatment for individuals and fair allocation of resources.

"LD" means a person duly licensed as a licensed dietitian under the Licensed Dietitian Act.

"Non-Maleficence" means is the intent to not inflict harm.

"PLD" means a person duly licensed as a provisional licensed dietitian under the Licensed Dietitian Act.

"RD" means registered dietitian.

"RDN" means registered dietitian nutritionist. This represents an accepted abbreviation for a registered dietitian according to the Commission.

[OAR Docket #21-374; filed 6-14-21]
TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
CHAPTER 1. ADMINISTRATION

[OAR Docket #21-429]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 1. General information
450:1-1-1.1 [AMENDED]
450:1-9-5 [AMENDED]
450:1-9-5.1 [REVOKED]
450:1-9-5.2 [REVOKED]
450:1-9-5.3 [REVOKED]
450:1-9-5.4 [NEW]
450:1-9-5.5 [NEW]
450:1-9-5.6 [NEW]
450:1-9-5.7 [NEW]
450:1-9-5.8 [NEW]
450:1-9-5.9 [NEW]
450:1-9-6 [AMENDED]
450:1-9-7 [AMENDED]
450:1-9-7.1 [AMENDED]
450:1-9-7.2 [AMENDED]
450:1-9-7.3 [AMENDED]
450:1-9-7.4 [AMENDED]

AUTHORITY:
Oklahoma Board of Mental Health and Substance Abuse Services; 43A O.S. §§ 2-101, 3-110, 3-306, 3-306.1, 3-314.1, 3-315, 3-317, 3-318, 3-319 and 3-415; 74 O.S. § 85.9G.

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
December 21, 2020

COMMENT PERIOD:
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PUBLIC HEARING:
February 19, 2021

ADOPTION:
March 26, 2021

SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:
March 29, 2021

LEGISLATIVE APPROVAL:
Approved June 11, 2021 by HJR 1046

FINAL ADOPTION:
June 11, 2021

EFFECTIVE:
September 15, 2021

SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
Accessibility Guidelines for Buildings and Facilities (ADAAG) for alterations and new construction; Universal Precautions for the Transmis-

sion of Infectious Diseases from the Occupational Safety and Health Administration (OSHA); 42 C.F.R., Part 2 and 45 C.F.R. §§ 160.101 et seq.;

Incorporating rules:
450:1-9-5.4(1); 450:1-9-5.5(a)(2); 450:1-9-5.6(c)(1)

Availability:
9:00 a.m. to 5:00 p.m., Monday through Friday at the Oklahoma Department of Mental Health and Substance Abuse Services, 2000 N. Classen, Suite 2-600, Oklahoma City, OK 73106, 405-271-9200

GIST/ANALYSIS:
The proposed rule revisions to Chapter 1 add language to specify general provider certification qualifications and categorizes them to align with existing language regarding core organizational, core operational, and quality clinical standards. The intent is to consolidate duplicative language across other chapters within Title 450 to increase consistency and reduce regulatory language in accordance with Executive Order 2020-03.

CONTACT PERSON:
Melissa Miller, Policy Director and Administrative Rules Liaison, Melissa.Miller@odmhsas.org or (405) 248-9345

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 15, 2021:

SUBCHAPTER 1. GENERAL INFORMATION

450:1-1-1.1. Definitions
The following words or terms, as defined below, when used in Chapters 1, 15, 16, 17, 18, 21, 22—23, 24, 27, 30, 50, 53, 55, 60, 65 and 70, shall have the following meaning, unless the context clearly indicates otherwise and will prevail in the event there is a conflict with definitions included elsewhere in Chapters 1, 15, 16, 17, 18, 21, 22—23, 24, 27, 30, 50, 53, 55, 60, 65 and 70:

"Administrative Hearing Officer" means an individual who is an attorney licensed to practice law in the State of Okla-

homa and is appointed by the Commissioner of ODMHSAS to preside over and issue a proposed order in individual proceed-

ings.

"AOA" means American Osteopathic Association.

"Behavioral Health Aide (BHA)" means individuals must have completed sixty (60) hours or equivalent of college credit or may substitute one year of relevant employment and/or responsibility in the care of children with complex emotional needs for up to two years of college experience, and:

(A) must have successfully completed the special-

ized training and education curriculum provided by the ODMHSAS; and

(B) must be supervised by a bachelor's level individual with a minimum of two years case management experience or care coordination experience; and

(C) treatment plans must be overseen and approved by a LBHP or Licensure Candidate; and

(D) must function under the general direction of a LBHP, Licensure Candidate and/or systems of care team, with a LBHP or Licensure Candidate available at all times to provide back up, support, and/or consul-

tation.

"Board" means the Oklahoma State Board of Mental Health and Substance Abuse Services.

"CARF" means Commission on Accreditation of Rehabilitation Facilities (CARF).

"Certification" means a status which is granted to a person or an entity by the Oklahoma State Board of Mental Health and Substance Abuse Services or the ODMHSAS, and indicates the provider is in compliance with minimum standards as incorporated in OAC 450 to provide a particular service. In accordance with the Administrative Procedures Act, 75 O.S. § 250.3(8), certification is defined as a "license."
"Certified Alcohol and Drug Counselor (CADC)" means Oklahoma certification as an Alcohol and Drug Counselor.

"Certified Behavioral Health Case Manager" or "CM" means any person who is certified by the ODMHSAS as a Behavioral Health Case Manager pursuant to Oklahoma Administrative Code, Title 450, Chapter 50.

"Certified facility" means any facility which has received a certification status by the Oklahoma State Board of Mental Health and Substance Abuse Services or the ODMHSAS.

"Certification report" means a summary of findings documented by ODMHSAS related to an applicant's compliance with certification standards.

"COA" means the Council on Accreditation of Services for Families and Children, Inc.

"Consumer" means an individual who has applied for, is receiving or has received evaluation or treatment services from a facility operated or certified by ODMHSAS or with which ODMHSAS contracts and includes all persons referred to in OAC Title 450 as client(s) or patient(s) or resident(s) or a combination thereof.

"Contractor" or "contractors" means any person or entity under contract with ODMHSAS for the provision of goods, products or services.

"Critical incident" means an occurrence or set of events inconsistent with the routine operations of a facility, service setting, or otherwise routine care of a consumer. Critical incidents specifically include, but are not necessarily limited to the following: adverse drug events; self-destructive behavior; deaths and injuries to consumers, staff, and visitor; medication errors; residential consumers that have absent without leave (AWOL); neglect or abuse of a consumer; fire; unauthorized disclosure of information; damage to or theft of property belonging to consumers or the facility; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or results.

"Discharge summary" means a clinical document in the treatment record summarizing the consumer's progress during treatment, with goals reached, continuing needs, and other pertinent information including documentation of linkage to after-care.

"Employment Consultant (EC)" means an individual who (i) has a high school diploma or equivalent; and (ii) successful completion of Job Coach training.

"Entities" or "entity" means sole proprietorships, partnerships and corporations.

"Facilities" or "facility" means entities as described in 43A O.S. § 1-103(7), community mental health centers, residential mental health facilities, community-based structured crisis centers, certified services for the alcohol and drug dependent, programs of assertive community treatment, eating disorder treatment, gambling addiction treatment, and narcotic treatment programs.

"Family" means the parents, brothers, sisters, other relatives, foster parents, guardians, and others who perform the roles and functions of family members in the lives of consumers.

"Family Support and Training Provider (FSP)" means

(A) have a high school diploma or equivalent;
(B) be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance, or have lived experience as the primary caregiver of a child or youth who has received services for substance use disorder and/or co-occurring substance use and mental health, or have lived experience being the caregiver for a child with Child Welfare/Child Protective Services involvement;
(C) successful completion of Family Support Training according to a curriculum approved by the ODMHSAS and pass the examination with a score of 80% or better;
(D) pass OSBI background check;
(E) treatment plans must be overseen and approved by a LBHP or Licensure Candidate; and
(F) must function under the general direction of a LBHP, Licensure Candidate or systems of care team, with a LBHP or Licensure Candidate available at all times to provide back up, support, and/or consultation.

"Follow-up" means the organized method of systematically determining the status of consumers after they have been discharged to determine post-treatment outcomes and utilization of post-treatment referrals.

"Governing authority" means the individual or group of people who serve as the treatment facility's board of directors and who are ultimately responsible for the treatment facility's activities and finances.

"Individual proceeding" means the formal process employed by an agency having jurisdiction by law to resolve issues of law or fact between parties and which results in the exercise of discretion of a judicial nature.

"Institutional Review Board" or "IRB" means the ODMHSAS board established in accordance with 45 C.F.R. Part 46 for the purposes expressed in this Chapter.

"Intensive Case Manager (ICM)" means an individual who is designated as an ICM and carries a caseload size of not more than twenty-five (25) individuals. They are a LBHP, Licensure Candidate, CADC, or certified as a Behavioral Health Case Manager II, and have:
(A) a minimum of two (2) years Behavioral Health Case Management experience,
(B) crisis diversion experience, and
(C) successfully completed ODMHSAS ICM training.

"IRB approval" means the determination of the IRB that the research has been reviewed and may be conducted within the constraints set forth by the IRB and by other agency and Federal requirements.

"Levels of performance" or "level of performance" means units of service by types of service.

"Licensed Alcohol and Drug Counselor" or "LADC" means any person who is licensed through the State of Oklahoma pursuant to the provisions of the Licensed Alcohol and Drug Counselors Act.
"Licensed Behavioral Health Professional" or "LBHP" means:

(A) An allopathic or osteopathic physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry;
(B) An Advanced Practice Registered Nurse 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 certified in a psychiatric mental health specialty;
(C) A Clinical Psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists;
(D) A Physician Assistant who is licensed in good standing in Oklahoma and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions;
(E) A practitioner with a license to practice in the state in which services are provided issued by one of the following licensing boards:

(i) Psychology;
(ii) Social Work (clinical specialty only);
(iii) Professional Counselor;
(iv) Marriage and Family Therapist;
(v) Behavioral Practitioner or
(vi) Alcohol and Drug Counselor.

(C) 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
(D) a physician assistant who is licensed in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or therapy functions.

"Licensed dietitian" means a person licensed by the Oklahoma Board of Medical Licensure and Supervision as a dietitian.

"Licensed mental health professional" or "LMHP" means an individual with a current license and board certification in a 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 certified in a psychiatric mental health specialty and is licensed in the state of Oklahoma to provide practical nursing services.

"Licensed practical nurse" means an individual who is a graduate of an approved school of nursing and is licensed in the State of Oklahoma to provide practical nursing services.

"Licenseure candidate" means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:

(A) Psychology;
(B) Social Work (clinical specialty only);
(C) Professional Counselor;
(D) Marriage and Family Therapist;
(E) Behavioral Practitioner; or

(F) Alcohol and Drug Counselor.

"Minimal risk" means that the probability and magnitude of harm or discomfort anticipated in the research are not greater, in and of themselves, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examination or tests.

"ODMHSAS" or "Department" means the Department of Mental Health and Substance Abuse Services.

"Oklahoma Administrative Code" or "OAC" means the publication authorized by 75 O.S. § 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"Paraprofessional" means a person who does not have an academic degree related to the scope of treatment or support services being provided but performs prescribed functions under the general supervision of that discipline.

"Peer Recovery Support Specialist" or "PRSS" means an individual certified by ODMHSAS as a Peer Recovery Support Specialist pursuant to requirements found in OAC 450:53.

"Performance improvement" means an approach to the continuous study and improvement of the processes of providing services to meet the needs of consumers and others.

"Probationary certification" means a certification status granted for a period less than three (3) years.

"Psychiatrist" means a licensed physician who specialized in the assessment and treatment of individuals having psychiatric disorders and who is licensed to practice medicine in the state in which he or she practices and is certified in psychiatry by the American Board of Psychiatry and Neurology, or has equivalent training or experience.

"Registered nurse" means an individual who is a graduate of an approved school of nursing and is licensed in the state of Oklahoma to practice as a registered nurse.

"Rehabilitative services" means face-to-face individual or group services provided by qualified staff to develop skills necessary to perform activities of daily living and successful integration into community life.

"Reimbursement rates" means the rates at which all contractors are reimbursed (paid) for services they provide under their ODMHSAS contract.

"Research" means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this Chapter, whether or not they are conducted or supported under a program that is considered research for other purposes. For example, some demonstration and service programs may include research activities.

"Respondent" means the person(s) or entity(ies) named in a petition for an individual proceeding against whom relief is sought.

"Sentinel event" means a type of critical incident that is an unexpected occurrence involving the death or serious physical or psychological injury to a consumer or risk thereof. Serious injury specifically includes loss of limb or function. The
phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a consumer. These events signal the need for immediate investigation and response. Sentinel events include, but are not limited to suicide, homicide, criminal activity, assault and other forms of violence, including domestic violence or sexual assault, and adverse drug events resulting in serious injury or death.

"Service area" means a geographic area established by the Department of Mental Health and Substance Abuse Services for support of mental health [43A O.S. § 3-302(1)].

"Service Provider" means a person who is allowed to provide substance abuse services within the regulation and scope of their certification level or license.

"Site Review Protocol" means an ODMHSAS document developed as a work document in the certification site visit(s) that is based primarily upon the rules (standards/criteria) being reviewed. The Site Review Protocol is used in preparing the Certification Report, which is provided to the facility as well as to the Board for its consideration and action related to certification.

"Staff privileging" means an organized method for facilities and programs to authorize an individual to provide specific care and treatment services to consumers within well-defined limits, based on the evaluation of the individual's license, education, certification, training, experience, competence, judgment, and other credentials.

"Support Services Provider (SSP)" means an individual age eighteen (18) or older with a high school diploma or equivalent.

"TJC" means The Joint Commission formerly referred to as the Joint Commission on Accreditation of Healthcare Organizations or JCAHO.

"Tobacco" means any nicotine delivery product or device that is not approved by the U.S. Food and Drug Administration (FDA) for the purpose of nicotine dependence treatment, including, but not limited to cigarettes, cigars, snuff, chewing tobacco, electronic cigarettes and vaping devices.

"Volunteer" means any person who is not on the program's payroll, but provides services and fulfills a defined role within the program and includes interns and practicum students.

SUBCHAPTER 9. CERTIFICATION AND DESIGNATION OF FACILITY SERVICES

450:1-9. Qualifications for certification of facilities and programs and individuals
(a) Qualifications for certification of facilities and programs providing mental health, substance related, or addictive disorder treatment services are as follows:
   (1) Compliance with applicable Standards and Criteria as authorized within the authority of Title 43A of the Oklahoma Statutes, including but not limited to those Core Organizational Standards, Core Operational Standards and Quality Clinical Standards formally codified in the Title 450 regulating the area for which certification is sought. Codified Standards and Criteria include but are not limited to:
      (A) Chapter 16, Standards and Criteria for Community Residential Mental Health Facilities;
      (B) Chapter 17, Standards and Criteria for Community Mental Health Centers;
      (C) Chapter 18, Standards and Criteria for Substance Related and Addictive Disorder Treatment Services;
      (D) Chapter 21, Certification of Alcohol and Drug Services; Abuse Courses (ADSAC), Organizations and Facilitators;
      (E) Chapter 22, Certification of Alcohol and Drug Assessment and Evaluations Related to Driver's License Revocation;
      (ED) Chapter 23, Standards and Criteria for Community Based Structured Crisis Centers;
      (GE) Chapter 24, Standards and Criteria for Comprehensive Community Addiction Recovery Centers;
      (HF) Chapter 27, Standards and Criteria for Mental Illness Service Programs;
      (I) Chapter 50, Standards and Criteria for Certified Behavioral Health Case Managers;
      (J) Chapter 53, Standards and Criteria for Certified Peer Recovery Support Specialists;
      (KG) Chapter 55, Standards and Criteria for Programs of Assertive Community Treatment;
      (L-H) Chapter 60, Standards and Criteria for Certified Eating Disorder Treatment Programs;
      (MI) Chapter 65, Standards and Criteria for Gambling Treatment Programs; and
      (NJ) Chapter 70, Standards and Criteria for Opioid Substitution Treatment Programs.
   (2) ODMHSAS will designate specific standards in the Chapters listed above, that are applicable to facilities and programs, as Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards and the requirements that must be present to determine minimal compliance with each type of standard.
   (2) Compliance with applicable Core Organizational Standards, Core Operational Standards and Quality Clinical Standards set forth in OAC 450:1-9-5.4, OAC 450:1-9-5.5 and OAC 450:1-9-5.6. Core Organizational Standards, Core Operational Standards and Quality Clinical Standards address separate requirements as follows:
      (A) Core Organizational Standards will address requirements necessary to assure the public and consumers of services that essential organizational functions are substantially in place at the facility and the facility is prepared to initiate services for which certification is being requested. These requirements can be verified prior to the initiation of services for which the organization is requesting certification.
      (B) Core Operational Standards will address other essential conditions and processes that must be in
place to assure basic safety and protection of consumer rights. Some of these requirements can also be verified prior to the initiation of service. Others must be verified when an organization begins providing services.

(C) Quality Clinical Standards will address actual services provided, qualifications of staff, clinical documentation, and processes designed to assure consistency in quality and efficacy of services. These requirements can only be verified after a reasonable time during which services have been provided.

(3) For each Chapter listed above ODMHSAS will designate certain core organizational, core operational and clinical standards that will be considered critical to the protection of the health, safety and welfare of the client. Compliance with all applicable Core Organizational Standards, Core Operational Standards and Quality Clinical Standards will be evaluated in the manner and methods prescribed by ODMHSAS. Compliance methods include, but are not limited to, on-site inspections and observation, staff interviews, and review of relevant records and documentation as determined by ODMHSAS. Failure to provide documentation or access requested by ODMHSAS will be grounds for disciplinary action. Failure to meet these demonstrate compliance with any applicable standard will result in immediate suspension and/or revocation.

(4) An applicant for certification must also comply with all other applicable statutory licensing provisions, including but not limited to individual professional licensure, other licenses, or permits required of organizational entities.

(b) A certified Community Mental Health Center that provides alcohol and drug treatment services in the course of its outpatient or inpatient services, but has no designated or specialized alcohol and drug abuse treatment program component, shall not be subject to additional certification under the Certified Services for Alcohol and Drug-Dependent Standards and Criteria in OAC 450, Chapter 18 of this Title.

(c) A certified Community Mental Health Center providing alcohol and drug abuse treatment services as a designated or specialized program component shall be subject to certification under the Certified Services for Alcohol and Drug-Dependent Standards and Criteria in OAC 450, Chapter 18 or Comprehensive Community Addiction Recovery Centers Standards and Criteria in OAC 450, Chapter 24 of this Title.

(d) Qualifications for certification of entities and individuals providing alcohol and drug course instruction or assessments are as follows:

(1) Compliance with applicable Standards and Criteria as authorized within the authority of Title 43A of the Oklahoma Statutes, including but not limited to those formally codified in Title 450, Chapter 21, Alcohol and Drug Substance Abuse Courses (ADSAC) and Assessments.

(2) An applicant for certification must also comply with all other applicable statutory licensing provisions, including but not limited to individual professional licensure and other licenses or permits.

(e) Qualifications for certification of individual providers of mental health, substance use, or addictive disorder services are as follows:

(1) Compliance with applicable Standards and Criteria as authorized within the authority of Title 43A of the Oklahoma Statutes, including but not limited to those formally codified in Title 450 regulating the area for which certification is sought:

(A) Chapter 50, Standards and Criteria for Certified Behavioral Health Case Managers; and

(B) Chapter 53, Standards and Criteria for Certified Peer Recovery Support Specialists.

(2) An applicant for certification must also comply with all other applicable statutory licensing provisions, including but not limited to individual professional licensure and other licenses or permits.

450:1-9-5.1. Types and duration of certification status for facilities and programs [REVOKED]

(a) The ODMHSAS may grant the following types of certification for the durations specified below.

(1) Permit for Temporary Operations. Permits for temporary operations may be granted upon ODMHSAS's verification that the organization has complied with all Core Organizational Standards and Core Operational Standards applicable to the related type of service for which certification is sought. In addition, for facilities that have provided services for 30 days or longer applicable to this type of certification ODMHSAS may review compliance with applicable Quality Clinical Standards. The Permit will expire at the end of six (6) months or if a subsequent certification is achieved by the organization and subsequently granted by ODMHSAS prior to the expiration of the Permit. ODMHSAS may extend a Permit for no more than 60 days in the event of extenuating circumstances as determined by ODMHSAS.

(2) Probationary Certification. Probationary Certification may be awarded for a one (1) year period by ODMHSAS in accordance with applicable chapters as stipulated in 450:1-9-5 and when ODMHSAS verifies that all conditions in 450:1-9-5.1(a)(3) exist but the program initiated operations prior to the awarding of a Permit for Temporary Operations for the services for which certification is statutorily required. Additionally, certified organizations that provide services out of a satellite prior to the satellite being approved by ODMHSAS will have their organization's certification reduced to a Probationary Certification. Organizations awarded Probationary Certification must apply for and be awarded Probationary Certification for two additional one (1) year terms, prior to being considered for other categories of ODMHSAS Certification.

(3) Certification. ODMHSAS may award Certification for a one (1) year or two (2) year period beyond the period approved for a Permit for Temporary Operations or as a renewal of a previously awarded Certification in accordance with applicable chapters as stipulated in 450:1-9-5 and when ODMHSAS determines that the
organization has met minimal compliance with each type of standard (i.e., Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards). To qualify for Certification, programs must meet the following:

(A) Demonstrate compliance with all Core Organizational Standards and all Core Operational Standards as verified by ODMHSAS and within timeframes stipulated by ODMHSAS; and,

(B) For a two (2) year certification, demonstrate compliance with at least 75% of all Quality Clinical Standards on the initial site review, and file an acceptable plan of correction and demonstrate compliance with 100% of Quality Clinical Standards, as verified by ODMHSAS in accordance with 450:1-9.7.1 and 450:1-9.7.3.

(C) Programs with fewer than five (5) active cases for which clinical records could be reviewed must meet the requirements in (B) above, but can be considered for no more than a one (1) year certification.

(D) Community Residential Mental Health Programs can be considered for no more than a one (1) year certification.

(E) Programs awarded a Probationary Certification are not eligible for Certification under the conditions described in 450:1-9.5.1(3) until all conditions of 450:1-9.5.1(2) have been satisfied.

(4) Certificate with Distinction. Certification with Distinction may be awarded for up to three (3) years by ODMHSAS in accordance with applicable chapters as stipulated in 450:1-9.5 for programs seeking renewal of previously awarded certification when ODMHSAS verifies all of the following minimal conditions are satisfied.

(A) Programs must have provided services with an approved ODMHSAS Certification as described in 450:1-9.5.1(3) for one (1) year or longer in addition to the time services were provided under an approved Permit for Temporary Operations or a Probationary Certification.

(B) Programs must demonstrate compliance with all Core Organizational Standards and with all Core Operational Standards as verified by ODMHSAS; and,

(C) Programs must also demonstrate compliance with at least 90% of all Quality Clinical Standards on the initial renewal site visit and review as verified by ODMHSAS. Compliance may be determined during initial site reviews or during additional site reviews following the implementation of a plan of correction as required by ODMHSAS, in accordance with 450:1-9.7.1 and 450:1-9.7.3.

(D) Programs for which ODMHSAS determines compliance with all standards as required in (a), (b), and (c) may be considered for Certification with Distinction for a three (3) year period.

(E) ODMHSAS may refund certification renewal application fees for organizations that demonstrate 100% compliance with all standards (i.e., Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards) during the initial renewal site visit and review.

(F) Community Residential Mental Health Programs can be considered for no more than a one (1) year Certification with Distinction.

(G) Programs awarded a Probationary Certification are not eligible for Certification under the conditions described in 450:1-9.5.1(4) until all conditions of 450:1-9.5.1(2) have been satisfied.

(5) Certification with Special Distinction. Certification with Special Distinction may be awarded for up to three (3) years by ODMHSAS in accordance with applicable chapters as stipulated in 450:1-9.5 for programs seeking renewal of previously awarded certification when ODMHSAS verifies all of the following minimal conditions are satisfied.

(A) The program must meet all conditions for Certification with Distinction as outlined in 1-9.5.1(a)(4), and,

(B) The program has attained national accreditation (COA, CARE, or TJC) for the services to which ODMHSAS Certification applies.

(C) Certification with Special Distinction will be reduced by ODMHSAS to Certification with Distinction by ODMHSAS if during the certification period for which the Special Distinction was approved, the program fails to maintain national accreditation status.

(D) ODMHSAS may refuse certification renewal application fees for organizations that demonstrate 100% compliance with all standards (i.e., Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards) during the initial renewal site visit and review.

(E) Community Residential Mental Health Programs can be considered for no more than a one (1) year Certification with Distinction.

(F) Programs awarded a Probationary Certification are not eligible for Certification under the conditions described in 450:1-9.5.1(a)(4) until all conditions of 450:1-9.5.1(a)(2) have been satisfied.

(b) Permits for Temporary Operations granted to applicants for initial certification of a facility, location, or level of service shall be for a period of six (6) months and shall become effective immediately upon approval by the ODMHSAS Board, the Commissioner or designee.

(c) Permits for Temporary Operations, granted to an applicant, shall become effective the first day of the month following the date of the action by the Board, provided however, that the Board may waive this requirement and make the Certification effective immediately.
450:1-9-5.2. Types and Duration of certification of individuals [REVOKED]
(a) Certification for Behavioral Health Case Managers will be in accordance with requirements and procedures stipulated in 450:50 Certification of Behavioral Health Case Managers.
(b) Certification for organizations and individuals providing alcohol and drug abuse course instruction will be in accordance with requirements and procedures stipulated 450:21 Certification of Alcohol and Drug Substance Abuse Courses (ADSAC), Organizations and Facilitators.
(c) Certification related to alcohol and drug assessment and evaluation related to driver’s license revocation will be in accordance with requirements and procedures stipulated in 450:22 Certification of Alcohol and Drug Assessment and Evaluations Related to Driver’s License Revocation.
(d) Certification for Recovery Support Specialists will be as done in accordance with requirements and procedures stipulated in 450:53 Certification of Recovery Support Specialists.

450:1-9-5.3. Additional conditions related to certification [REVOKED]
(a) Certification granted by ODMHSA is not transferable. A change of the ownership of a facility automatically terminates any certification status, requiring application for certification by the new ownership.
   (1) If the certified facility is owned by a corporation the following applies:
      (A) If the corporation is not-for-profit, a change in membership of the Board of Directors of more than fifty percent (50%) of the Directors in three (3) or less calendar months, unless such change was caused by the normal expiration of terms in accordance with the bylaws of the Board of Directors, shall require the facility to be recertified.
      (B) If the corporation is other than not-for-profit, a change in the ownership of more than forty percent (40%) of the stock in the corporation from the owners at the beginning of the period of certification shall require the facility to be recertified.
   (2) It is the responsibility of the facility to notify the ODMHSA of the occurrence of either of the conditions requiring recertification and to request the application materials for recertification.
(b) Organizations granted certification, including Permits for Temporary Operation, shall only publically refer to ODMHSA Certification in relationship to the specific services, locations, and dates applicable to each currently granted ODMHSA Certification. This includes all published materials, electronic media, and information posted within a facility. Failure to adhere to this restriction can be cause for action related to Certification in accordance with 1-5.4.
(c) ODMHSA shall conduct at least one unannounced additional certification site visit during each one (1) year term of a program granted Probationary Certification and each program granted 1-Year Certification.
   (1) If deficiencies are noted, the program or facility must file a Plan of Correction addressing all deficiencies within ten (10) days of receipt of the report.
   (2) Deficiencies verified during the unannounced site visit indicated danger to the health, safety and/or welfare of the clients will result in immediate suspension and/or revocation.
   (3) Certification may be suspended or revoked with the basis for such action being delineated in Section 450:1-9-9 of this Subchapter.

450:1-9-5.4. Core organizational standards for facilities and programs
(a) Governing Authority. With the exception of facilities certified under Chapter 16 of this Title, all facilities and programs shall have documents of authority, which shall be available to the public and ODMHSA upon request. Documents of authority shall identify the duly constituted authority and governance structure for assuring legal responsibility and for requiring accountability for performance and operation of the facility (including all components and satellites). The documents of authority shall indicate:
   (1) Eligibility criteria for governing body membership;
   (2) The number and types of membership;
   (3) The method of selecting members;
   (4) The number of members necessary for a quorum;
   (5) Attendance requirements for governing body membership;
   (6) The duration of appointment or election for governing body members and officers; and
   (7) The powers and duties of the governing body and its officers and committees or the authority and responsibilities of any person legally designated to function as the governing body.
(b) Organizational Description. All facilities and programs shall have a written organizational description which is reviewed and approved annually by its governing authority. The facility or program shall make the organizational description available to staff and, upon request, to the public. The organizational description shall minimally include descriptions of:
   (1) Population(s) to be served;
   (2) The overall program mission statement;
   (3) The annual goals and objectives for the program, including the goal of continued progress in providing evidence-based practices; and
   (4) The specific geographic area in which services are provided for programs certified under Chapter 55 of this Title.
(c) Personnel Policies and Procedures.
   (1) All facilities and programs shall have written personnel policies and procedures approved by the governing authority.
   (2) All employees shall have access to personnel policies and procedures, as well as other rules and regulations governing the conditions of their employment.
(3) The facility or program shall develop, adopt, and maintain policies and procedures at each provider location to provide for qualified personnel during all hours of operation.
(4) There shall be job descriptions for all positions setting forth minimum qualifications and duties of each position.

(d) Utilization of Volunteers.
(1) In facilities and programs where volunteers are utilized, specific policies and procedures shall be in place to define the purpose, scope, training, supervision and operations related to the use of volunteers.
(2) There shall be documentation to verify orientation of each volunteer which shall enable him or her to have knowledge of program goals and familiarity with routine procedures.
(3) All volunteers must receive in-service training pursuant to OAC 450:1-9-5.3(b).

(e) Information Analysis and Performance Improvement.
(1) With the exception of facilities certified under Chapter 16 of this Title, all facilities and programs shall have an ongoing information analysis and performance improvement system in order to objectively and systematically monitor, evaluate, and improve consumer outcomes and organizational performance.
(2) The system shall also address the fiscal management of the facility or program.
(3) Each facility and program shall prepare a year-end management report annually which shall include, at a minimum:

(A) An analysis of consumer outcomes and organizational processes, including:
   (i) A quarterly quality consumer record review to evaluate the quality of service delivery, including:
      (I) Appropriateness of services;
      (II) Patterns of service utilization;
      (III) Consumer involvement in service planning;
      (IV) Assessment processes;
      (V) Service planning procedures and compliance;
      (VI) Alignment between services provided and treatment goals;
      (VII) Service documentation procedures and compliance; and
      (VIII) Alignment between services provided and billed service encounters.
   (ii) A review of staff privileging processes;
   (iii) A review of critical and unusual incidents and consumer grievances and complaints;
   (iv) An assessment of service provision, including the provision of trauma-informed, co-occurring capable, culturally competent, and consumer-driven services; and
   (v) Consumer satisfaction.

(B) Identified areas of improvement; and

(C) Strategies that will be implemented to address areas of improvement.

(4) The management report shall be made available to consumers, staff, the governing authority and ODMHSAS upon request.

(f) Special Populations.
(1) Under Titles 11 and 111 of the Americans with Disabilities Act of 1990, all facilities shall comply with the “Accessibility Guidelines for Buildings and Facilities (ADAAG) for alterations and new construction.” State and local standards for accessibility and usability may be more stringent. Facilities shall assume responsibility for verification of all applicable requirements and comply with the most stringent standards.
(2) All facilities and programs shall have written policy and procedures for providing or arranging for services for persons who fall under the protection of the Americans with Disabilities Act of 1990 and provide documentation of compliance with applicable Federal, state, and local requirements. A recommended reference is the “Americans with Disabilities Handbook” published in U.S. Equal Employment Opportunities Commission and the U.S. Department of Justice.
(3) All facilities shall have a policy of non-discrimination against persons with Human Immunodeficiency Virus (HIV) and persons with Acquired Immunodeficiency Syndrome (AIDS).

450:1-9-5.5. Core operational standards for facilities and programs
(a) Physical facility environment and safety.
(1) All facilities shall have written policies and procedures to ensure the safety and protection of all persons within the facility's physical environment, including all leased or owned property and buildings.
(2) All facilities shall be in compliance with applicable fire and safety regulations, codes, and statutory requirements of the federal, state, and local government. This shall include, but not be limited to, the Universal Precautions for Transmission of Infectious Diseases from the Occupations Safety Health Administration (OSHA).
(3) All facilities shall have an annual fire and safety inspection from the State Fire Marshal or local fire department which documents approval for continued occupancy. All facilities shall keep a copy of the inspection documentation and any correspondence regarding any deficiency at the facility.
(4) All facilities shall have an emergency preparedness plan to meet the needs of consumers, visitors, and staff during a disaster. The emergency preparedness plan shall be evaluated annually and shall, at a minimum, address:

(A) Fires;
(B) Floods;
(C) Tornadoes;
(D) Explosions;
(E) Chemical spills; and
(F) Prolonged loss of heat, light, water, and air conditioning.
(5) All facilities shall have a designated Safety Officer.

(6) There shall be written plans and diagrams posted prominently noting emergency evacuation routes and shelter locations.

(7) All facilities shall have fire alarm systems. All alarms shall be in working order and have visual signals suitable for individuals with a hearing impairment.

(8) There shall be emergency power to supply lighting throughout each location where consumers receive services.

(9) Storage of dangerous substances (toxic or flammable substances) shall be in locked, safe areas or cabinets.

(10) There shall be a written plan for the protection and preservation of consumer records in the event of a disaster.

(11) If the facility serves children or adolescents in any form of residential care, there shall be outside play and recreational space and equipment provided which:

(A) Is protected and free from hazards;

(B) Is safely accessible from indoors;

(C) Has supplies and equipment maintained safely; and

(D) Has some shade provided.

(b) Hygiene and sanitation.

(1) Residential facilities shall provide the following services and applicable supporting documentation:

(A) Toilet facilities in a minimum ratio of one (1) per eight (8) resident beds. Each toilet facility shall include a sink in the same room or immediately adjacent thereto;

(B) Bathing facilities in a minimum ratio of one (1) tub or shower per each eight (8) resident beds;

(C) Sewage discharge into a municipal sewerage system or collected, treated, and disposed of in an independent sewerage system;

(D) Regular inspections and treatment by a licensed pest control operator;

(E) Solid waste disposal through public systems or in a manner approved by the local agency having jurisdiction and the OSDH or Department of Environmental Quality (DEQ), as necessary, with documentation from OSDH or DEQ that the solid waste disposal system is free from deficiencies if applicable;

(F) Water obtained from an approved public water supply or tested at least quarterly and treated as necessary, thereby maintaining a determination as an approved water supply by the authority having jurisdiction and the OSDH or DEQ, as necessary, with documentation from OSDH or DEQ that the solid waste disposal system is free from deficiencies if applicable;

(G) Linen in quantities adequate to provide at least two (2) changes of bedding each week; and

(H) Housekeeping services that provide a hygienic environment in the facility;

(2) Outpatient treatment facilities shall provide:

(A) Toilet facilities in a minimum ratio of one (1) per twenty (20) persons. Each toilet facility shall include a sink in the same room or immediately adjacent thereto;

(B) Water and sewerage in the same manner as prescribed for residential facilities; and

(C) Housekeeping services that provide a hygienic environment in the facility.

(c) Tobacco-free campus.

(1) With the exception of facilities certified under Chapter 16 of this Title, all facilities shall provide a tobacco-free campus for its employees, consumers and visitors. Possession and use of any tobacco product is prohibited on the grounds of the facility by employees, consumers, volunteers and visitors.

(2) All facilities shall visibly post signs on the property notifying consumers, employees and visitors that the visible possession and use of tobacco products is prohibited.

(3) Facility employees shall not share tobacco or tobacco replacement products with consumers.

(4) The facility shall offer assistance to employees who are tobacco users while employed by the facility. The facility shall have written policies describing the types of assistance offered to employees.

(5) The facility shall always inquire about consumers' tobacco use status and be prepared to offer treatment upon request of the consumer.

(d) Technology.

With the exception of facilities certified under Chapter 16 of this Title, all facilities and programs shall have policies and procedures regarding the use of technology and systems to support and advance effective and efficient service and business practices. The plan shall include, but not be limited to:

(1) Hardware and software;

(2) Security;

(3) Confidentiality;

(4) Backup policies;

(5) Assistive technology;

(6) Disaster recovery preparedness; and

(7) Virus protection.

(e) Confidentiality and information security.

(1) All facilities and programs shall have written policies and procedures describing the conditions under which consumer information may be disclosed and the procedures for releasing such information. These conditions and procedures shall adhere to all applicable federal and state rules and statutes, including:

(A) 42 C.F.R., Part 2 and 45 C.F.R. § 160.101 et seq.;

(B) 43A O.S. § 1-109 and 63 O.S. § 1-502.2; and

(C) OAC 450:15-3-20.1, OAC 450: 15-3-20.2 and OAC 450:15-3-60.

(2) It shall be the responsibility of facility or program to safeguard client information against loss, theft, defacement, tampering, or use by unauthorized persons.
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450:1-9.5.6. Quality clinical standards for facilities and programs

(a) Staff qualifications.
(1) All staff who provide clinical services within facilities and programs shall have documented qualifications or training specific to the clinical services they provide.
(2) Staff qualifications for contracted entities shall be in compliance with 450:1-1-1.1 and 450:1-3-5.
(3) Each facility or program shall have policies and procedures for documenting and verifying the training, experience, education, and other credentials of service providers prior to their providing treatment services for which they were hired. All staff shall be documented as privileged prior to performing treatment services.
(4) All direct care staff shall be at least eighteen (18) years old.
(5) Each facility or program shall minimally perform a review each calendar year of current licensure, certifications, and current qualifications for privileges to provide specific treatment services.

(b) Staff development and training.
(1) All facilities and programs shall have a written staff development and training plan for all administrative, professional and support staff. This plan shall include, at a minimum:
   (A) Orientation procedures;
   (B) In-service training and education programs;
   (C) Availability of professional reference materials;
   (D) Mechanisms for ensuring outside continuing educational opportunities for staff members; and
   (E) Performance improvement activities and their results.
(2) In-service training shall be conducted each calendar year and shall be required upon hire and each calendar year thereafter for all employees on the following topics:
   (A) Fire and safety, including the location and use of all fire extinguishers and first aid supplies and equipment;
   (B) Universal precautions and infection control;
   (C) Consumer's rights and the constraints of the Mental Health Patient's Bill of Rights;
   (D) Confidentiality;
   (E) Oklahoma Child Abuse Reporting and Prevention Act, 10 O.S. §§ 7101-7115;
   (F) Facility policy and procedures;
   (G) Cultural competence (including military culture if active duty or veterans are being served);
   (H) Co-occurring disorder competency and treatment principles;
   (I) Trauma informed service provision;
   (J) Crisis intervention; and
   (K) Age and developmentally appropriate trainings, where applicable.
(3) All clinical staff, direct care staff, and/or volunteers shall have non-physical intervention training in techniques and philosophies addressing appropriate non-violent interventions for potentially physical interpersonal conflicts, staff attitudes which promote dignity and enhanced self-esteem, keys to effective communication skills, verbal and non- verbal interaction and non-violent intervention within thirty (30) days of being hired with updates each calendar year thereafter. This standard shall not apply to facilities or programs subject to Chapter 27 of this Title.
(4) The local facility Executive Director shall designate which positions and employees, including temporary employees, will be required to successfully complete physical intervention training. An employee or volunteer shall not provide direct care services to consumers until completing this training. This standard shall not apply to facilities or programs subject to Chapter 16 or Chapter 27 of this Title.
(5) The training curriculum for (2) and (3) of this subsection must be approved by the ODMHSAS commissioner or designee in writing prior to conducting of any training pursuant to this provision.
(6) Each site shall have staff during all hours of operation who maintain current certification in basic first aid and Cardiopulmonary Resuscitation (CPR).

(c) Clinical supervision.
(1) With the exception of facilities certified under Chapter 16 of this Title, all facilities and programs shall have written policies and procedures, operational methods, and documentation of the provision of clinical supervision for all direct treatment and service staff. For facilities that employ only one service provider, supervision will be in the form of clinical consultation from a qualified service provider in the same field. These policies shall include, but are not limited to:
   (A) Credentials required for the clinical supervisor;
   (B) Specific frequency for case reviews with treatment and service providers;
   (C) Methods and time frames for supervision of individual, group, and educational treatment services; and
   (D) Written policies and procedures defining the program's plan for appropriate counselor-to-consumer ratio, and a plan for how exceptions may be handled.
(2) Ongoing clinical supervision shall be provided and shall address:
   (A) The appropriateness of treatment selected for the consumer;
   (B) Treatment effectiveness as reflected by the consumers meeting their individual goals; and
   (C) The provision of feedback that enhances the clinical skills of service providers.

(d) Clinical record keeping. basic requirements.
(1) All facilities and programs shall establish and maintain an organized clinical record system for the collection and documentation of information appropriate to the treatment processes; and which insures organized, easily retrievable, usable clinical records stored under confidential conditions and with planned retention and disposition.
(2) Each facility or program shall maintain an individual record for each consumer.
(3) The facility's or program's policies and procedures shall:
   (A) Define the content of the consumer record in accordance with all applicable state and federal rules, requirements, and statutes;
   (B) Define storage, retention and destruction requirements for consumer records in a manner that prevents unauthorized information disclosures;
   (C) Require consumer records be maintained in locked equipment which is kept within a locked room, vehicle, or premise;
   (D) Require legible entries in consumer records, signed with first name or initial, last name, and dated by the person making the entry;
   (E) Require the consumer's name or unique identifier be typed or written on each page in the consumer record; or appear on each screen of an electronic record;
   (F) Require a signed consent for treatment before a consumer is admitted on a voluntary basis; and
   (G) Require a signed consent for referral and payment, and for follow up before any contact after discharge is made.

(4) If electronic clinical (medical) records are maintained, there shall be proof of compliance with all applicable state and federal rules and statutes related to electronic medical records, encryption, and other required features.

(5) ODMHSAS operated facilities shall comply with Records Disposition Schedule 82-17 as approved by the Oklahoma Archives and Records Commission.

(6) The facility or program shall assure consumer records are readily accessible to all staff providing services to consumers. Such access shall be limited to the minimum necessary to carry out the staff member's job functions or the purpose for the use of the records.

d) Discharge summary.

(1) A completed discharge summary shall be entered in each consumer's record within fifteen (15) days of the consumer completing, transferring, or discontinuing services. The summary shall be signed and dated by the staff member completing the summary. Consumers who have received no services for one hundred eighty (180) days shall be discharged if it is determined that services are no longer needed or desired.

(2) A discharge summary shall include, but not be limited to, the consumer's progress made in treatment, the consumer's response to services rendered, initial condition and condition of the consumer at discharge, diagnoses, summary of current medications, when applicable, and recommendations for referrals, if deemed necessary. It shall include a discharge plan which lists written recommendations and specific referrals for implementing aftercare services, including medications. Aftercare plans shall be developed with the knowledge and cooperation of the consumer, when possible. This standard shall not apply to facilities certified under Chapter 16 of this Title.

(3) The signature of the staff member completing the summary and the date of completion shall be included in the discharge summary.

(4) In the event of death of a consumer, in lieu of a discharge summary, a summary statement including applicable information shall be documented in the record.

f) Critical incidents.

(1) All facilities and programs shall have written policies and procedures requiring documentation and reporting of critical incidents and analysis of the contributors to the incident to ODMHSAS.

(2) The documentation of critical incidents shall contain, at a minimum:
   (A) Facility name and signature of the person(s) reporting the incident;
   (B) Names of the resident(s), and/or staff member(s) involved;
   (C) Time, date, and physical location of the incident;
   (D) Time and date incident was reported and name of person within the facility to whom it was reported;
   (E) Description of incident;
   (F) Severity of each injury, if applicable. Severity shall be indicated as follows:
      (i) No off-site medical care required or first aid care administered on-site;
      (ii) Medical care by a physician or nurse or follow-up attention required; or
      (iii) Hospitalization or immediate off-site medical attention was required;
   (G) Resolution or action taken and date resolution or action was taken; and
   (H) Signature of the facility administrator, or designee of the facility administrator. The designee must be previously identified in writing to the Department and designated within the facility's policy and procedures by the facility administrator. Only one designee per facility shall be permitted.

(3) Critical incidents shall be reported to ODMHSAS with specific timeframes, as follows:
   (A) Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax, or ODMHSAS designated electronic system, to ODMHSAS within twenty-four (24) hours of the incident being documented.
   (B) Critical incidents involving allegations constituting a sentinel event or resident abuse shall be reported to ODMHSAS immediately via telephone or fax, but within not more than twenty-four (24) hours of the incident. If reported by telephone, the report shall be followed with a written report within twenty-four (24) hours of the incident.
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450:1-9.5.7. Types and duration of certification status for facilities and programs

(a) The ODMHSAS may grant the following types of certification for the durations specified below.

(1) Permit for temporary operations. Permits for temporary operations may be granted upon ODMHSAS’s verification that the organization has complied with all Core Organizational Standards and Core Operational Standards applicable to the related type of services for which certification is sought. In addition, for facilities that have provided services for 30 days or longer applicable to this type of certification ODMHSAS may review compliance with applicable Quality Clinical Standards. The Permit will expire at the end of six (6) months or if a subsequent certification is achieved by the organization and subsequently granted by ODMHSAS prior to the expiration of the Permit. ODMHSAS may extend a Permit for no more than 60 days in the event of extenuating circumstances as determined by ODMHSAS.

(2) Probationary certification. Probationary Certification may be awarded for a one (1) year period by ODMHSAS in accordance with applicable chapters as stipulated in 450:1-9-5 and when ODMHSAS verifies that all conditions in 450:1-9-5.7(a)(3) exist but the program initiated operations prior to the awarding of a Permit for Temporary Operations for the services for which certification is statutorily required. Additionally, certified organizations that provide services out of a satellite prior to the satellite being approved by ODMHSAS will have their organization’s certification reduced to a Probationary Certification. Organizations awarded Probationary Certification must apply for and be awarded Probationary Certification for two additional one (1) year terms, prior to being considered for other categories of ODMHSAS Certification.

(3) Certification. ODMHSAS may award Certification for a one (1) year or two (2) year period beyond the period approved for a Permit for Temporary Operations or as a renewal of a previously awarded Certification in accordance with applicable chapters as stipulated in 450:1-9-5 and when ODMHSAS determines that the organization has met minimal compliance with each type of standard (i.e. Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards). To qualify for Certification, programs must meet the following:

(A) Demonstrate compliance with all Core Organizational Standards and with all Core Operational Standards as verified by ODMHSAS and within time-frames stipulated by ODMHSAS; and,

(B) For a two (2) year certification, demonstrate compliance with at least 75% of all Quality Clinical Standards on the initial site review, and file an acceptable plan of correction and demonstrate compliance with 100% of Quality Clinical Standards, as verified by ODMHSAS in accordance 450:1-9-7.1 and 450:1-9-7.3.

(C) Programs with fewer than five (5) active cases for which clinical records could be reviewed must meet the requirements in (B) above, but can be considered for no more than a one (1) year certification.

(D) Community Residential Mental Health Programs can be considered for no more than a one (1) year certification.

(E) Programs awarded a Probationary Certification are not eligible for Certification under the conditions described in 450:1-9-5.7(3) until all conditions of 450:1-9-5.7(2) have been satisfied.

(4) Certification with distinction. Certification with Distinction may be awarded for up to three (3) years by ODMHSAS in accordance with applicable chapters as stipulated in 450:1-9-5 for programs seeking renewal of previously awarded certification when ODMHSAS verifies all of the following minimal conditions are satisfied.

(A) Programs must have provided services with an approved ODMHSAS Certification as described in 450:1-9-5.4(3) for one (1) year or longer in addition to the time services were provided under an approved Permit for Temporary Operations or a Probationary Certification.

(B) Programs must demonstrate compliance with all Core Organizational Standards and with all Core Operational Standards as verified by ODMHSAS; and,

(C) Programs must also demonstrate compliance with at least 90% of all Quality Clinical Standards on the initial renewal site visit and review as verified by ODMHSAS. Compliance may be determined during initial site reviews or during additional site reviews following the implementation of a plan of correction as required ODMHSAS, in accordance 450:1-9-7.1 and 450:1-9-7.3.

(D) Programs for which ODMHSAS determines compliance with all standards as required in (a), (b), and (c) may be considered for Certification with Distinction for a three (3) year period.

(E) ODMHSAS may refund certification renewal application fees for organizations that demonstrate 100% compliance with all standards (i.e. Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards) during the initial renewal site visit and review.

(F) Community Residential Mental Health Programs can be considered for no more than a one (1) year Certification with Distinction.

(G) Programs awarded a Probationary Certification are not eligible for Certification under the conditions described in 450:1-9-5.7(4) until all conditions of 450:1-9-5.7(2) have been satisfied.

(5) Certification with special distinction. Certification with Special Distinction may be awarded for up to three (3) years by ODMHSAS in accordance with applicable chapters as stipulated in 450:1-9-5 for programs seeking renewal of previously awarded certification when
ODMHSAS verifies all of the following minimal conditions are satisfied.

(A) The program must meet all conditions for Certification with Distinction as outlined in 450:1-9-5.7(a)(4); and
(B) The program has attained national accreditation (COA, CARF, or TJC) for the services to which ODMHSAS Certification applies.
(C) Certification with Special Distinction will be reduced by ODMHSAS to Certification with Distinction by ODMHSAS if during the certification period for which the Special Distinction was approved, the program fails to maintain national accreditation status.
(D) ODMHSAS may refund certification renewal application fees for organizations that demonstrate 100% compliance with all standards (i.e., Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards) during the initial renewal site visit and review.
(E) Community Residential Mental Health Programs can be considered for no more than one (1) year Certification with Distinction.
(F) Programs awarded a Probationary Certification are not eligible for Certification under the conditions described in 450:1-9-5.7(a)(4) until all conditions of 450:1-9-5.7(a)(2) have been satisfied.

(b) Permits for Temporary Operations granted to applicants for initial certification of a facility, location, or level of service shall be for a period of six (6) months and shall become effective immediately upon approval by the ODMHSAS Board, the Commissioner or designee.
(c) Certification, other than Permits for Temporary Operations, granted to an applicant shall become effective the first day of the month following the date of the action by the Board, provided however, the Board may waive this requirement and make the Certification effective immediately.

450:1-9-5.8. Types and duration of certification of individuals

(a) Certification for organizations and individuals providing alcohol and drug abuse course instruction or assessments will be in accordance with requirements and procedures stipulated in OAC 450:21.
(b) Certification for Behavioral Health Case Managers will be in accordance with requirements and procedures stipulated in OAC 450:50.
(c) Certification for Recovery Support Specialists will be done in accordance with requirements and procedures stipulated in OAC 450:53.

450:1-9-5.9. Additional conditions related to certification

(a) Certification granted by ODMHSAS is not transferable. A change of the ownership of a facility automatically terminates any certification status, requiring application for certification by the new ownership.

(1) If the certified facility is owned by a corporation the following applies:

(A) If the corporation is not-for-profit, a change in membership of the Board of Directors of more than fifty percent (50%) of the Directors in three (3) or less calendar months, unless such change was caused by the normal expiration of terms in accordance with the bylaws of the Board of Directors, shall require the facility to be recertified.
(B) If the corporation is other than not-for-profit, a change in the ownership of more than forty per cent (40%) of the stock in the corporation from the owners at the beginning of the period of certification shall require the facility to be recertified.

(2) It is the responsibility of the facility to notify the ODMHSAS of the occurrence of either of the conditions requiring recertification and to request the application materials for recertification.

(b) Organizations granted certification, including Permits for Temporary Operation, shall only publically refer to ODMHSAS Certification in relationship to the specific services, locations, and dates applicable to each currently granted ODMHSAS Certification. This includes all published materials, electronic media, and information posted within a facility. Failure to adhere to this restriction can be cause for action related to Certification in accordance with 1-5-4.
(c) ODMHSAS shall conduct at least one unannounced additional certification site visit during each one (1) year term of a program granted Probationary Certification and each program granted 1-Year Certification.

(1) A site visit report will be supplied to the program or facility within five (5) days of the site visit unless precluded by extenuating circumstances.

(2) If deficiencies are noted, the program or facility must file a Plan of Correction addressing all deficiencies within ten (10) days of receipt of the report.

(3) Deficiencies verified during the unannounced site visit that indicate danger to the health, safety and/or welfare of the clients will result in immediate suspension and/or revocation.

(d) Certification may be suspended or revoked with the basis for such action being delineated in Section 450:1-9-9 of this Subchapter.

450:1-9-6. Procedures for application for certification

(a) Applications for certification as a community mental health center, community residential mental health facility, community-based structured crisis center, comprehensive community addiction recovery centers, mental illness service programs, eating disorder treatment program, alcohol and drug treatment program, program of assertive community treatment, gambling addiction treatment program, and narcotic treatment program must be made to ODMHSAS in writing on a form and in a manner prescribed by the Commissioner of ODMHSAS and include the following:

(1) A fully completed ODMHSAS application for certification form signed by authorized officials;
(2) The necessary written documentation or supporting evidence required on the application for certification form; and

(3) The required certification fee in the form of a check or money order, payable to the Oklahoma Department of Mental Health and Substance Abuse Services.

(4) The following fees are required:
   (A) Application fee for all Treatment Programs is $1,000 per certification period.
   (B) Application fee for Community Residential Mental Health Programs is $100 per certification period.

(5) The application for certification form, required written documentation and fee must be submitted to Oklahoma Department of Mental Health and Substance Abuse Services, Provider Certification Division, P.O. Box 53277, Oklahoma City, Oklahoma 73152-3277.

(6) The application may require a listing of all services provided by the applicant, as well as specifics about the applicant including but not limited to governing authority, administrative, fiscal, proof of status as a business entity recognized by the State of Oklahoma, Secretary of State, all locations or sites where applicant will provide services and types of services to be provided.

(7) The application must include a listing of key personnel responsible for business and clinical operations of the facility. At a minimum, the application will require a listing of the following, along with current contact information:
   (A) Agency director;
   (B) Business director or financial officer;
   (C) Clinical director, currently licensed in the clinical area(s) for which certification is sought.
      (i) If both substance use disorder treatment and mental health treatment services will be provided by the entity, the Clinical Director must have evidence of dual license or additional training in the area for which they are not currently licensed.
      (ii) The facility must also provide evidence that the Clinical Director will be employed to serve as Clinical Director a minimum of ten (10) hours per week.

(8) ODMHSAS may refund certification fees based on exemplary performance during the Certification process for which the application has been submitted and based on guidelines established by ODMHSAS.

(b) Applications for certification or credentials as an individual provider must be made to ODMHSAS in writing on a form and in a manner prescribed by the Commissioner of ODMHSAS and, as applicable, in accordance with specific requirements stipulated in the following chapters of OAC 450:21, 450:22, OAC 450:50, and OAC 450:53 for Recovery Support Specialist, in accordance with application instructions stipulated by ODMHSAS.

(c) Failure to provide required materials within sixty (60) days of receipt of the application will result in a denial of the application.

450:1-9-7. Procedures for completion of the Permit for Temporary Operations certification process

(a) Completion of the certification process for a Permit for Temporary Operations will be done in cooperation between the applicant and ODMHSAS staff, and consists of the following:

(1) Each organization pursuing ODMHSAS certification shall initially apply for a Permit for Temporary Operations.

(2) Upon receipt of an application ODMHSAS will provide all applicants for a Permit for Temporary Operations a document listing the Core Organizational Standards, Core Operational Standards and Quality Clinical Standards required for a Permit for Temporary Operations. For facilities or programs that have provided clinical services for 30 days or longer, at the time of the initial application, ODMHSAS may also review applicable Quality Clinical Standards.

(3) The application shall be reviewed for completeness by ODMHSAS staff. If the application is deemed complete, a site review of the facility or program will be scheduled and completed. Failure to provide required materials within 60 days of receipt of the application will result in a denial of the application.

(4) Any deficiencies of applicable Core Organizational Standards and Core Operational Standards, and Quality Clinical Standards cited as a result of the site visit or subsequent review(s) of documents requested by ODMHSAS will be identified and a report will provided to the facility by ODMHSAS within five (5) working days of the site visit unless precluded by extenuating circumstances.

(5) The facility will have ten (10) working days from receipt of the deficiency report to correct deficiencies related to Core Organizational and Core Operational Standards and provide to ODMHSAS proof of compliance. ODMHSAS may conduct an additional site visit(s) to verify proof of compliance.

(6) If any pending deficiencies in Core Organizational Standards and Core Operational Standards are identified following this ten (10) day correction period, the program will have five (5) additional working days from receipt of any subsequent report to correct and verify compliance with any pending deficiencies.

(7) The following additional procedures will apply to programs or facilities reviewed for Quality Clinical Standards pursuant to an application for Permit for Temporary Operation as referenced in 1-9-7 (2) above.

   (A) The facility will also have ten (10) working days from receipt of the report to submit a plan for correction related to cited deficiencies in Quality Clinical Standards. The plan of correction will indicate the earliest date by which ODMHSAS should schedule an additional site visit or documentation review to determine compliance with Quality Clinical Standards for which deficiencies were cited but not more than twenty (20) working days from receipt of report as referenced in (5) above.
(B) Any deficiencies of applicable standards identified during the additional site visit or review referenced in (A) above will be identified by ODMHSAS and included in a report provided to the facility by ODMHSAS within three (3) working days of the site visit or review unless precluded by extenuating circumstances. Facilities for which ODMHSAS cannot determine compliance with all pending Clinical Standards during the follow up site visit or review referenced in (A) above may request ODMHSAS to complete one additional site visit or review prior to the finalization of a certification report. Facilities desiring this additional review must do so in writing to the Director of Provider Certification within three (3) working days of receipt of the follow up report referenced in (A) above and indicate the earliest date by which ODMHSAS should schedule the final review but not more than fifteen (15) working days from receipt of report as referenced in (A) above.

(8) Facilities for which ODMHSAS can verify compliance with all applicable Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards, within the timeframes specified in (3) through (7) above may be considered for Permit for Temporary Operation in accordance with guidelines established in 450:1-9-5.1 through 450:1-9-5.7.

(9) Anytime, during the process outlined above, ODMHSAS may request one or more written plan(s) of correction in a form and within a timeframe designated by ODMHSAS.

(10) Failure of any applicant for a Permit for Temporary Operation to clear deficiencies of all applicable Standards within timeframes stipulated in (3) through (7), shall result in a notice of denial of the application for a Permit for Temporary Operations.

(b) Additional certification procedures related to a Permit for Temporary Operations.

(1) Re-application for a Permit can be accepted no sooner than six months after issuance of a notification of denial.

(2) If an applicant fails a second time to satisfy requirements for a Permit for Temporary Operations as stipulated in 450:1-9-7(a)(8), ODMHSAS can accept an additional re-application no sooner than twelve (12) months from the time of the second notification of denial.

(3) Organizations granted a Permit for Temporary Operations must achieve a subsequent level of ODMHSAS certification prior to the expiration of a Permit for Temporary Operations. Failure to do so will result in a cancellation by ODMHSAS of the Permit for Temporary Operations. ODMHSAS will provide notice of the cancellation and stipulate to the organization that it is must discontinue services subject to any statutory provisions that mandate the applicable ODMHSAS Certification. Re-application for a Permit for Temporary Operations, following a cancellation by ODMHSAS or by the organization to which a Permit was issued, may occur after six months and in accordance with the requirements of 450:1-9-7 and 450:1-9-12.

450:1-9-7.1. Procedures for completion of additional certification processes subsequent to a Permit for Temporary Operations

(a) The following procedures apply for organizations awarded Permit for Temporary Operation pursuant to 450:1-9-7 that elect to progress to an additional certification by ODMHSAS. The process outlined below will be done in cooperation between the applicant and ODMHSAS staff, and consists of the following:

(1) Ninety (90) days prior to the expiration of a Permit for Temporary Operations, ODMHSAS will notify the permitted facility that a supplemental certification application form must be completed so the organization can be reviewed for a new certification level. Along with a request for a supplemental certification application, ODMHSAS will provide a document listing Quality Clinical Standards applicable to the new certification level. The document will also indicate the Core Organization Standards and Core Operational Standards for which continued compliance must be verified.

(2) Each organization desiring to be considered for certification subsequent to being awarded a Permit for Temporary Operations will complete a supplemental certification application form at least sixty (60) days prior to the expiration of the Permit for Temporary Operations.

(3) In the event an organization, after being awarded a Permit for Temporary Operations, fails to supply the supplemental certification application in accordance with (1) and (2) above or elects to not pursue further ODMHSAS certification, the Permit for Temporary Operations will be allowed to expire.

(4) No additional fee, beyond that required for a Permit for Temporary Operation will be required along with the supplemental certification application.

(5) The application shall be reviewed for completeness by ODMHSAS staff. If the application is deemed complete, a site review of the facility or program will be scheduled and completed.

(6) Any deficiencies of applicable standards identified as a result of the subsequent certification site visit or documentation reviews requested by ODMHSAS will be identified and a report will provided to the facility by ODMHSAS within five (5) working days of the site visit unless precluded by extenuating circumstances.

(7) The facility will have ten (10) working days from receipt of the report to correct deficiencies of all Core Organizational Standards and Core Operational Standards and provide ODMHSAS proof of compliance with these standards. ODMHSAS may require an additional site visit(s) to determine of compliance with Core Organizational Standards and Core Operational Standards. The facility will have no more than twenty (20) working days from the certification site visit referenced in (6) above to achieve complete compliance with all Core Organizational Standards and Core Operational Standards.
in an entity being awarded Certification, Certification with Distinction, or Certification with Special Distinction. The process will be done in cooperation between the applicant and ODMHSAS staff, and consists of the following:

1. Ninety (90) days prior to the expiration of a current Certification, except a Permit for Temporary Operations, ODMHSAS will provide the certified facility with a notice of certification expiration and advise the facility that a renewal certification application form must be completed so the organization can be reviewed for consideration for a renewal of certification. Along with the notice of certification expiration, ODMHSAS will provide a document listing Core Organization Standards, Core Operational Standards, and Quality Clinical Standards potentially applicable to the renewed certification.

2. Each organization desiring to renew Certification must submit a completed certification application form, fees and other required materials in accordance with 450:1-9-6 and at least sixty (60) days prior to the expiration of the current Certification.

3. In the event an organization, after being notified of the Certification expiration in accordance with (1) and (2) above fails to submit the renewal certification application, fees, or other materials as referenced in (2) above, the current Certification will be allowed to expire.

4. The application shall be reviewed for completeness by ODMHSAS staff. If the application is deemed complete, a site visit of the facility or program will be scheduled and completed.

5. Any deficiencies of applicable standards identified as a result of the renewal site visit or subsequent review(s) of documents requested by ODMHSAS will be identified and a report will provided to the facility by ODMHSAS within five (5) working days of the initial renewal site visit unless precluded by extenuating circumstances.

6. The facility will have ten (10) working days from receipt of the report to correct deficiencies of all Core Organizational Standards and Core Operational Standards and provide to ODMHSAS proof of compliance with these standards. ODMHSAS may require an additional site visit to verify proof of compliance of Core Organizational Standards and Core Operational Standards. If deficiencies continue, the facility will have no more than twenty (20) working days from the initial renewal site visit to achieve complete compliance with all Core Organizational Standards and Core Operational Standards.

7. The facility will also have ten (10) working days from receipt of the report to submit a plan for correction related to cited deficiencies in Quality Clinical Standards. The plan of correction will indicate the earliest date by which ODMHSAS should schedule an additional site visit or documentation review to determine compliance with Quality Clinical Standards for which deficiencies were cited but not more than twenty (20) working days from receipt of report as referenced in (5) above. The site visit may or may not be conducted in conjunction with a site visit to verify compliance with pending Core Organizational Standards, and Core Operational Standards.
(8) Any deficiencies of applicable standards identified during the additional site visit or review referenced in (7) above will be identified by ODMHSAS and included in a report provided to the facility by ODMHSAS within three (3) working days of the site visit or review unless precluded by extenuating circumstances. Facilities for which ODMHSAS cannot determine compliance with all pending Clinical Standards during the follow up site visit or review referenced in (8) above may request ODMHSAS to complete one additional site visit or review prior to the finalization of a report. Facilities desiring this additional review must do so in writing to the Director of Provider Certification within three (3) working days of receipt of the follow up report referenced in (8) above and indicate the earliest date by which ODMHSAS should schedule the final review but not more than fifteen (15) working days from receipt of report as referenced in (8) above.

(9) Facilities for which ODMHSAS can verify compliance with all applicable Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards, within the timeframes specified in 450:1-9-7.3 may be considered for renewal of Certification in accordance with guidelines established in 450:1-9-5.4 450:1-9-5.7.

(10) Anytime, during the process outlined above, ODMHSAS may request one or more written plan(s) of correction in a form and within a timeframe designated by ODMHSAS.

(11) If the applicant fails to submit a plan of correction within the required time frame, fails to submit a timely and adequate revised plan of correction, or fails to provide evidence of correction for all cited deficiencies, a recommendation to initiate revocation proceedings must be made to the Commissioner or designee. If the Commissioner or designee approves the initiation of revocation proceedings, the provisions of Subchapter 5 will be followed.

450:1-9-7.3. Additional certification procedures

(a) Site reviews. The following conditions will apply to site visits and other related certification reviews conducted by ODMHSAS.

(1) Initial, renewal or follow-up site reviews, based on the current certification status of the applicant, will be scheduled and conducted by designated representatives of the ODMHSAS at each location or site of the applicant.

(2) ODMHSAS may require materials be submitted to Provider Certification, in a form determined by ODMHSAS, prior to on-site visits to verify compliance with one or more applicable Core Organizational Standards, Core Operational Standards, and/or Quality Clinical Standards.

(3) One or more site review(s) may be conducted to determine compliance with prior deficiencies as well as with standards not applicable during the prior certification visit(s).

(4) A minimum number of consumer records, as determined by ODMHSAS, shall be made available for review to determine compliance with applicable Quality Clinical Standards. For organizations, unable to provide the required minimum of records, the current certification status, including a Permit for Temporary Operations, will be allowed to expire. ODMHSAS may require review of additional consumer records to assure a representative sample of records is evaluated to determine compliance with Quality Clinical Standards.

(5) A Site Review Protocol shall be completed during each certification review. Protocols shall contain the current ODMHSAS Standards and Criteria applicable to the facility.

(A) A facility must be prepared to provide evidence of compliance with each applicable standard.

(B) In the event the reviewer(s) identifies some aspect of facility operation that adversely affects consumer safety or health, the reviewer(s) shall notify the facility director and appropriate ODMHSAS staff. An immediate suspension of certification may be made by the Commissioner of ODMHSAS.

(b) Accreditation status. The ODMHSAS may accept accreditation granted by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation of Services for Families and Children, Inc. (COA), or the American Osteopathic Association (AOA) as compliance with certain specific ODMHSAS standards. For such to be considered, the facility shall make application and submit evidence to the ODMHSAS of current accreditation status. This evidence shall include documentation of the program or programs included in the most recent accreditation survey, including survey reports of all visits by the accrediting organization, any reports of subsequent actions initiated by the accrediting organization, any plans of correction, and the dates for which the accreditation has been granted.

(c) Deficiencies. A deficiency shall be cited for each rule of compliance with each applicable standard.

(d) Report to applicant and plan of correction.

(1) During the course of the certification process, and prior to determination of certification status, ODMHSAS staff shall report the results of the certification review to the facility. The facility shall receive written notice of the deficiencies in a Certification Report in accordance with 450:1-9-7, 450:1-9-7.1, and 450:1-9-7.3.

(2) The facility may be required to submit a written plan of correction as determined by 450:1-9-7, 450:1-9-7.1, and 450:1-9-7.3. Approval of the plan of correction by Provider Certification may be required before a final report of findings can be presented to ODMHSAS or the Board.

(3) If a request for a revised plan of correction is necessary, the facility must submit an acceptable plan of correction within the required time frame to continue the certification process. Failure to submit a timely and adequate revised plan of correction shall result in either a notice of denial of the application, expiration of certification, or revocation of the certification status, as applicable.

(e) Notification of consideration and possible action for certification.

(1) After consideration of materials requested by ODMHSAS pursuant to certification procedures, and
completion of the necessary review(s), ODMHSAS staff shall prepare a report that summarizes findings related to compliance with applicable certification standards.

(2) Reports regarding applications for Permit for Temporary Operations will be forwarded to the ODMHSAS Board, the Commissioner, or designee.

(3) Reports for all other Certification applications will be forwarded to the ODMHSAS Board for consideration or in accordance with procedures outlined in OAC 450:21, 450:22, or OAC 450:50 or OAC 450:53.

(4) Prior to the ODMHSAS staff's presentation of its report related to the applicant's certification to the Board or the Commissioner or designee the ODMHSAS staff shall notify the applicant of:

(A) the findings included in the report, and
(B) the date and time of the Board meeting at which the facility's application, and the certification will be considered.

(5) Achievement of certain scores is a prerequisite for consideration of a specific certification status but may not be the sole determinant. Individual deficiencies that meet the criteria in 450:1-9-9 may be grounds for suspending or revoking certification or denying applications for certification.

(6) Consideration of certification may be deferred while additional information regarding a facility's compliance status is reviewed.

(7) The minimum conditions for compliance that must be verified by ODMHSAS for consideration of a certification status shall be stipulated in 450:1-9-5.1, 450:1-9-5.7.

(f) Recommendations for revocation of certification. In the event ODMHSAS can not verify compliance with applicable certification standards in accordance with 450:1-9-5.1, 450:1-9-5.7, except for Permits for Temporary Operations, ODMHSAS shall forward recommendation for revocation of certification to the Commissioner or designee. If the Commissioner or designee approves a recommendation to revoke certification, an individual proceeding shall be initiated pursuant to Subchapter 5. Applicants unable to demonstrate compliance with standards required for Permit for Temporary Operation are not subject to the provisions for revocation and are simply denied the Permit as stipulated in 450:1-9-7.

**450:1-9-7.4. Actions on Non-Certified Providers**

If at the initial site review it is found the facility is providing services prior to the granting of an ODMHSAS Certification status, applicable for those services being provided and in violation of statutory requirements, including prior to the granting of a Permit for Temporary Operations, the following actions will be taken:

(1) The review will be continued and will include a review of all applicable Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards.

(2) The facility must comply with the requirements cited in 450:1-9-5. to continue the certification process. An organization providing services statutorily subject to ODMHSAS Certification prior to the issuance of a Permit for Temporary Operations cannot be considered for a Permit for Temporary Operations specific to those services. Such organizations are eligible only for a consideration of a Probationary Certification.

(3) The applicant must comply within twenty (20) working days of the initial certification visit, with all applicable Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards for a report for consideration of Probationary Certification to be made to the Board. Failure to achieve the required compliance level for Probationary Certification shall result in a denial for Certification and an Order issued to cease the provision of services, if applicable.

(4) If the applicant achieves the required compliance level within the required time frame, a Probationary Certification may be considered for no more than one (1) year.

(5) Continued certification after the Probationary Certification period of one year will require the submission of a new application for each of the next two (2) years. The requirements in 450:1-9-5.1(a)(2), 450:1-9-5.7(a)(3) shall apply. If the applicant achieves the required compliance level within the required time frame, a Probationary Certification can be considered for no more than one (1) year for each of the next two years.

[OAR Docket #21-429; filed 6-14-21]

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**TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES**

**CHAPTER 16. STANDARDS AND CRITERIA FOR COMMUNITY RESIDENTIAL MENTAL HEALTH FACILITIES**

[OAR Docket #21-430]

**RULEMAKING ACTION:**

PERMANENT final adoption

**RULES:**

450:16-1-1 [AMENDED]
450:16-1-2 [AMENDED]

Subchapter 3. Governing Authority/Owneership [REVOKED]
450:16-3-1 [REVOKED]

Subchapter 7. Critical Incidents [REVOKED]
450:16-7-1 [REVOKED]

Subchapter 9. Licensure and Compliance
450:16-9-1 [AMENDED]

Subchapter 11. Safety [REVOKED]
450:16-11-1 [REVOKED]
450:16-11-2 [REVOKED]

Subchapter 13. Quality of Life
450:16-13-1 [REVOKED]
450:16-13-6 [REVOKED]
450:16-13-21 [REVOKED]
450:16-13-23 [REVOKED]
450:16-13-26 [REVOKED]
450:16-13-27 [REVOKED]
450:16-13-29 [REVOKED]
450:16-13-33 [REVOKED]

Subchapter 17. Security and Disclosure of Resident Information [REVOKED]
450:16-17-1 [REVOKED]
450:16-17-2 [REVOKED]
450:16-17-3.1 [REVOKED]
450:16-17-5 [REVOKED]
Subchapter 19. Client Records [REVOKED]
450:16-19-1 [REVOKED]
450:16-19-2 [REVOKED]
Subchapter 21. Personnel, Staffing and Training
450:16-21-2 [REVOKED]

AUTHORITY:
Oklahoma Board of Mental Health and Substance Abuse Services; 43A O.S. §§ 2-101 and 3-315

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Incorporated standards:
310:680

Incorporating rules:
450:16-9-1

Availability:
9:00 a.m. to 5:00 p.m., Monday through Friday at the Oklahoma Department of Mental Health and Substance Abuse Services, 2000 N. Classen, Suite 2-600, Oklahoma City, OK 73106, 405-271-9200

GIST/ANALYSIS:
The proposed rule revisions to Chapter 16 amend language to remove duplicative language that is either addressed under another title or addressed under new proposed language in Chapter 1. The intent is to consolidate duplicative language to increase consistency and reduce regulatory language in accordance with Executive Order 2020-03.

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., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 15, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS

450:16-1-1. Purpose
This chapter sets forth the Standards and Criteria used for determining certification of mental health residential care facilities. (43A O.S. § 3-315) The rules regarding factors relating to the certification processes, including, but not necessarily limited to, applications, fees, requirements for, levels of, required scoring levels, and administrative sanctions, are found in OAC 450:1, Subchapter 9. Rules outlining general certification qualifications applicable to facilities and organizations certified under this Chapter are found in OAC 450:1-9-5 through OAC 450:1-9-5.3.

450:16-1-2. Definitions
The following words or terms when used in this chapter shall have the following meaning, unless the context clearly indicates otherwise:

"Abuse" means the causing or permitting of harm or threatened harm to the health, safety, or welfare of a resident by a caretaker responsible for the resident's health, safety, or welfare, including but not limited to: non-accidental physical injury or mental anguish; sexual abuse; sexual exploitation; use of mechanical restraints without proper authority; the intentional use of excessive or unauthorized force aimed at hurting or injuring the resident; or deprivation of food, clothing, shelter, or healthcare by a caretaker responsible for providing these services to a resident.

"ADL" means activities of daily living.

"Administrator" means the person who is in charge of a community residential mental health facility and who devotes at least one-third (1/3) of his or her full working time to on-the-job supervision of the community residential mental health facility.

"Adults who have a serious mental illness" means persons eighteen (18) years of age or older who show evidence of points (A), (B) and (C) below:

(A) The disability must have persisted for six months and be expected to persist for a year or longer.
(B) A condition or serious mental illness as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious mental illness.
(C) The adult must exhibit either (i) or (ii) below:
   (i) Psychotic symptoms of a serious mental illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or
   (ii) Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):
      (I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.
      (II) Impairment in community function manifested by a consistent lack of appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):

(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers.

(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations.

(V) Impairment in functioning at school or work manifested by the inability to pursue educational or career goals.

"Clubhouse" means a psychiatric rehabilitation program currently certified as a Clubhouse through the International Center for Clubhouse Development (ICCD).

"CMHC" means community mental health center.

"Continuity of care agreements" means an agreement between the community residential mental health facility and providers of critical and comprehensive community based behavioral health services, including but not limited to a provider of inpatient behavioral health care and a local provider of community-based behavioral health services. Continuity of care agreements shall specify the responsibility of each entity related to assuring continuous and coordinated care on behalf of the residents.

"Co-occurring disorder" means any combination of mental health and substance abuse symptoms or diagnosis in a resident.

"Corporeal punishment" means any physical punishment including, but not limited to punching, slapping, kicking, spanking, or whipping.

"Crisis stabilization" means emergency, psychiatric, and substance abuse services for the resolution of crisis situations and may include placement of an individual in a protective environment, basic supportive care, and medical assessment, and, if needed, referral to an ODMHSAS certified facility having nursing and medical support available.

"Critical incident" means an occurrence or set of events inconsistent with the routine operation of the community residential mental health facility or the routine care of a resident. Critical incidents specifically include but are not necessarily limited to the following: adverse drug events; self-destructive behavior; deaths and injuries to residents, staff and visitors; medication errors; residents that are absent without leave (AWOL); neglect or abuse of a resident; fire; unauthorized disclosure of information; damage to or theft of property belonging to a resident or the community residential mental health facility; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or results.

"Direct care staff" means any staff member who, in the performance of his or her routine duties has contact with residents and is required to meet the training requirements for community residential mental health staff as listed in the "Standards and Criteria for Community Mental Health Residential Facilities".

"Enhanced residential care facility" means a community residential mental health facility meeting all statutory and regulatory requirements of the ODMHSAS and OSDH and which specifically serves only "Adults who have a serious mental illness" who cannot be accommodated in a non-enhanced community residential mental health facility.

"General psychiatric rehabilitation program" or "PSR" means a type of psychiatric rehabilitation program which focuses on long term recovery and maximization of self-sufficiency, role function and independence. General psychiatric rehabilitation programs may be organized within a variety of structures which seek to optimize the participants' potential for occupational achievement, goal setting, skill development and increased quality of life.

"Health care services" means services provided by health care professionals and includes, but is not limited to dentists, optometrists, and podiatrists.

"Independent living skills, assistance in development of" means all activities directed at assisting individuals in the development of skills necessary to live and function within the community.

"Medication administration technician course" is an educational program from an institute of higher learning which has been reviewed and approved by the OSDH pursuant to 310:680-11.1 and affords the student a certificate of training in the administration of medication and measuring and documenting vital signs.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"Oklahoma Administrative Code" or "OAC" means the publication authorized by 75 O.S. § 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A) (1) (a) and maintained in the Office of Administrative Rules.

"OSDH" means Oklahoma State Department of Health.

"Personal care" means assistance with meals, dressing, movement, bathing, or other personal needs, or general supervision of the physical and mental well-being of a person who is currently unable to maintain a private, independent residence, or who has limited abilities in the managing of his or her person, whether or not a guardian has been appointed for such person.

"PICIS" is a comprehensive management information system based on national standards for mental health and substance abuse databases. It is a repository of diverse data elements that provide information about organizational concepts, staffing patterns, client profiles, program or treatment focus, and many other topics of interest to clinicians, administrators and consumers. It includes unique identifiers for agencies, staff and clients that provide the ability to monitor the course of client services throughout the statewide ODMHSAS network. PICIS collects data from hospitals, community mental health centers, substance abuse agencies, domestic violence service providers, community residential mental health facilities, prevention programs, and centers for the homeless which are operated or funded in part by ODMHSAS.
"Recovery" means a journey of healing and transformation enabling a person with a mental health and/or substance abuse diagnosis to live a meaningful life in the community of his or her choice while striving to achieve his or her full potential. The process of recovery leads individuals toward the highest level of autonomy of which they are capable. Key characteristics of recovery include:

(A) Recovery is self directed, personal and individualized (not defined by treatment providers or agencies);

(B) Recovery is holistic. Recovery is a process through which one gradually achieves greater balance of mind, body and spirit in relation to other aspects of one's life that can include family, work and community;

(C) Recovery moves beyond symptom reduction and relief (i.e. meaningful connections in the community, overcoming specific skill deficits, establishing a sense of quality and well-being);

(D) Recovery is both a process of healing (regaining) and a process of discovery (moving beyond);

(E) Recovery encompasses the possibility for individuals to test, make mistakes and try again; and

(F) Recovery can occur within or outside the context of professionally directed treatment.

"Registered/licensed dietitian" means a person who is registered as a dietitian by the American Dietetic Association and licensed by the Oklahoma Board of Medical Licensure and Supervision.

"Resident" means a person residing in a residential care facility certified by ODMHSA.

"Resident committee" or "Resident government" means any established group within the facility comprised of residents, led by residents and meets regularly to address resident concerns to support the overall operations of the facility.

"Residential care facility" or "RCF" means any house, home, establishment or institution licensed pursuant to the provisions of the Oklahoma Residential Care Home Act 63 O.S., §§ 1-819 through 1-840, other than a hotel, fraternity or sorority house, or college or university dormitory, is certified pursuant to 43 O.S. § 3-315 as a Community Residential Mental Health Facility and offers or provides residential accommodations, food service and supportive assistance to its residents or houses any resident requiring supportive assistance that are ambulatory, essentially capable of managing their own affairs and not routinely requiring nursing care or intermediate care.

"Restraint" refers to manual, mechanical, and chemical methods that are intended to restrict the movement or normal functioning of a portion of the individual's body.

"Seclusion" means the placement of an individual or individuals alone in a room or other area from which egress is prevented by a physical barrier.

"Sentinel event" is a type of critical incident that is an unexpected occurrence involving the death or serious physical or psychological injury to a consumer, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a consumer. These events signal the need for immediate investigation and response. Sentinel events include, but are not limited to: suicide, homicide, criminal activity, assault and other forms or violence, including domestic violence or sexual assault, and adverse drug events resulting in serious injury or death.

"Socialization activities" means all activities which encourage interaction and the development of communication, interpersonal, social and recreational skills, and can include client education.

"Special need (persons with)" means any persons with a condition which is considered a disability or impairment under the "American with Disabilities Act of 1990" including, but not limited to the deaf or hard of hearing, visually impaired, physically disabled, developmentally disabled, persons with disabling illness, persons with mental illness. See "Americans with Disabilities Handbook," published by U.S. Equal Employment Opportunity Commission and U.S. Department of Justice.

"Supportive assistance" means the service rendered to any person which is sufficient to enable the person to meet an adequate level of daily living. Supportive assistance includes but is not limited to housekeeping, assistance in the preparation of meals, assistance in the safe storage, distribution and administration of medications, and assistance in personal care as is necessary for the health and comfort of such person. The term "supportive assistance" shall not be interpreted or applied so as to prohibit the participation of residents in housekeeping or meal preparation tasks as a part of the written treatment plan for the training, habilitation or rehabilitation of the resident prepared with the participation of the resident, the mental health or drug or alcohol services case manager assigned to the resident and the administrator of facility, or his or her designee. Supportive assistance shall not include medical service.

"Volunteer" means any individual providing direct services to residents, and who is not on the facility's payroll, but fulfills a defined role within the facility. This definition does not include special entertainment/visiting groups.

**SUBCHAPTER 3. GOVERNING AUTHORITY/OWNERSHIP [REVOKED]**

450:16-3-1. Responsibility [REVOKED]

(a) An RCF shall have either a governing authority, or owner, having overall responsibility for the operation of the facility, including all components and services.

(b) Compliance with 450:16-3-1 shall be determined by a review of Oklahoma Department of Health Licensure, ODMHSA certification documentation, or other documentation which may be supplied by the RCF.

**SUBCHAPTER 7. CRITICAL INCIDENTS [REVOKED]**
Permanent Final Adoptions

450:16-7-1. Critical incidents [REVOKED]
(a) The RCF shall have written policies and procedures requiring documentation and reporting of critical incidents to ODMHSAS.
(b) The documentation of critical incidents shall contain, at a minimum:
   (1) Facility name and signature of the person(s) reporting the incident;
   (2) Names of the resident(s), or staff member(s) involved;
   (3) Time, date, and physical location of the incident;
   (4) Time and date incident was reported and name of person within the facility to whom it was reported;
   (5) Description of incident;
   (6) Severity of each injury, if applicable. Severity shall be indicated as follows:
      (A) No off-site medical care required or first aid care administered on-site;
      (B) Medical care by a physician or nurse or follow-up attention required; or
      (C) Hospitalization or immediate off-site medical attention was required;
   (7) Resolution or action taken, date resolution or action was taken, and signature of the facility administrator.
(c) Critical incidents shall be reported to ODMHSAS with specific timeframes, as follows:
   (1) Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax, or ODMHSAS designated electronic system, to ODMHSAS Provider Certification within twenty-four (24) hours of the incident being documented.
   (2) Critical incidents involving allegations constituting a sentinel event or resident abuse shall be reported to ODMHSAS immediately via telephone or fax, but not more than twenty-four (24) hours of the incident. If reported by telephone, the report shall be followed with a written report within twenty-four (24) hours.
(d) Compliance with 450:16-7-1 shall be determined by a review of RCF policy and procedures, and critical incident reports at the RCF and those submitted to ODMHSAS.

450:16-7-6. Annual fire and life safety inspection [REVOKED]
(a) RCFs shall be licensed by the Oklahoma State Department of Health in accordance with 63 O.S. §§1-820 through 1-840 and OAC 310:680-3-1.
(b) RCFs shall comply with all applicable state and federal regulations, including but not limited to OAC 310:680.
(c) RCFs shall provide evidence of such licensure and compliance to the Department.

SUBCHAPTER 11. SAFETY [REVOKED]

450:16-11-1. Emergency equipment [REVOKED]
(a) Residents and staff are entitled to a safe environment and accommodations. Staff of an RCF shall know the exact location, contents, and use of first aid supply kits and fire fighting equipment. First aid supplies and fire fighting equipment shall be located in areas in the RCF as designated by the State Fire Marshall or local authorities.
(b) The RCF shall have smoke detectors and each smoke detector shall be in working order.
(c) The RCF shall have battery back-up lights and the back-up lights shall be in working order.
(d) Compliance with 450:16-11-1 shall be determined by on-site observation a review of RCF training documentation; a review of OSDH reports; interviews of staff on duty, but not less than one (1) or more than five (5).

(a) The RCF shall obtain an annual fire and safety inspection from the State Fire Marshall or local authorities which documents approval for continued occupancy.
(b) Compliance with 450:16-11-2 shall be determined by a review of the RCF's annual fire and safety inspection report.

SUBCHAPTER 13. QUALITY OF LIFE

450:16-13-1. Meals [REVOKED]
(a) To insure proper diet and nutrition, residents shall be offered three (3) meals per day, seven (7) days per week.
(b) Meals must be well balanced and, if required by OSDH, approved by a registered/licensed dietitian.
(c) Residents shall receive meal servings adequate to satisfy nutritional needs and satisfy hunger.
(d) Residents must receive between-meal snacks at least one (1) time per day, unless contraindicated due to a special diet approved by a registered/licensed dietitian.
(e) Meals shall be served in a clean, sanitary environment.
(f) Compliance with 450:16-13-1 shall be determined by resident, staff and CMHC staff interviews; review of menus with documentation of dietician's approval; comparison of menu with meal served; review of OSDH inspection reports; review of documentation on staff training by dietician, if applicable; observation of at least one (1) meal; and review of activity and meal schedule.
450:16-13-6. Availability of liquids [REVOKED]
(a) The RCF shall make available for residents, outside of meal time, fresh water and ice upon request, or a refrigerated water fountain, in order to assure the prevention of dehydration.
(b) Compliance with 450:16-13-6 shall be determined by on-site observation, and resident, staff, and CMHC staff interviews.

(a) Residents shall be provided at minimum twenty-five dollars ($25.00) per month, in accordance with OAC 310:68-15-2.
(b) Compliance with 450:16-13-21 shall be determined by a review of RCF documentation, and resident, staff, and CMHC staff interviews.

450:16-13-23. Management of resident accounts [REVOKED]
(a) The RCF shall manage resident funds/accounts according to applicable regulations of the Oklahoma State Department of Health.
(b) Compliance with 450:16-13-23 shall be determined by a review of OSDH inspection reports.

450:16-13-26. Mattress and bed [REVOKED]
(a) Each resident's mattress and bed shall be clean and in good repair.
(b) Compliance with 450:16-13-26 shall be determined by on-site observation, and a review of OSDH reports.

450:16-13-27. Linens [REVOKED]
(a) The RCF shall provide bed linens, to minimally include, bedspreads, upper and bottom bed sheets, and pillow cases. Blankets should be provided if requested by the resident. All bed linens shall be clean and in good repair.
(b) The RCF shall provide pillows, which are clean and in good repair.
(c) The RCF shall provide sufficient clean towels and wash cloths to all residents as needed.
(d) Compliance with 450:16-13-27 shall be determined by on-site observation, and a review of OSDH reports.

450:16-13-29. Infestations of insects and vermin [REVOKED]
(a) The RCF shall be free from insects, spiders, and rodents.
(b) Compliance with 450:16-13-29 shall be determined by on-site observation, and a review of OSDH reports.

450:16-13-33. Cleanliness and condition [REVOKED]
(a) The indoor environment of the RCF shall be free from offensive odors, and free from any accumulation of dirt, rubbish, and dust.
(b) The exterior environment of the RCF shall be free from an accumulation of rubbish, and safety hazards.
(c) The furniture of the RCF shall be clean and in good repair.
(d) The floors of the RCF shall be clean and in good repair.
(e) The walls of the RCF shall be clean and in good repair.
(f) The ceilings of the RCF shall be clean and in good repair.
(g) Compliance with 450:16-13-33 shall be determined by on-site observation, and a review of OSDH reports.

450:16-17-1. Disclosure of resident information [REVOKED]
(a) Confidentiality of information concerning a resident is applicable throughout the RCF.
(1) Staff shall be made aware of conditions for release of information in compliance with state and federal laws and regulations.
(2) The RCF's written policies and procedures shall describe the conditions under which information on applicants or residents may be disclosed and the procedure for releasing such information. These conditions and procedures shall be in compliance with state and federal laws and regulations, which include, but are not limited to, 43A O.S. §1-109, and 3-423; 63 O.S. §1-502.2, 42 C.F.R., Part 2, and 45 C.F.R. §§160.101 et seq.
(b) Compliance with 450:16-17-1 shall be determined by a review of the RCF's written policies and procedures and documented staff training.

450:16-17-2. Responsibility for security of resident records [REVOKED]
(a) It shall be the responsibility of the RCF to safeguard any client information contained in the records against loss, theft, defacement, tampering, or use by unauthorized persons.
(b) Compliance with 450:16-17-2 shall be determined by a review of resident records, and RCF policy and procedure.

450:16-17-3. Confidentiality of mental health and drug or alcohol abuse treatment information [REVOKED]
Confidentiality policy, procedures, and practices must comply with federal and state law, guidelines, and standards, and with OAC 450:15-3-20.1 and OAC 450:15-30-60.

450:16-17-5. Employee and volunteer training in security and confidentiality of residents' information [REVOKED]
(a) Confidentiality of all information regarding the resident shall be included in orientation of new RCF employees and volunteers, and during staff development and in-service training of ongoing employees and volunteers. All employee and volunteer training shall emphasize verbal confidentiality, both inside and outside the RCF, regarding residents.
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(b) Compliance with 450:16-17-5 shall be determined by a review of the policy and procedures on confidentiality, personnel files; and orientation materials of new employees and volunteers.

SUBCHAPTER 19. CLIENT RECORDS

[REVOKED]

450:16-19-1. Components of record entry

[REVOKED]

(a) The RCF shall maintain an individual record for each resident. Each record entry shall be legible, dated, and signed by the RCF staff member making the entry.

(b) Compliance with 450:16-19-1 shall be determined by a review of resident records. Records entries reviewed shall include notes made regarding medical services and other professional services facilitated, etc.

450:16-19-2. Storage, retention, disposal/destruction of records [REVOKED]

(a) The RCF shall have written policies which define the storage retention and destruction of residents' records. These policies shall be compatible with the protection of residents' rights against unauthorized confidential information disclosures.

(b) Compliance with 450:16-19-2 shall be determined by a review of the storage of residents' records, and policy and procedures for retention and disposal/destruction of records.

SUBCHAPTER 21. PERSONNEL, STAFFING AND TRAINING

450:16-21-2. Direct care staff, minimum age

[REVOKED]

(a) All RCF direct care staff in the RCF shall be at least eighteen (18) years old.

(b) Compliance with 450:16-21-2 shall be determined by a review of applications for employment and copy of employee's driver's license or birth certificate.

[OAR Docket #21-430; filed 6-14-21]

TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

CHAPTER 17. STANDARDS AND CRITERIA FOR COMMUNITY MENTAL HEALTH CENTERS

[OAR Docket #21-431]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

450:17-1-1 [REVOKED]
Subchapter 15. Performance Improvement and Quality Management
450:17-15-1 [REVOKED]
450:17-15-5 [AMENDED]
Subchapter 19. Human Resources [REVOKED]
450:17-19-1 [REVOKED]
450:17-19-2 [REVOKED]
450:17-19-3 [REVOKED]
Subchapter 21. Staff Development and Training [REVOKED]
450:17-21-1 [REVOKED]
450:17-21-2 [REVOKED]
450:17-21-3 [REVOKED]
450:17-21-4 [REVOKED]
450:17-21-6 [REVOKED]
Subchapter 23. Facility Environment [REVOKED]
450:17-23-2 [REVOKED]
450:17-23-3 [REVOKED]
Subchapter 25. Governing Authority
450:17-25-1 [REVOKED]
Subchapter 27. Special Populations [REVOKED]
450:17-27-1 [REVOKED]
450:17-27-2 [REVOKED]

AUTHORITY:
Oklahoma Board of Mental Health and Substance Abuse Services; 43A O.S. §§ 2-101, 3-306, 3-306.1 and 3-315

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n/a

GIST/ANALYSIS:
The proposed rule revisions to Chapter 17 amend language to remove duplicative language that is addressed under new proposed language in Chapter 1 and language that is addressed in provider manuals or otherwise unnecessary. The intent is to consolidate duplicative language to increase consistency and reduce regulatory language in accordance with Executive Order 2020-03. Rule revisions also include amended language and removal of language to align with programmatic changes to Community Mental Health Centers, Health Homes, and Certified Community Behavioral Health Centers.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 15, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS

450:17-1-1. Purpose
(a) This chapter sets forth the Standards and Criteria used in the certification of Community Mental Health Centers and implements 43A O.S. § 3-306.1, which authorizes the Board of Mental Health and Substance Abuse Services, or the Commissioner upon delegation by the Board, to certify Community Mental Health Centers.
(b) The rules regarding the certification process including but not necessarily limited to application, fees and administrative sanctions are found in the Oklahoma Administrative Code, Title 450 Chapter 1, Subchapters 5 and 9.
(c) Rules outlining general certification qualifications applicable to facilities and organizations certified under this Chapter are found in OAC 450:1-9-5 through OAC 450:1-9-5.3.

450:17-1-2. Definitions
The following words or terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:
"Abuse" means the causing or permitting of harm or threatened harm to the health, safety, or welfare of a consumer by a staff responsible for the consumer's health, safety, or welfare, including but not limited to: non-accidental physical injury or mental anguish; sexual abuse; sexual exploitation; use of mechanical restraints without proper authority; the intentional use of excessive or unauthorized force aimed at hurting or injuring the resident; or deprivation of food, clothing, shelter, or healthcare by a staff responsible for providing these services to a consumer.
"Adults who have a Serious Mental Illness" means persons eighteen (18) years of age or older who show evidence of points of (A), (B) and (C) below:
(A) The disability must have persisted for six months and be expected to persist for a year or longer.
(B) A condition or Serious Mental Illness as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable Serious Mental Illness.
(C) The adult must exhibit either (i) or (ii) below:
(i) Psychotic symptoms of a Serious Mental Illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or
(ii) Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):
(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.
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(II) Impairment in community function manifested by a consistent lack of appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the criminal justice system.

(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers.

(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations.

(V) Impairment in functioning at school or work manifested by the inability to pursue educational or career goals.

"Advance Practice Registered Nurse" means a registered nurse in good standing with the Oklahoma Board of Nursing, and has acquired knowledge and clinical skills through the completion of a formal program of study approved by the Oklahoma Board of Nursing Registration and has obtained professional certification through the appropriate National Board recognized by the Oklahoma Board of Nursing. Advance Practice Registered Nurse services are limited to the scope of their practice as defined in 59 Okla. Stat. § 567.3a and corresponding rules and regulations at OAC 485:10-5-1 through 10-16-9.

"AOA" means American Osteopathic Association

"ASAM" means the American Society of Addiction Medicine.

"ASAM criteria" means the most current edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.

"Behavioral Health Home or BHH" means a specifically organized entity that functions within a currently ODMHSAS certified mental health treatment program organization to promote enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness. BHHs ensure comprehensive team based health care, meeting physical, mental health, and substance use disorder care needs. Health care is delivered utilizing a whole person, patient centered, coordinated care model for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED). Care coordination is provided for all aspects of the individual's life and for transitions of care the individual may experience.

"Case management services" means planned referral, linkage, monitoring and support, and advocacy provided in partnership with a consumer to assist that consumer with self sufficiency and community tenure and take place in the individual's home, in the community, or in the facility, in accordance with a service plan developed with and approved by the consumer and qualified staff.

"CARF" means Commission on Accreditation of Rehabilitation Facilities

"Child with Serious Emotional Disturbance" or "SED" means a child under the age of 18 who shows evidence of points of (A), (B) and (C) below:

(A) The disability must have persisted for six months and be expected to persist for a year or longer.

(B) A condition or Serious Emotional Disturbance as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance use disorders, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious emotional disturbance.

(C) The child must exhibit either (i) or (ii) below:

(i) Psychotic symptoms of a Serious Mental Illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(ii) Experience difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected development level):

(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(II) Impairment in community function manifested by a consistent lack of appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the juvenile justice system.

(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare or self or others (e.g., fire setting, serious and chronic destructive ness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent).

(V) Impairment in functioning at school manifested by the inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others).
"Children's Health Home Specialist" means an individual within the children’s Behavioral Health Home interdisciplinary team that will provide support, coaching and activities that promote good physical and mental health to individuals, families and groups. The focus of the Children's Health Home Specialist will include nutrition, healthy living habits, exercise, and preventing and/or managing chronic health conditions. Children’s Health Home Specialists must be credentialed by ODMHSAS as a Behavioral Health Aide or higher and complete training in Well Power or credentialed as a Wellness Coach through ODMHSAS.

"Chronic Homelessness" refers to an individual with a disabling condition who has either: (a) been continuously homeless for a year or more, or (b) has had at least 4 episodes of homelessness in the past 3 years. For this condition, the individual must have been on the streets or in an emergency shelter (i.e. not transitional housing) during these episodes. Chronic homelessness only includes single individuals, not families. A disabling condition is a diagnosable substance abuse disorder, serious mental illness, or developmental disability, including the co-occurrence of two or more of these conditions.

"Clinical privileging" means an organized method for treatment facilities to authorize an individual permission to provide specific care and treatment services to consumers within well-defined limits, based on the evaluation of the individual's license, education, training, experience, competence, judgment, and other credentials.

"Clubhouse" means a psychiatric rehabilitation program currently certified as a Clubhouse through the International Center for Clubhouse Development (ICCD).

"Community living programs" means either transitional or permanent supported housing for persons not in crisis who need assistance with obtaining and maintaining an independent living situation.

"Community-based Structured Crisis Center" or "CBSCC" means a program of non-hospital emergency services for mental health and substance abuse crisis stabilization as authorized by 43A O.S. §3-317, including, but not limited to, observation, evaluation, emergency treatment and referral, when necessary, for inpatient psychiatric or substance abuse services. This service is limited to CMHC's and Comprehensive Community Addiction Recovery Centers (CCARCs) who are certified by the Department of Mental Health and Substance Abuse Services or facilities operated by the Department of Mental Health and Substance Abuse Services.

"Community mental health center" or "CMHC" means a facility offering a comprehensive array of community-based mental health services, including but not limited to, inpatient treatment, outpatient treatment, partial hospitalization, emergency care, consultation and education; and, certain services at the option of the center, including, but not limited to, prescreening, rehabilitation services, pre-care and aftercare, training programs, and research and evaluation.

"Consultation" means the act of providing information or technical assistance to a particular group or individual seeking resolution of specific problems. A documented process of interaction between staff members or between facility staff and unrelated individuals, groups, or agencies for the purpose of problem solving or enhancing their capacities to manage consumers or facilities.

"Consumer" means an individual, adult, adolescent, or child— who has applied for, is receiving or has received evaluation or treatment services from a facility operated or certified by ODMHSAS or with which ODMHSAS contracts and includes all persons referred to in OAC Title 450 as client(s) or patient(s) or resident(s) or a combination thereof.

"Consumer advocacy" includes all activities on behalf of the consumer to assist with or facilitate resolution of problems in the acquisition of resources or services needed by the consumer.

"Consumer committee" or "consumer government" means any established group within the facility comprised of consumers, led by consumers and meets regularly to address consumer concerns to support the overall operations of the facility.

"Contract" means a document adopted by the governing authority of a treatment facility and any other organization, facility, or individual, which specifies services, personnel, or space to be provided by the program, as well as the monies to be expended in exchange.

"Co-occurring disorder" (COD) means any combination of mental health symptoms and substance use disorder symptoms or diagnoses that affect a consumer and are typically determined by the current Diagnostic and Statistical Manual of Mental Disorders.

"Co-occurring disorder capability" means the organized capacity within any type of program to routinely screen, identify, assess, and provide properly matched interventions to consumers with co-occurring disorders.

"Co-occurring disorder enhanced" means that the program (or subunit of the program) provides a specialized service designed for individuals with co-occurring disorders, usually with a higher level of available service capacity or intensity for the co-occurring substance use disorder than would be the case in a comparable co-occurring disorder capable program.

"Crisis Diversion" means an 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.

"Crisis Intervention" means actions taken, and services provided to address emergency psychological, physiological, and safety aspects of alcohol, drug-related, and mental health crises.

"Crisis stabilization" means emergency, psychiatric, and substance use disorder treatment services for the resolution of crisis situations and may include placement of an individual in a protective environment, basic supportive care, and medical assessment, and, if needed, referral to an ODMHSAS certified facility having nursing and medical support available.

"Critical incident" means an occurrence or set of events inconsistent with the routine operation of a facility, service setting, or otherwise routine care of a consumer. Critical incidents specifically include but are not necessarily limited to the following: adverse drug events; self-destructive behavior; deaths
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and injuries to consumers, staff and visitors; medication errors; residential consumers that are absent without leave (AWOL); neglect or abuse of a consumer; fire; unauthorized disclosure of information; damage to or theft of property belonging to consumers or the facility; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or results.

"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, religious, sexual orientation, and/or social group.

"DSM" means the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"Emergency detention" means the detention of a person who appears to be a person requiring treatment in a facility approved by the Commissioner of Mental Health and Substance Abuse Services as appropriate for such detention after the completion of an emergency examination, either in person or via telemedicine, and a determination that emergency detention is warranted for a period not to exceed one hundred twenty (120) hours or five (5) days, excluding weekends and holidays, except upon a court order authorizing detention beyond a one hundred twenty (120) hour period or pending the hearing on a petition requesting involuntary commitment or treatment as provided by 43A of the Oklahoma Statutes.

"Emergency examination" means the examination of a person who appears to be a mentally ill person, an alcohol-dependent person, or drug-dependent person and a person requiring treatment, and whose condition is such that it appears that emergency detention may be warranted by a licensed mental health professional to determine if emergency detention of the person is warranted.

"Emergency services" means a twenty-four (24) hour capability for assessment, intervention, and resolution of a consumer's crisis or emergency provided in response to unanticipated, unscheduled emergencies requiring prompt intervention to resolve immediate, overwhelming problems that severely impair the individual's ability to function or remain in the community and may include placement of the individual in a protective environment, withdrawal management, individual and group consultation, and medical assessment.

"Face-To-Face" for the purposes of the delivery of behavioral health care, means a face-to-face physical contact and in-person encounter between the health care provider and the consumer, including the initial visit. The use of telemedicine shall be considered a face-to-face encounter.

"Facilities" or "Facility" means entities as described in Title 43A O.S. § 1-103(7), community mental health centers, residential mental health facilities, community based structured crisis centers, certified services for the alcohol and drug dependent, programs of assertive community treatment, eating disorder treatment, gambling addiction treatment, and narcotic treatment programs.

"Family" means the parents, brothers, sisters, other relatives, foster parents, guardians, and others who perform the roles and functions of family members in the lives of consumers.

"Follow-up" means the organized method of systematically determining the status of consumers after they have been discharged to determine post-treatment outcomes and utilization of post-treatment referrals.

"Gambling disorder treatment services" means treatment activities for consumers by a gambling treatment professional that include, but are not limited to, the following:

(A) Assessment and diagnostic impression, ongoing;
(B) Treatment planning and revision, as necessary;
(C) Individual, group and family therapy;
(D) Case management;
(E) Psychosocial rehabilitation; and
(F) Discharge planning.

"Gambling related disorders/problems" means persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as defined by the most recent edition of the DSM.

"Gambling disorder treatment professional" means an individual holding a valid NGCC I or II certification or has documented completion of at least thirty hours of ODMHAS recognized core problem gambling training requirements and documented completion of ten hours of problem gambling specific continuing education every twelve months, and is either a Licensed Behavioral Health Professional or Licensure Candidate.

"General psychiatric rehabilitation" or "PSR" means a type of psychiatric rehabilitation program which focuses on long term recovery and maximization of self-sufficiency, role function and independence. General psychiatric rehabilitation programs may be organized within a variety of structures which seek to optimize the participants' potential for occupational achievement, goal setting, skill development and increased quality of life.

"Historical timeline" means a method by which a specialized form is used to gather, organize and evaluate information about significant events in a consumer's life, experience with mental illness, and treatment history.

"Home-based services to children and adolescents" means intensive therapeutic services provided in the home to children for the purpose of reduction of psychiatric impairment and preventing removal of the child to a more restrictive setting for care. Services include a planned combination of procedures developed by a team of qualified mental health professionals, including a physician.

"Homeless" refers to a person who is sleeping in an emergency shelter; sleeping in places not meant for human habitation, such as cars, parks, sidewalks, or abandoned or condemned buildings; spending a short time (30 consecutive days or less) in a hospital or other institution, but ordinarily sleeping in the types of places mentioned above; living in transitional/supportive housing but having come from streets or emergency shelters; being evicted within a week from a private dwelling unit and having no subsequent residence identified and lacking the resources and support networks needed to obtain access to housing; being discharged from an institution.
and having no subsequent residence identified and lacking the resources and support networks needed to obtain access to housing; or is fleeing a domestic violence situation and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing.

"Hospital liaison" means an individual within the Behavioral Health Home interdisciplinary team that works closely with hospital staff to assess the suitability of transition plans for consumers enrolled in a Behavioral Health Home. Hospital Liaisons will also work with other long term, residential facilities to plan for coordination of care during and after the consumer's residential stay. Hospital liaisons must be certified by ODMHSAS as a Behavioral Health Case Manager I or II and complete trainings as required by ODMHSAS.

"ICCD" means the International Center for Clubhouse Development.

"Independent living skills, assistance in development of" means all activities directed at assisting individuals in the development of skills necessary to live and function within the community, e.g., cooking, budgeting, meal planning, house-cleaning, problem-solving, communication and vocational skills.

"Licensed Behavioral Health Professional" or "LBHP" means:

(A) An Allopathic or Osteopathic Physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry;

(B) An Advanced Practice Registered Nurse 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 certified in a psychiatric mental health specialty;

(C) A Clinical Psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists;

(D) A Physician Assistant who is licensed in good standing in Oklahoma and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions;

(E) A Practitioner with a license to practice in the state in which services are provided by one of the following licensing boards:

(i) Psychology;

(ii) Social Work (clinical specialty only);

(iii) Professional Counselor;

(iv) Marriage and Family Therapist;

(v) Behavioral Practitioner; or

(vi) Alcohol and Drug Counselor.

(C) 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.

(D) A Physician Assistant who is licensed in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

"Licensed mental health professional" or "LMHP" as defined in Title 43A §1-103(11).

"Licensure candidate" means practitioners actively and regularly receiving board approved supervision, and extended supervision by a licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:

(A) Psychology;

(B) Social Work (clinical specialty only);

(C) Professional Counselor;

(D) Marriage and Family Therapist;

(E) Behavioral Practitioner; or

(F) Alcohol and Drug Counselor.

"Linkage" refers to the communication and coordination with other service providers to assure timely appropriate referrals between the CMHC and other providers.

"Medical resident" means an allopathic physician or an osteopathic physician who is a graduate of a school of medicine or college of osteopathic medicine and who is receiving specialized training in a teaching hospital under physicians who are certified in that specialty.

"Medically necessary" means health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms that meet accepted standards of medicine.

"Medication error" means an error in prescribing, dispensing or administration of medication, regardless if the error reached the consumer, e.g., omission of prescribed drugs, giving drugs not prescribed, prescribing inappropriate drugs, prescribing or administering incorrect dosages, incorrectly filling or labeling prescriptions, incorrectly transcribing medication orders.

"NCGCC" means Nationally Certified Gambling Counselor, offered at levels I or II through the National Council on Problem Gambling.

"Nurse Care manager" means a Licensed Practical Nurse (LPN) or a Registered Nurse (RN).

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"Oklahoma Administrative Code" or "OAC" means the publication authorized by 75 O.S. § 256 known as The Oklahoma Administrative Code or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A) (1) (a) and maintained in the Office of Administrative Rules.

"Peer Recovery Support Specialist" or "PRSS" means an individual who meets the qualifications and is certified as a PRSS pursuant to OAC 450:53.

"Performance Improvement" or "PI" means an approach to the continuous study and improvement of the processes of providing health care services to meet the needs of consumers and others. Synonyms, and near synonyms include continuous quality improvement, continuous improvement, organization-wide quality improvement and total quality management.

"Permanent supported housing" means a type of Community Living Program, either permanent scattered site
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housing or permanent congregate housing, where consumers are assisted with locating housing of their choice and are offered on-going support services based on need and choice to ensure successful independent living.

"PICIS System" means a management information system based on national standards for mental health and substance abuse databases. Information gathered through PICIS is used for prior authorizations, service utilization management and continuous quality improvement processes. PICIS data is reported throughout the treatment episode to ensure service recipients receive appropriate types and levels of care and are making satisfactory progress. Numerous reports are developed using PICIS data and are provided to clinicians, administrators and the general public.

"Primary Care Practitioner (PCP)" means a licensed allopathic physician, osteopathic physician, Advance Practice Registered Nurse (APRN), or Physician Assistant (PA) licensed in the State of Oklahoma.

"Program of Assertive Community Treatment" or "PACT" is a clinical program that provides continuous treatment, rehabilitation, and support services to persons with mental illness in settings that are natural to the consumer.

"Progress notes" mean a chronological written description of services provided to a consumer, resident, client, or patient that documents, utilizing acceptable documentation practices, the consumer's response related to the intervention plan or services provided.

"Psychiatric Residential Treatment Facility" or "PRTF" means a non-hospital facility that provides inpatient psychiatric services to individuals under the age of twenty-one (21).

"Psychological-Social evaluationsPsychosocial assessments" are in-person interviews conducted by professionally trained personnel designed to elicit historical and current information regarding the behavior and experiences of an individual, and are designed to provide sufficient information for problem formulation and intervention.

"Psychosocial rehabilitation" or "PSR" means curriculum based education and skills training performed to improve an individual's ability to function in the community. PSR provides an array of services that focus on long term recovery and maximization of self-sufficiency, role functioning, and independence, as distinguished from the symptom stabilization function of acute care.

"Psychotherapy" or "Therapy" means a goal directed process using generally accepted clinical approaches provided face-to-face by a qualified service provider with consumers in individual, group or family settings to promote positive emotional or behavioral change.

"Rehabilitation Services" means face-to-face individual or group services provided by qualified staff to develop skill necessary to perform activities of daily living and successful integration into community life.

"Resident" means a person residing in a community living program certified by ODMHAS.

"Residential treatment" means a structured, 24-hour supervised treatment program for individuals who are mentally ill with a minimum of twenty-one (21) hours of therapeutic services provided per week with the emphasis on stabilization and rehabilitation for transfer to a less restrictive environment. Stay in the program is time limited.

"Restraint" refers to manual, mechanical, and chemical methods that are intended to restrict the movement or normal functioning of a portion of an individual's body.

"Risk Assessment" means a clinical function that aims to determine the nature and severity of the mental health problem, determine which service response would best meet the needs of the consumer, and how urgently the response is required.

"Screening" means the process to determine whether the person seeking assistance needs further comprehensive assessment.

"Sentinel event" is a type of critical incident that is an unexpected occurrence involving the death or serious physical or psychological injury to a consumer, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a consumer. These events signal the need for immediate investigation and response. Sentinel events include, but are not limited to: suicide, homicide, criminal activity, assault and other forms of violence, including domestic violence or sexual assault, and adverse drug events resulting in serious injury or death.

"Service area" means a geographic area established by the Department of Mental Health and Substance Abuse Services for support of mental health and substance abuse services [43A O.S.§3-302(1)]. Only one certified Community Mental Health Center is allowed per service area.

"Service Intensity" means the frequency and quantity of services needed, the extent to which multiple providers or agencies are involved, and the level of care coordination required.

"Service plan" or "Treatment plan" means the document used during the process by which a qualified service provider and the consumer together and jointly identify and rank problems, establish agreed-upon immediate short-term and long-term goals, and decide on the treatment process and resources to be utilized.

"Socialization" means all activities, which encourage interaction and the development of communication, interpersonal, social and recreational skills and can include consumer education.

"SoonerCare" means Oklahoma's Medicaid program.

"Supportive services" refers to assistance with the development of problem-solving and decision-making skills to maintain or achieve optimal functioning within the community and can include consumer education.

"Systems of Care values" means a philosophy, which embraces a family-driven, child centered model of care that integrates and coordinates the efforts of different agencies and providers to individualize care in the least restrictive setting that is clinically appropriate.

"TJC" means The Joint Commission formerly referred to as the Joint Commission on Accreditation of Healthcare Organizations or JCAHO.
"Tobacco" means any nicotine delivery product or device that is not approved by the U.S. Food and Drug Administration (FDA) for the purpose of nicotine dependence treatment, including, but not limited to cigarettes, cigars, snuff, chewing tobacco, electronic cigarettes and vaping devices.

"Transitional housing program" means a type of Community Living Program in which the consumer's stay in the residence is considered temporary and time-limited in nature. The actual program model may include a range of approaches, including but not limited to supervised transitional living programs and supervised transitional housing programs.

"Trauma informed capability" means the capacity for a facility and all its programs to recognize and respond accordingly to the presence of the effects of past and current traumatic experiences in the lives of its consumers.

"Urgent recovery clinic" means a program of non-hospital emergency services for mental health and substance use crisis response including, but not limited to, observation, evaluation, emergency treatment, and referral, when necessary to a higher level of care. This service is time limited and cannot exceed 23 hours and 59 minutes. This service is limited to CMHCs and Comprehensive Community Addiction Recovery Centers (CCARCs) certified by ODMHSAS or facilities operated by ODMHSAS.

"Vocational assessment services" means a process utilized to determine the individual's functional work-related abilities and vocational preferences for the purpose of the identification of the skills and environmental supports needed by the individual in order to function more independently in an employment setting, and to determine the nature and intensity of services which may be necessary to obtain and retain employment.

"Vocational placement services" means a process of developing or creating an appropriate employment situation matched to the functional abilities and choices of the individual for the purpose of vocational placement. Services may include, but are not limited to, the identification of employment positions, conducting job analysis, matching individuals to specific jobs, and the provision of advocacy with potential employers based on the choice of the individual served.

"Vocational preparation services" means services that focus on development of general work behavior for the purpose of vocational preparation such as the utilization of individual or group work-related activities to assist individuals in understanding the meaning, value and demands of work; to modify or develop positive work attitudes, personal characteristics and work behaviors; to develop functional capacities; and to obtain optimum levels of vocational development.

"Volunteer" means any person who is not on the program's payroll, but provides services and fulfills a defined role within the program and includes interns and practicum students.

"Walk through" means an exercise in which staff members of a facility walk through the program's treatment processes as a consumer. The goal is to view the agency processes from the consumer's perspective for the purpose of removing barriers and enhancing treatment.

"Wellness" means the condition of good physical, mental and emotional health, especially when maintained by an appropriate diet, exercise, and other lifestyle modifications.

"Wellness Coach" means an individual who is actively working on personal wellness and who is designated to collaborate with others to identify their personal strengths and goals within the eight dimensions of wellness (spiritual, occupational, intellectual, social, physical, environmental, financial, and emotional).

(A) In order to qualify to be a Wellness Coach, individuals shall:

(i) Have a behavioral health related associates degree or two years of experience in the field and/or have an active certification and/or license within the behavioral health field (e.g. PRSS, Case Management, LBHP, LPN, etc.); and

(ii) Complete the ODMHSAS Wellness Coach Training Program and pass the examination with a score of 80% or better.

(B) Wellness Coach roles and responsibilities include:

(i) Role model wellness behaviors and actively work on personal wellness goals;

(ii) Apply principles and processes of coaching when collaborating with others;

(iii) Facilitate wellness groups;

(iv) Conduct motivational interventions;

(v) Practice motivational interviewing techniques;

(vi) Provide referrals to community resources for nutrition education, weight management, Oklahoma Tobacco Helpline, and other wellness-related services and resources;

(vii) Create partnerships within local community to enhance consumer access to resources that support wellness goals;

(viii) Raise awareness of wellness initiatives through educational in-service and community training;

(ix) Elevate the importance of wellness initiatives within the organization;

(x) Promote a culture of wellness within the organization for both consumers and staff;

(xi) Respect the scope of practice and do not practice outside of it, referring people to appropriate professionals and paraprofessionals as needed.

"Wraparound approach" means a team-based planning and implementation process to improve the lives of children with complex needs and their families by developing individualized plans of care. The key characteristics of the process are that the plan is developed by a family centered team, is individualized based on the strengths and culture of the child and their family, and is driven by needs rather than services.

"Young Adults in Transition" are persons between sixteen to twenty-five (16-25) years of age who have a Serious Mental Illness (ages 18 - 25), or Serious Emotional Disturbance (ages 16 - 18).
SUBCHAPTER 3. REQUIRED SERVICES

PART 1. REQUIRED SERVICES

450:17-3-2. Required community mental health services
(a) Each CMHC shall provide the following services:
(1) Screening, assessment and referral services;
(2) Emergency services;
(3) Outpatient therapy;
(4) Case management services;
(5) Psychiatric rehabilitation services;
(6) Medication clinic services;
(7) Service to homeless individuals;
(8) Peer Support Services, and
(9) Wellness Activities and Support.
(b) Compliance with 450:17-3-2 shall be determined by a review of the following:
(1) On-site observation;
(2) Staff interviews;
(3) Written materials;
(4) Program policies;
(5) Program Evaluations;
(6) Data reporting; and
(7) Clinical records.

PART 3. SCREENING, ASSESSMENT AND REFERRAL

450:17-3-21. Integrated screening and assessment services
(a) CMHC policy and procedure shall require that a screening of each consumer's service needs is completed in a timely manner. An integrated screening should be welcoming and culturally appropriate, include screening of whether the consumer is a risk to self or others, including suicide risk factors, as well as maximize recognition of the prevalence of co-occurring disorders among those who typically present for services at a Community Mental Health Center.
(b) Upon determination of appropriate admission, a consumer assessment shall be completed by a LBHP or licensure candidate and shall include, but not be limited to, the following information:
(1) Behavioral, including mental health and addictive disorders as well as the following:
   (A) presenting problem and current symptomology;
   (B) previous treatment history;
   (C) current and past psychotropic and addiction medications, including name, dosage and frequency; and
   (D) Family history of mental health and other addictive disorders.
(2) Emotional, including issues related to past or current trauma and domestic violence;
(3) Physical/medical, including:
   (A) health history and current biomedical conditions and complications;
   (B) current and past physical health medications, including name, dosage and frequency;
   (C) Mental Health and Substance Use Disorders History;
   (D) Social work assessment for children and their families.
(b) Compliance with 450:17-3-21 shall be determined by a review of the facility's written policy and procedures.

PART 5. EMERGENCY SERVICES
Emergency services

(a) CMHCs shall provide, on a twenty-four (24) hour basis, accessible co-occurring disorder capable services for substance use disorder and/or psychiatric emergencies.

(b) This service shall include the following:

(1) 24-hour assessment and evaluation, including emergency examinations, characterized by welcoming engagement of all individuals and families;

(2) Availability of 24-hour inpatient/crisis center referral and crisis diversion/intervention;

(A) CMHC staff shall be actively involved in the emergency services and referral process to state-operated psychiatric inpatient units, crisis centers and urgent recovery clinics.

(B) Referral to state-operated psychiatric inpatient units by the CMHC shall occur only after all other community resources, including crisis centers and urgent recovery clinics, are explored with the individual and family if family is available and the consumer gives written consent for release.

(C) Prior notification to and approval from the state-operated psychiatric inpatient unit of all referrals from CMHCs is required.

(3) Availability of assessment and evaluation in external settings unless immediate safety is a concern. This shall include but not be limited to schools, jails, and hospitals;

(4) Referral services, which shall include actively working with local sheriffs and courts regarding the appropriate referral process and appropriate court orders (43A O.S. §§ 5-201 through 5-407);

(5) CMHCs serving multiple counties shall provide or arrange for on-site face-to-face assessment of persons taken into protective custody [43A O.S. § 5-206 et seq.] in each county;

(6) The CMHC's emergency telephone response time shall be less than fifteen (15) minutes from initial contact, unless there are extenuating circumstances;

(7) Face-to-face strength based assessment, unless there are extenuating circumstances, addressing both mental health and substance use disorder issues which, if practicable, include a description of the client's strengths in managing mental health and/or substance use issues and disorders during a recent period of stability prior to the crisis;

(8) Intervention and resolution; and

(9) Access to an evaluation. No arbitrary barriers to access of an evaluation based on active substance use or designated substance levels shall be implemented unless the facility provides written justification approved by ODMH-SAS Provider Certification.

(c) Compliance with 450:17-3-41 shall be determined by a review of policy and procedures, and clinical records.

Case management services for consumers admitted to higher levels of care

(a) Case managers shall maintain contact with existing CMHC consumers, and establish contact with newly referred persons who are receiving services in inpatient psychiatric settings, Community Based Structured Crisis Centers, (CBSCC), or 24-hour settings providing substance use disorder treatment.

(b) Each CMHC shall assign at least one (1) staff member who is responsible for linkage between psychiatric inpatient units, CBSCCs, and/or the substance use disorder treatment facility and the CMHC. Linkage shall include, but not limited to, the following activities, pursuant to appropriately signed releases and adherence to applicable privacy provisions:

(1) Regular visits or communication with the psychiatric inpatient unit, CBSCC, and/or substance use disorder treatment facility to monitor progress of those consumers hospitalized and/or in facility-based substance use disorder treatment from the CMHC’s service area.

(2) Provide knowledge and communication to other CMHC staff regarding psychiatric inpatient unit admission, CBSCC and/or substance use disorder treatment facility and discharge procedures.

(c) Case managers from the CMHC to which the consumer will be discharged shall assist the consumer and psychiatric inpatient unit, CBSCC, and/or substance use disorder treatment facility with discharge planning for consumers returning to the community.

(d) Individuals discharging from an inpatient psychiatric unit setting, CBSCC, and/or substance use disorder treatment facility, who have not already been engaged, shall be offered case management and other supportive services. This shall occur as soon as possible, but shall be offered no later than one (1) week seventy-two (72) hours post-discharge.

(e) Compliance with 450:17-3-103 shall be determined by a review of the following: clinical records; staff interviews; information from ODMH/SAS operated psychiatric inpatient unit; CBSCC facilities, substance use disorder treatment facilities; meetings minutes (CMHC or state-operated psychiatric inpatient unit); and a review of a minimum of ten (10) clinical records of consumers who received services at an inpatient unit, CBSSC, and/or 24-hour setting providing substance use disorder treatment within the past twelve (12) months.

Case management services, staff credentials

(a) Individuals providing case management services shall be a LBHP, licensure candidate, CADC or certified as a behavioral health case manager pursuant to Oklahoma Administrative Code, Title 450, Chapter 50.

(b) Facility supervisors must be a certified behavioral health case manager pursuant to Oklahoma Administrative Code, Title 450, Chapter 50 if they directly supervise the equivalent of two (2) or more FTE certified behavioral health case managers who provide case management services as part of their regular duties. A facility supervisor certified as a behavioral health case manager prior to becoming a facility supervisor shall meet this requirement if acceptable documentation of certification is provided to the Department.
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(c) Compliance with 450:17-3-106 shall be determined by a review of the facility personnel records and credentialing files.

PART 15. BEHAVIORAL HEALTH REHABILITATION SERVICES

450:17-3-141. Psychiatric rehabilitation services
(a) This section governs psychiatric rehabilitation services for Adults with Serious Mental Illness, and Children with Serious Emotional Disturbance. These standards reflect two recovery focused programs for adults: General psychiatric rehabilitation program (PSR) and ICCD Clubhouse; along with individual and group rehabilitation services for both adults and children.
(b) The CMHC shall provide one or more of the following for adults: a PSR program, or ICCD Clubhouse program, or individual and group rehabilitation services. In addition, the CMHC shall provide individual and group rehabilitation services for children. —CMHC policy and procedures shall reflect that all psychiatric rehabilitation programs and services incorporate the following core principles:
   (1) Recovery is the ultimate goal of psychiatric rehabilitation. Interventions must facilitate the process of recovery.
   (2) Psychiatric rehabilitation practices help people re-establish normal roles in the community and their integration into community life.
   (3) Psychiatric rehabilitation practices facilitate the development of personal support networks.
   (4) Psychiatric rehabilitation practices facilitate an enhanced quality of life for each person receiving services.
   (5) People have the capacity to learn and grow.
   (6) People receiving services have the right to direct their own affairs, including those that are related to their psychiatric disability.
   (7) People are to be treated with respect and dignity.
   (8) Psychiatric rehabilitation practitioners make conscious and consistent efforts to eliminate labeling and discrimination, particularly discrimination based upon a disabling condition.
   (9) Culture and ethnicity play an important role in recovery. They are sources of strength and enrichment for the person and the services.
   (10) Psychiatric rehabilitation interventions build on the strength of each person.
   (11) Psychiatric rehabilitation services are to be coordinated, accessible, and available as long as needed.
   (12) Services are to be designed to address the unique needs of each individual, consistent with the individual's cultural values and norms.
   (13) Psychiatric rehabilitation practices actively encourage and support the involvement of persons in normal community activities, such as school and work, throughout the rehabilitation process.
   (14) The involvement and partnership of persons receiving services and family members is an essential ingredient of the process of rehabilitation and recovery.
   (15) Psychiatric rehabilitation practitioners should constantly strive to improve the services they provide.
(c) CMHC policy and procedures shall reflect that psychiatric rehabilitation services shall be co-occurring disorder capable and facilitate processes for dual recovery for these individuals.
(d) Compliance with 450:17-3-141 shall be determined by on-site observation; interviews with participants; interviews with staff; a review of policy and procedures; and a review of clinical records; or proof of compliance with 450:17-3-146.

450:17-3-144. General psychiatric psychosocial rehabilitation (PSR) program (PSR)
(a) The PSR shall be designed to provide an array of services that focus on long term recovery and maximization of self-sufficiency, role functioning, and independence as distinguished from the symptom stabilization function of acute care. Program services shall seek to optimize the participant's potential for occupational achievement, goal setting, skill development, and increased quality of life, therefore maximizing the individual's independence from institutional care and supports in favor of community and peer support.
(b) Proof of completion of orientation in the PSR model shall be kept on file for all program staff members. The CMHC policies and procedures shall document a plan by which employees who are staff members in the PSR program are to be oriented to the PSR model.
(c) Program participants shall be referred to as members, as opposed to patients or clients. Members choose the way they utilize the program. Participation is voluntary; there shall be no artificial reward systems such as, but not limited to, tokens, economy and point systems.
(d) The program shall incorporate the following functions:
   (1) Recovery Orientation. The service elements include a Recovery oriented treatment plan, member goal setting, employment and educational support services, and a staff philosophy of recovery that permeates all service elements and activities.
   (2) Empowerment Orientation. The service elements include peer support, leadership skill development, member participation on agency boards, and participation in consumer advocacy groups. All PSR programs shall establish an advisory committee consisting of members and a staff person, which will address issues such as program development and planning, and program problem solving.
   (3) Competency Orientation. The service elements include curriculum based life skills training (covering self-management of illness, independent living skills, social skills, and work related skills), a multi-dynamic learning approach, an explicit focus on generalization to contexts beyond the immediate learning task and transfer of skills to real life situations and a community based supports component that provides on-going in home or community based support services, based on consumer need and choice, in the areas of housing, employment, education and the development of natural supports (i.e., family, cultural and social). Curricula shall include attention to building decision making capacity and life skills to
implement decisions regarding substance use, including nicotine and caffeine, to promote health choices. Decision making should not be mandated abstinence but should be client-centered within the overall context of recovery goals. Service elements also include a work unit component that adheres to the following standards:

(A) Members and staff work side-by-side.

(B) The work completed is work generated by the PSR program. No work for outside individuals or agencies is acceptable.

(C) All work in the PSR program is designed to help members regain self-worth, purpose and confidence; it is not intended to be job specific training.

(D) The program is organized into one or more work units, each of which has sufficient staff, members and meaningful work.

(ee) PSR programs are required to maintain minimum staff ratios to assure participants have choices in activities and staff with whom they work. The following staffing ratios shall be maintained for each location at which a psychiatric rehabilitation program is in operation.

(1) Fourteen (14) or fewer participants in attendance; at least one staff member present provided arrangements for emergency back-up staff coverage are in place and described in the program's policy and procedures;

(2) Fifteen (15) to twenty eight (28) participants in attendance; at least two staff members present; or,

(3) Programs with twenty nine (29) or more participants shall maintain a 14:1 participant-to-staff ratio.

(fd) Compliance with 450:17-3-144 shall be determined by on-site observation; interviews with members; interviews with staff; a review of policy and procedures; and a review of clinical records.

450:17-3-146. ICCD Clubhouse program

(a) The Clubhouse program shall be certified as a Clubhouse through the International Center for Clubhouse Development (ICCD). A Clubhouse shall be considered certified when a copy of the Clubhouse’s current ICCD certification has been received by ODMHSAS Provider Certification. When a Clubhouse is renewing certification, a Clubhouse will continue to be considered certified provided the following conditions are met:

(1) At least (60) days prior to expiration of ICCD certification a copy of the application to ICCD for re-certification has been received by ODMHSAS Provider Certification.

(2) A copy of the re-certification visit schedule from the ICCD has been received by ODMHSAS Provider Certification.

(3) Within one-hundred and twenty (120) days of the ICCD re-certification visit, a copy of the re-certification letter from the ICCD reflecting that the Clubhouse has been recertified has been received by ODMHSAS Provider Certification.

(b) Compliance with 450:17-3-146 shall be determined by receipt of the identified documentation needed to support that a Clubhouse program is ICCD certified.

PART 21. PEER RECOVERY SUPPORT SERVICES

450:17-3-191. Peer Recovery support services

(a) Peer recovery support services are provided as a program integrated within the overall structure of Community Mental Health Center services and must be offered to children ages 16 and 17 with SED, and adults age 18 and older with (SMI), including co-occurring disorders.

(b) Peer recovery support services may be offered to other consumers of the community mental health center and their families.

(c) These services shall have written policies specific to these services.

(1) Be based on an individualized, recovery focused service philosophy that allows individuals the opportunity to learn to manage their own recovery and advocacy process;

(2) Recognize the unique value of services being provided by persons with lived experience who are able to demonstrate their own hopefulness and recovery;

(3) Enhance the development of natural supports, coping skills, and other skills necessary to function as independently as possible in the community, including, but not limited to assisting re-entry into the community after a hospitalization or other institutional settings;

(4) Have written policies specific to these services.

(5) Be provided by Peer Recovery Support Specialist(s) as defined by 450:17-2-192.

(d) Each CMHC shall have in place provisions for direct supervision and other supports for staff providing this service.

(e) Compliance with 450:17-3-191 shall be determined by a review of the following: documentation of linkage activities and agreements; clinical records; PICIS reporting data; and, CMHC policy and procedures.

SUBCHAPTER 5. OPTIONAL SERVICES

PART 7. DAY TREATMENT SERVICES, CHILDREN AND ADOLESCENTS

450:17-5-34. Day treatment services for children and adolescents

(a) Day treatment services are designed for non-residential consumers who spend only a part of a twenty-four (24) hour period in the program.

(1) Hours of operation shall be held during periods which make it possible for consumers to receive a minimum of three (3) hours of treatment and services each day for five (5) days each week in the program, excluding
time spent in fulfillment of academic educational activities as required by law; days and hours of operation shall be regularly scheduled and conspicuously displayed so as to communicate the schedule to the public; and
(2) Services provided shall be co-occurring disorders capable and include, at a minimum, the following:
   (A) Weekly individual therapy, group, and family therapy;
   (B) Social skills development through activities which encourage interaction and the development of communications and interpersonal skills;
   (C) Integrated attention to decision making and healthy skill building regarding substance use, including nicotine and caffeine;
   (D) Recreation and leisure activities;
   (E) Emergency services;
   (F) Habilitation services;
   (G) Referral to other resources when indicated by treatment goals and objectives; and
   (H) Provide, or arrange for, academic education as required by state or federal law.
(b) Compliance with 450:17-5-34 shall be determined by on-site observation; and a review of the following: clinical records, policy and procedures, and program descriptions.

PART 9. VOCATIONAL EMPLOYMENT SERVICES

450:17-5-45. Vocational employment services
(a) The vocational employment services program is an identified program within the CMHC that assists in the rehabilitation and support of persons with psychiatric disabilities, which may include but is not limited to the following:
   (1) Vocational assessment services;
   (2) Vocational preparation services;
   (3) Vocational placement services; and
   (4) Other on and off-site employment support services.
(b) If offered by a CMHC, vocational employment services should be co-occurring disorder capable and available to individuals with co-occurring disorders who are interested in work as a goal, even if they are not yet abstinent.
(cb) Compliance with 450:17-5-45 shall be determined by on-site observation and a review of the following: organization chart; interagency agreements; written policy and procedures; and contractual agreements.

PART 15. INPATIENT SERVICES

450:17-5-95. Inpatient services within the community mental health setting
(a) Any community mental health center providing inpatient services must demonstrate current compliance with applicable accreditation requirements for inpatient psychiatric or behavioral health services as stipulated by any of the following: the Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), or AOA, and the Council on Accreditation (COA). Facilities shall also demonstrate current licenses as required by the Oklahoma State Department of Health.
(b) Compliance with 17-5-95(a) will be determined by a review of current documentation related to applicable accreditation and licensure.

PART 23. BEHAVIORAL HEALTH HOME [REVOKED]

450:17-5-140. Program description and purpose [REVOKED]
(a) The purpose of Behavioral Health Homes within the mental health delivery array is to promote enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness, including adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). Care must be delivered using an integrated team that will comprehensively address physical, mental health, and substance use disorder treatment needs.
(b) The BHH must maintain facility policies and program descriptions that clearly describe that the purpose of the BHH is to improve the health status of individuals with Serious Mental Illness and/or Serious Emotional Disturbance by integrating behavioral and primary health care and promoting wellness and prevention.
(c) The BHH must provide program descriptions and demonstrate evidence that the following functions are implemented:
   (1) Quality-driven, cost-effective, culturally appropriate, and person and family-centered health home services;
   (2) Coordinated access to:
      (A) High-quality health care services informed by evidence-based clinical practice guidelines;
      (B) Preventive and health promotion services, including prevention of mental illness and substance use disorders;
      (C) Mental health and substance abuse services;
      (D) Comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric or adult system of health care;
      (E) Chronic disease management, including self-management support to individuals and their families;
      (F) Individual and family supports, including referral to community, social support, and recovery services; and
      (G) Long-term care supports and services;
   (3) Person-centered care plans for each individual that coordinates and integrates all of his or her clinical and non-clinical health care related needs and services;
   (4) Proper and continuous use of health information technology to link services, facilitate communication among team members, and between the health team and...
permanent final adoptions

individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
(5) Quality improvement program, which collects and reports on data that permits an evaluation of increased co-
ordination of care and chronic disease management on in-
dividual level clinical outcomes, experience of care out-
comes, and quality of care outcomes at the population
level.

(d) Compliance with this Section will be determined by
on-site observation, review of organizational documents,
program descriptions, outcome monitoring and other perfor-
ance improvement activity reports, and clinical records.

450:17-5-141. Target populations [REVOKED]
(a) The BHH must be established to serve only the following
target populations:
(1) Adults with a serious mental illness (SMI);
(2) Children with a serious emotional disturbance (SED); or
(3) Both.

(b) Organizational documents must clearly describe the tar-
get population(s) to be served by the BHH.

c) Target population descriptions should not be interpreted
as to limit access to individuals based on funding sources, in-
cluding not limiting access to those who are uninsured but oth-
erwise meet the target population criteria. Although not re-
quired, BHHs are encouraged to identify funding in order to
provide BHH services to individuals who meet the target pop-
ulation criteria but do not have Medicaid.

(d) Compliance with this Section will be determined by
on-site observation, review of organizational documents,
program descriptions, outcome monitoring and other perfor-
ance improvement activity reports, and clinical records.

450:17-5-142. Outreach and engagement [REVOKED]
(a) The BHH must have policies and procedures to describe
how outreach and engagement activities will occur to identify
individuals within the target population(s) who could benefit
from BHH services.

(b) The BHH must have memoranda of agreements to ar-
range for outreach and engage in settings outlined further in
these rules in Section 450:17-5-160.

c) Facility records will identify which staff members are
responsible for specific elements of outreach and engagement.

(d) Compliance with this Section will be determined by
on-site observation, review of organizational documents,
program descriptions, outcome monitoring and other perfor-
ance improvement activity reports, and clinical records.

450:17-5-143. Structure of Behavioral Health Home
and administrative staff [REVOKED]
(a) The BHH policies must describe how it is organized
within one of the following structures:

(1) In-house model where the behavioral health agency
is directly providing primary care performed by a qualified
employee, or purchasing through a contract; or

(2) Co-located partnership model where the behavioral
health agency arranges for primary care services to be pro-
vided onsite, establishing written agreements with exter-
nal primary care providers; or

(3) Facilitated referral model, where most primary care
services are not provided onsite at the facility, however,
the facility has processes in place to ensure the coordina-
tion of care that is provided onsite.

(b) In the event the BHH does not directly provide the full
array of required services, there must be organizational proce-
dures and clinical records to document that the BHH has oth-
erwise ensured the services are coordinated on behalf of each
consumer.

c) The facility operating the BHH will have policies and
program descriptions to define how the BHH will operate a
team dedicated to provide the range of specific services artic-
ulated elsewhere in this Subchapter.

(d) The facility shall verify the health home director for
adults meets or exceeds the following qualifications:

(1) Possess a Bachelor's degree from an accredited uni-
versity and have at least two years' experience in health
administration;

(2) Possess a Master's degree from an accredited uni-
versity in a health or social services related field;

(3) Be licensed as a Registered Nurse with the Okla-
ahoma Board of Nursing; or

(4) Be licensed as a Physician or be licensed as a Nurse
Practitioner.

c) The BHH shall verify the Project Director for children
possesses a Bachelor's degree in the field of social or human
sciences from an accredited university, has at least three years' work
experience in the social service field and has a minimum of one year experience in an administrative position.

c) The BHH will adhere to the following ratios in terms of the
full time equivalent (FTE) for the health home director.

(1) The BHH shall maintain a health home director at a
ratio of 1 FTE per 500 BHH participants. BHHs with less
than 500 participants shall maintain a health home director at
a minimum of .5 FTE.

(2) A health home requiring a health home director and
health home nurse care manager of .5 FTE each may em-
ploy 1 FTE individual to serve in both roles, provided that
individual meets the requirements for both positions.

(3) A health home requiring more than .5 FTE health
home director, may choose to designate a lead health home
director and fulfill the additional FTE requirement with key
management staff who meet the requirements of (1) and (2) above.

c) Compliance with this Section will be determined by
on-site observation, review of organizational documents,
signed agreements, personnel records, job descriptions, out-
come monitoring and other performance improvement activity
reports, and clinical records.

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450:17-5-144. Treatment team; general requirements [REVOKED]
(a) The BHH must designate an interdisciplinary treatment team that is responsible, with each consumer’s input and guidance, to direct, coordinate, and manage the care and services to be provided or arranged for by the BHH.
(b) The interdisciplinary team must identify for each consumer a specified licensed behavioral health professional (LBHP) or licensure candidate to lead the process of the initial assessment and plan and to provide therapy services if indicated on the integrated plan. This will ensure that each consumer’s needs are assessed, and that the active treatment plan is implemented as indicated.
(c) Compliance with this Section will be determined by on-site observation, review of organizational documents, signed agreements, activity reports, and clinical records.

450:17-5-145. Treatment team; adult team [REVOKED]
(a) Each BHH team serving adults shall include the following positions, unless otherwise arranged as permitted in (b) below:
   (1) Health Home Director;
   (2) Nurse Care Manager;
   (3) Consulting Primary Care Physician, Advance Practice Registered Nurse, or Physician Assistant;
   (4) Licensed Psychiatric Consultant;
   (5) Licensed Behavioral Health Professional or Licensure Candidate;
   (6) Certified Behavioral Health Case Manager I or II;
   (7) Hospital Liaison/Health Home Specialist; and
   (8) Wellness Coach credentialed through ODMHSAS.
(b) Variations from the above staff pattern on a continuous basis, must be approved in advance by the ODMHSAS Commissioner or a designee.
(c) If the health team experiences difficulty in recruiting staff to fill any of the above positions, a recruitment and contingency plan to maintain essential services, will be submitted to the ODMHSAS Director of Provider Certification for approval.
(d) The facility must have written policies and procedures defining the program’s plan for staff-to-consumer ratio for each adult BHH team and a plan for how exceptions will be handled.
(e) Staffing ratios must be regularly monitored and evaluated within the facilities performance improvement activities.
(f) Compliance with this Section will be determined by on-site observation, review of organizational documents, personnel records, staffing schedules, and clinical records.

450:17-5-147. Required services [REVOKED]
(a) The BHH must have policies and clear descriptions to delineate each specific service provided by the BHH.
(b) The BHH must provide the following services within the framework described in 450:17-5-140:
   (1) Comprehensive Care Management;
   (2) Care Coordination;
   (3) Health Promotion;
   (4) Comprehensive Transitional Care;
   (5) Individual and Family Support services; and
   (6) Referral to Community and Social Support Services.
(c) Program descriptions, personnel and privileging records, and other organizational documents will specify which staff members are qualified to provide each BHH service.
(d) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:17-5-148. Access to specialists [REVOKED]
(a) The facility must have procedures and agreements in place to facilitate referral for other medical services needed beyond the scope of the BHH.
(b) Referral documents and releases of information shall comply with applicable privacy and consumer consent regulations.
(c) Clinical documentation will track referrals to and use of specialists.
(d) Compliance with this Section will be determined by on-site observation, review of organizational documents, signed agreements, outcome monitoring and other performance improvement activity reports, and clinical records.
450:17-5-149. Admission [REVOKED]
(a) The facility must determine the extent to which each consumer's needs and preferences can be adequately addressed within the array of required BHII services.
(b) An integrated screening and assessment approach in accordance with OAC 450:17-3-21 will be used to determine clinical eligibility for BHII services.
(c) Facility policies and procedures must assure that adults who meet the criteria for a SMI or children who meet the criteria for SED are eligible for BHII services.
(d) The facility must obtain informed consent specific to enrollment in the Behavioral Health Home.
   (1) The consent must be specific to the extent that it permits the BHII team members to share information relevant to the delivery of BHII services.
   (2) The process for obtaining consent must educate the consumer of their right to choose among qualified BHII services.
   (3) The BHII must obtain consent for a child in state custody from the Child Welfare or Juvenile Justice worker.
   (4) The BHII consent can be integrated into the facility's overall consent to treat as long as the requirements above are met.
(e) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:17-5-150. Initial assessment [REVOKED]
(a) A Licensed Behavioral Health Professional (LBHP) or Licensure Candidate, acting within his or her state scope of practice requirements, must complete the initial assessment for health home services in accordance with the standard in OAC 450:17-3-21 for consumers who have not been assessed by the facility within the past 6 months.
(b) In addition to the items required in 17-3-21, the initial assessment for home health services must include at a minimum, the following:
   (1) The admitting diagnosis as well as other diagnoses;
   (2) The source of referral;
   (3) The reason for admission as well as stated by the client or other individuals who are significantly involved; and
   (4) A list of current prescriptions and over the counter medications as well as other substances the client may be taking.
(c) The BHII should provide access to an appropriate health care professional and a health screening within 72 hours of placement for children entering foster care.
(d) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:17-5-151. Comprehensive assessment [REVOKED]
(a) A comprehensive assessment must be completed by the interdisciplinary team performing within each team member's scope of practice consistent with each consumer's immediate needs and include a written narrative in each of the following areas:
   (1) Psychiatric and substance abuse history, mental status, and a current DSM diagnosis;
   (2) Medical, dental, and other health needs;
   (3) Education and/or employment;
   (4) Social development and functioning;
   (5) Activities of daily living; and
   (6) Family structure and relationships.
(b) The BHII must provide or arrange for a functional assessment for all children using a tool approved by ODMHSAS. Assignment to high intensity Wraparound or Resource coordination intensity of care must be determined by clinically informed decision-making by LBHP or licensure candidate.
(c) The comprehensive assessment must be updated as needed but no less than every six (6) months.
(d) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:17-5-152. Integrated care plan [REVOKED]
(a) The BHII team must develop a consumer directed, integrated active care plan for each enrolled consumer that reflects input of the team (including the involvement of the consulting primary care physician or APRN in managing the medical component of the plan), and others the consumer chooses to involve.
(b) The plan shall clearly address physical and behavioral health goals, consumer preferences, and the overall health and wellness needs of the consumer.
(c) The plan must be documented and completed within thirty (30) working days of admission to the BHII.
(d) The BHII must provide for each consumer and primary caregiver, as applicable, education and training consistent with the consumer and caregiver responsibilities as identified in the active treatment plan and relative to their participation in implementing the plan of care.
(e) Compliance with this Section will be determined by on-site observation, review of organizational documents, personnel records, staffing schedules, and clinical records.

450:17-5-153. Integrated care plan; content [REVOKED]
(a) The integrated care plan must address all services necessary to assist the client in meeting his or her physical and behavioral health goals and include the following:
   (1) Consumer diagnoses, relative to behavioral and physical health conditions assessed by and addressed by the BHII in terms of direct services provided and/or conditions for which the individual is referred elsewhere for treatment.
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450:17-5-154. Review of plan [REVOKED]
(a) The BHH will review, revise, and document the individualized integrated care plan as frequently as the consumer’s conditions require, but no less frequently than every six (6) months.
(b) A revised active plan must include information from the consumer’s initial evaluation and comprehensive assessments and updates, the progress toward goals specified in the written care plan, and changes, as applicable, in goals.
(c) Compliance with this Section will be determined by outcome monitoring, performance improvement activity reports.

450:17-5-155. Intensive care coordination for children and adolescents; wraparound approach [REVOKED]
(a) If the BHH serves children or adolescents with SED, care coordination must be delivered with a single point of accountability to ensure that medically necessary services and supports are accessed, coordinated, and delivered in strength-based, individualized, family-driven, youth-guided, and ethnically, culturally and linguistically relevant manner.
(b) The BHH will document that delivery of specific services and supports are guided by the needs, strengths and culture of the child and family, developed through a wraparound care planning process consistent with System of Care values.
(c) Program policies and descriptions will define the wraparound approach and related values as identified in (a) and (b) above and stipulate these must be followed by staff to develop care coordination plans.
(d) Care plans and other clinical records reflect implementation of services based on the foundations described in (a) through (c).
(e) Compliance with this Section will be determined by review of policies and procedures, staff training logs, outcome monitoring, performance improvement activity reports, clinical records, and related documentation.

450:17-5-156. Behavioral Health Home medication monitoring [REVOKED]
(a) When medication services are provided as a component of the BHH’s services, medication administration, storage and control, and consumer reactions shall be regularly monitored.
(b) Facilities shall assure proper storage and control of medications, immediate response if incorrect or overdoes occur, and have appropriate emergency supplies available if needed.
(1) Written procedures for medication administration shall be available and accessible in all medication storage areas, and available to all staff authorized to administer medications.
(2) All medications shall be kept in locked, non-consumer accessible areas. Conditions which shall be considered in medication storage are light, moisture, sanitation, temperature, ventilation, and the segregation and safe storage of poisons, external medications, and internal medications.
(3) Telephone numbers of the state poison centers shall be immediately available in all locations where medications are prescribed, administered and stored.
(e) The facility shall make available access to pharmacy services to meet consumers’ pharmacological needs that are addressed by the BHH’s physicians and other BHH licensed prescribers. Provision of services may be made through agreement with another program, through a pharmacy in the community, or through their own Oklahoma licensed pharmacy.
(d) Compliance with this Section will be determined by on-site observation and a review of the following: Written policy and procedures, clinical records, written agreements for pharmacy services, State of Oklahoma pharmacy license and PI records.

450:17-5-158. Health promotion and wellness; consumer self-management [REVOKED]
(a) The BHH must assist members to participate in the implementation of their comprehensive care plan.
(b) This must include, but not be limited to providing health education specific to a member’s chronic conditions; development of self-management plans with the individual; support to improve social networks; and providing health-promoting lifestyle interventions. Health-promoting lifestyle interventions include, but are not limited to substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and increasing physical activity; and assisting to understand and self-manage chronic health conditions.
(c) In addition, BHHs that serve children and adolescents must provide child-specific health promotion activities. These include but are not limited to education regarding the importance of immunizations and screenings, child physical and emotional development; linking each child with screening in accordance with the EPSDT periodicity schedule; monitoring usage of psychotropic medications through report analysis and follow up with outliers; identifying children in need of immediate or intensive care management for physical health
needs; and providing opportunities and activities for promoting wellness and preventing illness, including the prevention of chronic physical health conditions.

(d) Compliance with this Section will be determined by review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:17-5-159. Discharge or transfer from Behavioral Health Home [REVOKED]

(a) The BHH shall, on behalf of any consumer that transfers to another facility, forward the following within fifteen (15) days as permitted by privacy and confidentiality and if requested:

(1) The BHH discharge summary; and
(2) The consumer’s clinical record.

(b) For consumers who initiate BHH service and later decline those services, or are discharged from a BHH based on non-adherence to care plans, the BHH must forward to the primary health care provider of record, if any, and if requested by the consumer:

(1) The BHH discharge summary; and
(2) The consumer’s clinical record.

(c) As applicable to (a) and/or (b) above, the BHH discharge summary shall include the following:

(1) A summary of the services provided, including the consumer’s symptoms, treatment and recovery goals and preferences, treatments, and therapies.
(2) The client’s current active treatment plan at time of discharge.
(3) The client’s most recent physician orders.
(4) Any other documentation that will assist in post-discharge continuity of care.

(d) A completed discharge summary shall be entered in each consumer’s record within fifteen (15) days of the consumer completing or discontinuing services.

(e) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:17-5-160. Linkage and transitional care [REVOKED]

(a) The BHH shall have procedures and agreements in place to facilitate referral for other medical services needed by consumers beyond the scope of the BHH, as well as to assist the consumer to obtain services that are needed following discharge from the BHH.

(b) The BHH will also document referrals to community and social support services to facilitate access to formal and informal resources beyond the scope of services covered by SoonerCare, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith-based organizations, etc.

(e) The BHH will develop contracts or memoranda of understandings (MOUs) with regional hospital(s), Psychiatric Residential Treatment Facilities (PRTF) or other system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of BHH participants.

(1) Transitional care will be provided by the BHH for existing BHH consumers who have been hospitalized or placed in other non-community settings, such as psychiatric residential treatment facilities, as well as to newly identified, potential BHH consumers who are entering the community.

(2) The BHH team will collaborate with all parties involved including the facility, primary care physician, and community providers to ensure a smooth discharge and transition into the community and prevent subsequent re-admission(s).

(3) Transitional care is not limited to institutional transitions, but applies to all transitions that will occur throughout the development of the enrollee and includes transition from and to school-based services and pediatric services to adult services.

(4) The BHH will document transitional care provided in the clinical records.

(d) Compliance with this Section will be determined by on-site observation, review of organizational documents, contracts, MOUs, and clinical records.

450:17-5-161. Consumer (Patient Care) Registries and Population Health Management [REVOKED]

(a) The BHH must implement clinical decision support mechanisms, including but not limited to point of care reminders, following nationally published evidence-based guidelines for:

(1) A mental health or substance use disorder;
(2) A chronic medical condition;
(3) An acute condition;
(4) A condition related to unhealthy behaviors; and
(5) Well child or adult care.

(b) BHH must have descriptions of programs in place to demonstrate how it encourages healthier lifestyles for BHH members, including increased physical activity, better nutrition, avoidance of behavioral risks, and wider use of preventive care.

(e) The BHH shall electronically submit data to a health home information management system, subject to prior approval by the Director of ODMHSAS Provider Certification, which will act as a consumer registry, care management device and outcomes measurement tool.

(d) The BHH shall utilize information provided through the approved information system for the purpose of enrollment and discharge tracking, compliance, quality assurance, and outcome monitoring.

(e) Compliance will be determined by on-site observation, review of information available through an approved information system, and consultation with the ODMHSAS Decision
Support Services and ODMHSAS Information Services Division.

450:17-5-162. Electronic health records and data sharing [REVOKED]
(a) The BHH shall have a functioning electronic health record (EHR) system that meets Meaningful Use standards, as defined in the Medicare and Medicaid Incentive Programs, or have a facility approved written plan with timeframes to obtain one.
(b) The BHH shall document a plan to work with health information organizations to share referrals, continuity of care documents, lab results, and other health information and develop partnerships that maximize the use of Health Information Technology (HIT) across all treating providers.
(c) Compliance with (a) will be determined by review of documentation that certifies the electronic health record meets Meaningful Use standards or documentation of a plan to obtain one with implementation timeline.
(d) Compliance with (b) will be determined by on-site observation, review of information available through an approved information system documenting that BHH consumers’ records have been accessed and shared through a Health Information Exchange (HIE), and consultation with the ODMHSAS Decision Support Services and ODMHSAS Information Services Division.

450:17-5-163. Performance measurement and quality improvement [REVOKED]
(a) There shall be an ongoing performance improvement program designed to objectively and systematically monitor, evaluate and improve the quality of consumer care related to BHH operations.
(b) The BHH performance improvement activities must:
(1) Focus on high risk, high volume, or problem-prone areas.
(2) Consider incidence, prevalence, and severity of problems.
(3) Give priority to improvements that affect behavioral outcomes, client safety, and person centered quality of care.
(c) Performance improvement activities must also track adverse client events, analyze their causes, and implement preventive actions and mechanisms.
(d) The program must use quality indicator data, including client care, and other relevant data in the design of its program.
(e) The BHH must use the data collected to monitor the effectiveness and safety of services and quality of care and identify opportunities and priorities for improvement.
(f) The functions and processes outlined in (a) through (e) shall be evidenced in an annual written plan for performance improvement activities. The plan shall include but not be limited to:
(1) Outcomes management processes which include measures required by CMS and the State and may also include measures from the SAMHSA National Outcomes Measures, NCQA, and HEDIS as required to document improvement in population health.
(2) Quarterly record review to minimally assess:
(A) Quality of services delivered;
(B) Appropriateness of services;
(C) Patterns of service utilization;
(D) Treatment goals and objectives based on assessment findings and consumer input;
(E) Services provided which were related to the goals and objectives;
(F) Patterns of access and utilization of specialty care; and
(G) The care plan is reviewed and updated as prescribed by policy.
(g) Compliance with this Section will be determined by a review of the written program evaluation plan, program goals and objectives and other supporting documentation provided.

PART 25. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

450:17-5-170. Certified Community Behavioral Health Clinic
The purpose of this Part is to set forth, in addition to all other applicable rules, rules regulating program requirements, activities and services for CMHCs who opt to provide Certified Community Behavioral Health Clinic (CCBHC) services. The purpose of a CCBHC is to: 1) provide access to integrated services for all individuals regardless of pay source or ability to pay; 2) provide a full array of mental health and substance use disorder services available in every certified location, and provide, or coordinate with, primary care services; 3) provide quality driven services as demonstrated through data reports and outcomes reports generated by the ODMHSAS or its contractor; and 4) provide enhanced integration and coordination of mental health, primary, and substance use disorder services and supports for persons across the lifespan. Services and supports shall be delivered utilizing an interdisciplinary, team-based approach and in compliance with all requirements in the CCBHC Manual.

450:17-5-172. General Staffing
(a) In order to ensure adequate staffing, the facility must complete an assessment of the needs of the target consumer population and a staffing plan. The needs assessment will include cultural, linguistic, and treatment needs. The needs assessment will include both consumer and family/caregiver input and will be updated regularly, but no less frequently than every three (3) years.
(b) The facility operating the CCBHC will have policies and program descriptions to define how the CCBHC will operate a team dedicated to provide the range of specific services articulated elsewhere in this Subchapter.
(c) The facility shall have a fully staffed management team as appropriate for the size and needs of the clinic as determined.
Each facility shall have protocols addressing the needs of consumers who do not have access to all required services.

d) The facility must maintain liability/malpractice insurance adequate for the staffing and scope of services provided.

c) Compliance with this Section shall be determined by a review of personnel files and privileging documents.

450:17-5-174. Staff Training

(a) In addition to the requirements found in 450:17-34-5(b), in-service presentations shall be conducted upon hire/contracting and each calendar year thereafter for all CCBHC employees on the following topics:

1. Person/Family-centered, recovery oriented, evidence-based and trauma-informed care;
2. Primary care/behavioral health integration;
3. Risk assessment, suicide prevention and suicide response;
4. Roles of families and peers: Best practices in utilization of family support providers and peer recovery support specialists; and
5. Crisis response and management.

(b) The facility shall assess the skills and competence of each individual furnishing services and, as necessary, provide in-service training and education programs. The facility will have written policies and procedures describing its method(s) of assessing competency and maintains a written accounting of the in-service training provided during the previous 12 months.

c) Individuals providing staff training must be qualified as evidenced by their education, training and experience.

d) The training curriculum for (a) must be approved by the ODMHSAS commissioner or designee in writing prior to conducting any training pursuant to this provision.

e) Compliance with this Section shall be determined by a review of policies and procedures and personnel records.

450:17-5-176. Availability and accessibility of services

(a) A CCBHC must conduct outreach activities to engage those consumers who are difficult to find and engage, with an emphasis on the special population list also known as the "Most in Need" list that is determined and supplied to the CCBHC by the ODMHSAS. These activities must be services reported through the Medicaid Management Information System (MMIS). The CCBHC must have dedicated staff who do not carry a caseload. The CCBHC must have policies and procedures to describe how outreach and engagement activities will occur to assist consumers and families to access benefits and formal or informal services to address behavioral health conditions and needs.

(b) Facility records will identify which staff members are responsible for specific elements of outreach and engagement.

c) To the extent possible, the facility should make reasonable efforts to provide transportation or transportation vouchers for consumers to access services provided or arranged for by the facility.

d) To the extent allowed by state law, facility will make services available via telemedicine in order to ensure consumers have access to all required services.

e) The facility will ensure that no individuals are denied services, including but not limited to crisis management services, because of an individual's inability to pay and that any fees or payments required by the clinic for such services will be reduced or waived to enable the facility to fulfill this assurance. The Facility will have a published sliding fee discount schedule(s) that includes all services offered.

(f) The facility will ensure no individual is denied behavioral healthcare services because of place of residence or homelessness or lack of a permanent address. Facility will have protocols addressing the needs of consumers who do not live within the facility's service area. At a minimum, facility is responsible for providing crisis response, evaluation, and stabilization services regardless of the consumer's place of residence and shall have policies and procedures for addressing the...
management of the consumer's ongoing treatment needs. In addition, for those consumers who are homeless, the CCBHC must attempt to obtain at least two contact phone numbers for persons of the consumer's choice who know how to reach the consumer in the consumer's record, and/or a location where the consumer is most likely to be found, and/or a location to find a person of the consumer's choice likely to know where the consumer is located.

(g) Compliance with this Section shall be determined by a review of policies, consumer records and facility fee schedule.

450:17-5-178. Initial Preliminary screening, assessment and comprehensive evaluation

(a) The facility will directly provide screening, assessment and diagnosis, including risk assessment, for behavioral health conditions. The facility must determine the extent to which each consumer's needs and preferences can be adequately addressed within the array of required services.

(b) For new consumers requesting or being referred for behavioral health services, an integrated screening approach in accordance with OAC 450:17-3-21 will be used to determine the consumer's acuity of needs. The facility shall use standardized and validated screening and assessment tools, and where appropriate, brief motivational interviewing techniques. The preliminary screening shall be completed upon initial contact with the consumer.

(1) If the screening identifies an emergency/crisis need, the facility will take appropriate action immediately, including any necessary subsequent outpatient follow-up.

(2) If the screening identifies an urgent need, clinical services are provided and the initial evaluation completed within one business day of the time the request is made. An urgent need is one that if not addressed immediately could result in the person becoming a danger to self or others, or could cause a health risk.

(3) If screening identifies unsafe substance use including problematic alcohol or other substance use, the facility will conduct a brief intervention and the consumer is provided or referred for and successfully linked with a full assessment and treatment, if applicable, with appropriate follow up to ensure that the consumer made contact with the treatment facility.

(4) If the screening identifies routine needs, services will be provided and the initial evaluation assessment completed within 10 business days in accordance with OAC 450:17-5-180.

(c) A Licensed Behavioral Health Professional (LBHP) or Licensure Candidate, acting within his/her scope of practice requirements, must complete an initial assessment in accordance with the standard in OAC 450:17-3-21 for consumers who have not been assessed by the facility within the past 6 months.

(d) For consumers presenting with emergency or urgent needs, the initial assessment may be conducted by telemedicine but an in-person assessment is preferred. If the initial assessment is conducted via telemedicine, once the emergency is resolved, the consumer must be seen in person at the next subsequent encounter and the initial assessment reviewed.

(e) Prior to assigning a consumer to a CCBHC intensive level of care, a comprehensive evaluation must be completed by the interdisciplinary team performing within each team member's scope of practice consistent with each consumer's immediate needs and include a written narrative in each of the following areas:

(1) Psychiatric and substance use history, mental status, and a current DSM diagnosis;
(2) Medical, dental, and other health needs;
(3) Education and/or employment;
(4) Social development and functioning;
(5) Activities of daily living; and
(6) Family structure and relationships.

(g) The facility must ensure access to the comprehensive evaluation within 60 calendar days of the initial request for services. This requirement does not preclude the provision of treatment during the 60 day period.

(h) The comprehensive evaluation must be updated as needed but no less than every six (6) months.

(i) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:17-5-180. Person-centered and family-centered service planning/Initial assessment and initial care plan

(a) The facility must directly develop a consumer directed and family-centered, integrated active care plan for each enrolled consumer that reflects input of the team in managing the medical component of the plan, and other the consumer chooses to involve.

(b) The plan shall clearly address consumers' needs, strengths, abilities, physical and behavioral health goals, consumer preferences, and the overall health and wellness needs of the consumer.

(c) The plan is comprehensive, addressing all services required, with provision for monitoring of progress toward goals.

(d) The plan must be documented and completed within thirty (30) working days of admission to the CCBHC.

(e) The CCBHC must provide for each consumer and primary caregiver(s), as applicable, education and training consistent with the consumer and caregiver responsibilities as identified in the active treatment plan and relative to their participation in implementing the plan of care.

(f) Compliance with this Section will be determined by on-site observation, review of organizational documents, personnel records, staffing schedules, and clinical records.

(a) The initial assessment and the initial care plan must be completed within ten (10) business days after the first contact. The initial care plan must include, at a minimum, the following:

(1) Preliminary diagnoses;
(2) Source of referral;
(3) Reason for seeking care, as stated by the client or other individuals who are significantly involved;
(4) Identification of the client's immediate clinical care needs related to the diagnosis for mental and substance use disorders;
(5) A list of current prescriptions and over-the-counter medications, as well as other substances the client may be taking;
(6) An assessment of whether the client is a risk to self or to others, including suicide risk factors;
(7) An assessment of whether the client has other concerns for their safety; assessment of need for medical care (with referral and follow-up as required);
(8) A determination of whether the person presently is or ever has been a member of the U.S. Armed Services; and
(9) At least one (1) immediate treatment goal.

(b) A Licensed Behavioral Health Professional (LBHP) or Licensure Candidate, acting within his/her scope of practice requirements, must complete the initial assessment and initial care plan in accordance with OAC 450:17-3-21 for consumers who have not been assessed by the facility within the past six (6) months.

450:17-5-181. Service plan content

(a) The service plan must address all services necessary to assist the client in meeting his or her physical and behavioral health goals, and include the following:

(1) Consumer diagnoses, relative to behavioral and physical health conditions assessed by and addressed by the facility in terms of direct services provided and/or conditions for which the individual is referred elsewhere for treatment;

(2) Treatment goals, including preventive/primary care services;

(3) Interventions, including care coordination, physical health services, peer and family support services, targeted case management, as well as any accommodations to ensure cultural and linguistically competent services as applicable;

(4) A detailed statement of the type, duration, and frequency of services, including primary medical and specialty care, social work, psychiatric nursing, counseling, and therapy services, necessary to meet the consumer’s specific needs;

(5) Medications, treatments, and individual and/or group therapies;

(6) As applicable, family psychotherapy with the primary focus on treatment of the consumer’s conditions; and

(7) The interdisciplinary team's documentation of the consumer’s or representative’s and/or primary caregiver’s (if any) understanding, involvement, and agreement with the care plan.

(b) The CCBHC team must develop a consumer directed, comprehensive care plan for each enrolled consumer that reflects input of the interdisciplinary team, and others the consumer chooses to involve.

(b) The comprehensive care plan shall clearly address physical and behavioral health goals, consumer preferences, and the overall health and wellness needs of the consumer. The plan shall address the services necessary to assist the client in meeting his or her mental health and physical health goals, and include the following:

(1) Consumer diagnoses, relative to behavioral and physical health conditions assessed by and addressed in terms of direct services provided and/or conditions for which the individual is referred and linked elsewhere for treatment;

(2) Consumer integrated care service needs, relative to behavioral and physical health conditions assessed by and addressed in terms of direct services provided and/or conditions for which the individual is referred and linked elsewhere for treatment;

(3) One to three treatment goals for the upcoming six (6) months, including preventive, primary care, and wellness services;

(4) Interventions, including identification of and follow up with necessary medical providers, and identification of any specific care pathways for chronic conditions; and

(5) The interdisciplinary treatment team’s documentation of the consumer’s or representative’s and/or primary caregiver’s (if any) understanding, involvement, and agreement with the integrated care plan.

(c) The CCBHC must provide for each consumer and primary caregiver(s), as applicable, education and training consistent with the consumer and caregiver responsibilities as identified in the plan and relative to their participation in implementing the plan.

(d) The comprehensive care plan must be signed by an LBHP or licensure candidate in accordance with OAC 450:17-7-8, with participation by the interdisciplinary team performing within each team member’s scope of practice consistent with each consumer’s immediate needs.

(e) Compliance with this Section will be determined by on-site review of clinical records and supported documentation. The ODMHSA or its contractor may utilize site observation, staff surveys and/or interviews to assist Provider Certification with determining compliance.

450:17-5-182. Review of plan

(a) The facility will review, revise, and document the individualized service plan as frequently as the consumer’s conditions require, but no less frequently than every six (6) months.

(b) A revised active plan must include information from the consumer’s initial assessment and comprehensive assessments and updates, the progress toward goals specified in the written care plan, and changes, as applicable, in goals.
(e) Compliance with this Section will be determined by outcome monitoring, performance improvement activity reports and consumer records.

(a) The comprehensive care plan must be documented and completed within sixty (60) calendar days after the first contact.

(b) The comprehensive care plan must be updated as needed but no less than every six (6) months thereafter. The update shall include an addendum to the plan showing progress toward goals specified in the plan, goals and objectives that have been achieved, and any new goals or objectives.

(c) Additionally, a review of the comprehensive care plan shall be completed every three (3) months. A review shall consist of a review of the consumer's needs and progress as compared to the content of the comprehensive care plan to determine if an update to the comprehensive care plan is needed more frequently than required in (b) above.

(d) Compliance with this Section will be determined by on-site review of clinical records and supported documentation. The ODMHSAS or its contractor may utilize site observation, staff surveys and/or interviews to assist Provider Certification with determining compliance.

450:17-5-183. Care coordination

(a) Based on a person and family-centered care plan and as appropriate, the facility will coordinate care for the consumer across the spectrum of health services, including access to physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. This care coordination shall include not only referral but follow up after referral to ensure that services were obtained, to gather the outcome of those services, and to identify next steps needed.

(b) The facility must have procedures and agreements in place to facilitate referral for services needed beyond the scope of the facility. At a minimum, the facility will have agreements establishing care coordination expectations with Federally Qualified Health Centers (FQHCs) and, as applicable, Rural Health Centers (RHCs) to provide healthcare services for consumers who are not already served by a primary healthcare provider.

(c) The facility must have procedures and agreements in place establishing care coordination expectations with community or regional services, supports and providers including but not limited to:

1. Schools;
2. OKDHS child welfare;
3. Juvenile and criminal justice agencies;
4. Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department; and
5. Indian Health Service regional treatment centers.

(d) The facility will develop contracts or memoranda of understandings (MOUs) with regional hospital(s), Emergency Departments, Psychiatric Residential Treatment Facilities (PRTF), ambulatory and medical withdrawal management facilities or other system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of BHH participants.

1. Transitional care will be provided by the facility for consumers who have been hospitalized or placed in other non-community settings, such as psychiatric residential treatment facilities. The CCBHC will provide care coordination while the consumer is hospitalized as soon as it becomes known. A team member will go to the hospital setting to engage the consumer in person and/or will connect through telehealth as a face to face meeting. Reasonable attempts to fulfill this important contact shall be documented. In addition, the facility will make and document reasonable attempts to contact all consumers who are discharged from these settings within 24 hours of discharge.

2. The facility will collaborate with all parties involved including the discharging/admitting facility, primary care physician, and community providers to ensure a smooth discharge and transition into the community and prevent subsequent re-admission(s).

3. Transitional care is not limited to institutional transitions, but applies to all transitions that will occur throughout the development of the enrollee and includes transition from and to school-based services and pediatric services to adult services.

4. The facility will document transitional care provided in the clinical records.

(e) Care Coordination activities shall include use of population health management tools, such as dashboards, patient registries, and team staffings.

(f) Care coordination activities will be carried out in keeping with the consumer's preferences and needs for care, to the extent possible and in accordance with the consumer's expressed preferences, with the consumer's family/caregiver and other supports identified by the consumer. The facility will work with the consumer in developing a crisis plan with each consumer, such as a Psychiatric Advanced Directive or Wellness Recovery Action Plan.

(g) Referral documents and releases of information shall comply with applicable privacy and consumer consent requirements.

(h) Compliance with this Section will be determined by on-site observation, review of organizational documents, contracts, MOUs, and clinical records.

450:17-5-184. Crisis services

(a) The Facility shall make crisis management services available through clearly defined arrangements, for behavioral health emergencies during hours when the facility is closed. The Facility will also provide crisis management services that are available and accessible 24 twenty-four (24) hours a day and delivered within three (3) hours from the time services are requested.

(b) Facility will make available, either directly or through a qualified DCO, the following co-occurring capable services:

1. Twenty-four (24) hour mobile crisis teams, that are available via telehealth/secure tablet, or if an in-person
response is required, arrival within one (1) hour from the time requested;
(2) Emergency crisis intervention services; and
(3) Any additional crisis stabilization service available through the facility, such as a PACT team or dedicated outreach staff/team.
(c) Crisis services must include suicide crisis response and services capable of addressing crises related to substance use disorder and intoxication, including ambulatory and medical withdrawal management.
(d) Facility will have an established protocol specifying the role of law enforcement during the provision of crisis services.
(e) Compliance with this Section shall be determined by facility policies and clinical records. The ODMHSAS may also utilize surveys and/or interviews with law enforcement agencies, consumers, families and community partners to determine if these requirements are met.

450:17-5-185. Outpatient therapy services
(a) The facility will directly provide outpatient mental health and substance use disorder services that are evidence-based or best practices, consistent with the needs of the individual consumers as identified in their individual service plan. In the event specialized services outside the expertise of the facility are required for purposes of outpatient treatment, the facility will make them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through the use of telemedicine services.
(b) Evidence-based or best practices could include but not be limited to the following: those referenced in the CCBHC Manual,
1. Cognitive Behavior Therapy (CBT);
2. Trauma Focused Cognitive Behavior Therapy (TF-CBT);
3. Collaborative Assessment and Management of Suicidality (CAMS);
4. Chronic Care Disease Management; and
5. Motivational Interviewing.
(c) Outpatient therapy services shall include:
1. Individual therapy;
2. Group therapy;
3. Family therapy;
4. Psychological/psychometric evaluations or testing; and
(d) Compliance with this Section shall be determined by facility policies and clinical records.

450:17-5-186. Case management services
(a) The facility is responsible for high quality targeted case management (TCM) services that will assist individuals in sustaining recovery, and gaining access to needed medical, social, legal, educational, and other services and supports. TCM should include supports for persons deemed at high risk of suicide, particularly during times of transitions such as from an emergency department or psychiatric hospitalization— as outlined in the provider's suicide care pathway.
(b) The provision of TCM shall meet the requirements set forth in OAC 450:17-3 Part 11 and will be made available to all consumers as appropriate and identified in the individual service plan.
(c) Compliance with this Section shall be determined by a review of facility policy and clinical records.

450:17-5-187. Behavioral health rehabilitation services
(a) The facility is responsible for providing evidence-based and other psychiatric rehabilitation services. Services to be considered include:
1. Medication education;
2. Self-management education;
3. Community integration services;
4. Recovery support services including Illness Management & Recovery;
5. Financial management education; and
6. Dietary and wellness education; and
7. Other services referenced in the CCBHC Manual.
(b) Evidence based and best practices shall include but not be limited to:
1. Individual Placement and Support (IPS) supported employment;
2. Illness Management & Recovery (IMR) and Enhanced Illness Management & Recovery (EIMR);
3. Housing First Philosophy; and
4. Matrix model components, including contingency management.
(c) The provision of behavioral health rehabilitation services shall meet the requirements set forth in OAC 450:17-3 Part 15 and will be made available to all consumers, as appropriate and identified in the individual service plan.
(d) Compliance with this Section shall be determined by a review of facility policy and clinical records.

450:17-5-189. Community-based mental health care for members of the Armed Forces and Veterans
(a) The facility is responsible for screening all individuals inquiring about services for current or past service in the US Armed Forces.
(b) The facility is responsible for intensive, community-based behavioral health care for certain members of the US Armed Forces and veterans, particularly those Armed Forces members located 50 miles or more from a Military Treatment Facility (MTF) and veterans living 40 miles or more from a VA Veterans Affairs (VA) medical facility.
1. Active Duty Service Members (ADSM) must use their servicing MTF, and their MTF Primary Care Managers (PCMs) are contacted by the CCBHC regarding referrals outside the MTF.
2. ADSMs and activated Reserve Component (Guard/Reserve) members who reside more than 50 miles (or one hour's drive time) from a military hospital or military clinic enroll in TRICARE PRIME Remote and
use the network PCM, or select any other authorized TRICARE provider as the PCM. The PCM refers to the member to specialists for care he or she cannot provide; and works with the regional managed care support contact for referrals/authorizations;

(3) Members of the Selected Reserves, not on Active Duty (AD) orders, are eligible for TRICARE Reserve Select and can schedule an appointment with any TRICARE-authorized provider, network or non-network.

(4) Persons affirming former military service (veterans) are offered assistance to enroll in VHA for the delivery of health and behavioral health services. Veterans who decline or are ineligible for VHA services will be served by the CCBHC consistent with minimum clinical guidelines contained in the Uniform Mental Health Services Handbook.

(c) Care provided to veterans is required to be consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including guidelines contained in the Uniform Mental Health Services Handbook of such Administration. Clinical care and services for veterans will adhere to SAMSHA’s definition and guiding principles of recovery, VHA recovery, and other VHA guidelines.

(d) The facility will ensure that every veteran seen for behavioral health services is assigned a Principal Behavioral Health Provider which will be made clear to the veteran and identified in the medical record. The principal behavioral health provider will ensure the following requirements are fulfilled:

(1) Regular contact is maintained with the veteran as clinically indicated by the treatment plan as long as ongoing care is required;

(2) A psychiatrist, or such other independent prescriber as satisfies the current requirements of the VHA Uniform Mental Health Services Handbook, reviews and reconciles each veteran’s psychiatric medications on a regular basis;

(3) Coordination and development of the veteran’s treatment plan incorporates input from the veteran and veteran’s family when allowed and appropriate;

(4) Implementation of the treatment plan is monitored and documented which includes tracking progress in the care delivered, outcomes achieved and the goals attained;

(5) The treatment plan is revised, as necessary, but no less than once every six (6) months;

(6) The principal therapist or Principal Behavioral Health Provider communicates with the veteran about the treatment plan, and for addressing any of the veteran’s concerns about their care. For veterans who are at high risk of losing decision-making capacity such as those with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future behavioral health care treatment.

(7) The treatment plan reflects the veteran’s goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook requirements. For veterans who have been determined to lack capacity, the provider must identify the authorized surrogate and document the surrogate’s verbal consent to the treatment plan.

(c) All members of the Armed Forces and veterans will be afforded the complete array of services and supports available through the CCBHC, regardless of pay source or diagnosis. Need will be determined through a thorough assessment that includes any necessary communications with and records from any part of the military or veterans systems.

(d) The CCBHC will maintain Memoranda of Agreement and letters of collaboration necessary to easily receive referrals from the military or a VA medical facility, and to obtain all needed information from them, for successful treatment of all persons currently serving in the military or veterans.

(e) Compliance with this Section shall be determined by a review of facility policies and clinical records. In addition, the ODMHSA may conduct surveys and/or interviews, or utilize a contracted agent to conduct them.

SUBCHAPTER 7. FACILITY CLINICAL RECORDS

450:17-7.3. Basic requirements [REVOKED]

(a) The CMHC’s policies and procedures shall:

(1) Define the content of the consumer record in accordance with 450:17-7.4 through 17.7-9.

(2) Define storage, retention and destruction requirements for consumer records. ODMHSA- operated CMHCS shall comply with the Department’s Records Disposition Schedule as approved by the Oklahoma Archives and Records Commission.

(3) Require consumer records be maintained in locked equipment which is kept within a locked room, vehicle, or premise.

(4) Require legible entries in consumer records, signed with first name or initial and last name, of the person making the entry.

(5) Require the consumer’s name be typed or written on each page in the consumer record.

(6) Require a signed consent for treatment before a consumer is admitted on a voluntary basis.

(7) Require a signed consent for follow-up before any contact after discharge is made.

(b) Compliance with 450:17-7.3 shall be determined by a review of the following: facility policy, procedures or operational methods, clinical records, other facility provided documentation, and PI information and reports. A CMHC may propose administrative and clinical efficiencies through a streamlining of the requirements noted in this subchapter if client outcomes are maintained or improved and face-to-face clinical time is able to be increased by proposed reduction in record-keeping requirements. Such proposal shall be submitted for consideration and approval by the Department.
450:17-7-5. Clinical record content, screening and assessment
(a) All facilities shall complete a face-to-face screening with each individual to determine appropriateness of admission.
(b) The CMHC shall document the face-to-face screening between the potential consumer and the CMHC including how the consumer was assisted to identify goals, how the consumer received integrated screening to identify both immediate and ongoing needs and how the consumer was assisted to determine appropriateness of admission, and/or to access other appropriate services.
(c) Upon determination of appropriate admission, consumer demographic information shall be collected.
(d) All programs shall complete a psychological-social-psychosocial assessment which gathers sufficient information to assist the consumer in developing an individualized service plan.
(e) The CMHC shall have policy and procedures that stipulate content required for items (c) and (d).
(f) An assessment update, to include date, identifying information, source of information, present needs, present life situation, current level of functioning, and what consumer wants in terms of service, is acceptable only on re-admissions within one (1) year of previous admission.
(g) Compliance with 450:450:17-7-5 shall be determined by a review of the following: psychological-social-psychosocial assessment instruments; consumer records; case management assessments; interviews with staff and consumers; policies and procedures and other facility documentation.

450:17-7-12. Discharge summary [REVOKED]
(a) A discharge summary shall document the consumer's progress made in treatment; response to services rendered; and recommendation for any referrals, if deemed necessary. It shall include a discharge plan which lists written recommendations, and specific referrals for implementing aftercare services, including medications. Aftercare plans shall be developed with the knowledge and cooperation of the consumer, when possible.
(b) A discharge summary shall be entered in each consumer's record within fifteen (15) days of release, discharge, or transfer from inpatient treatment or upon discharge from facility services. Consumers who have received no services for one hundred twenty (120) days shall be discharged if it is determined that services are no longer needed or desired.
(c) In the event of death of a consumer: A summary statement including this information shall be documented in the record.
(d) Compliance with 450:17-7-12 shall be determined by a review of closed consumer records.

SUBCHAPTER 9. CONSUMER RECORDS AND CONFIDENTIALITY [REVOKED]

450:17-9-1. Confidentiality of mental health and drug or alcohol abuse treatment information [REVOKED]
Confidentiality policy, procedures and practices must comply with federal and state law, guidelines, and standards, and with OAC 450:15-3-20.1, OAC 450-15-3-20.2 and OAC 450-15-30.60.

SUBCHAPTER 13. ORGANIZATIONAL AND FACILITY MANAGEMENT [REVOKED]

450:17-13-1. Organizational and facility description [REVOKED]
(a) The CMHC shall have a written organizational description which is reviewed annually and minimally includes:
(1) The overall target population to be served;
(2) The overall mission statement; and
(3) The annual facility goals and objectives, including the goal of continued progress for the agency in providing recovery-oriented, culturally competent, trauma informed and co-occurring capable services.
(b) The CMHC's governing authority shall review and approve the mission statement and annual goals and objectives and document their approval.
(c) The CMHC shall make the organizational description, mission statement and annual goals available to staff.
(d) The CMHC shall make the organizational description, mission statement and annual goals available to the general public upon request.
(e) Each CMHC shall have in writing, by program component or service, the following:
(1) Philosophy and description of services, including the philosophy of recovery oriented and welcoming service delivery;
(2) Identity of the professional staff that provides these services;
(3) Admission and exclusionary criteria that identify the type of consumers for whom the services is primarily intended, with no exclusion criteria based on active substance use disorders;
(4) Goals and objectives, including making progress toward co-occurring capable, trauma informed, and culturally competent service delivery; and
(5) Delineation of processes to assure welcoming accessible, integrated, and co-occurring capable services and a plan for how each program component will address the needs of individuals with co-occurring disorders.
(f) The CMHC shall have written statement of the quality improvement processes, procedures and plans for attaining the organization's goals and objectives. These procedures and plans shall define specific tasks, including actions regarding the organization's co-occurring capability set target dates and designate staff responsible for carrying out the procedures and plans.
(g) Compliance with OAC 450:18-13-1 shall be determined by a review of the facility's target population definition; facility policy and procedures; mission statement; written plan

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for professional services; other stated required documentation; and any other supporting documentation.

450:17-13-2. Information analysis and planning [REVOKED]
(a) The CMHC shall have a defined and written plan for conducting an organizational needs assessment which specifies the methods and data to be collected, to include, but not limited to information from:

1. Consumers;
2. Governing Authority;
3. Staff;
4. Stakeholders;
5. Outcomes management processes;
6. Quality record review and
7. Self-assessment tools to determine progress toward co-occurring, recovery-oriented, trauma-informed and consumer-driven capability.
(b) The CMHC shall have a defined ongoing system to collect data and information on a quarterly basis to manage the organization.
(c) Information collected shall be analyzed to improve consumer services and organizational performance.
(d) The CMHC shall prepare an end of year management report, which shall include but not be limited to:

1. An analysis of the needs assessment process, and
2. Performance improvement program findings.
(e) The management report shall be communicated and made available to, among others:

1. The governing authority,
2. Facility staff, and
3. ODMHAS as if and when requested.
(f) Compliance with OAC 450:17-13-2 shall be determined by a review of the written program evaluation plan(s); written annual program evaluation(s) special or interim program evaluations; program goals and objectives; and other supporting documentation provided.

SUBCHAPTER 15. PERFORMANCE IMPROVEMENT AND QUALITY MANAGEMENT

450:17-15-1.1. Performance improvement program [REVOKED]
(a) The CMHC shall have an ongoing performance improvement program designed to objectively and systematically monitor, evaluate and improve the quality of consumer care.
(b) The Performance improvement program shall also address the fiscal management of the organization.
(c) The facility shall have an annual written plan for performance improvement activities. The plan shall include but not be limited to:

1. Outcomes management specific to each program component which minimally measures:
   - Efficiency;
   - Effectiveness; and
   - Consumer satisfaction.
2. A quarterly quality consumer record review to evaluate and ensure, among others:
   - The quality of services delivered;
   - The appropriateness of services;
   - Patterns of service utilization;
   - Consumers are provided an orientation to services, and actively involved in making informed choices regarding the services they receive;
   - Assessments are thorough, timely and complete;
   - Treatment goals and objectives are based on, at a minimum:
     - Assessment findings, and
     - Consumer input;
   - Services provided are related to the treatment plan goals and objectives;
   - Services are documented as prescribed by policy; and
   - The service plan is reviewed and updated as prescribed by policy.
3. Clinical privileging;
4. Review of critical and unusual incidents and consumer grievances and complaints; and
5. Improvement in the following:
   - Co-occurring capability, including the utilization of self-assessment tools as determined or recommended by ODMHAS;
   - Provision of trauma informed services;
   - Provision of culturally competent services; and
   - Provision of consumer driven services; and
6. Activities to improve access and retention within the treatment program, including an annual "walk through" of the admission process.
(d) The CMHC will identify a performance improvement officer.
(e) The CMHC shall monitor the implementation of the performance improvement plan on an ongoing basis and make adjustments as needed.
(f) Performance improvement findings shall be communicated and made available to, among others:

1. The governing authority;
2. Facility staff;
3. Consumers;
4. Stakeholders; and
5. ODMHAS as requested.
(g) Compliance with 450:17-15-1.1 shall be determined by a review of the written program evaluation plan; written program evaluations (annual and or special or interim; program goals and objectives; and other supporting documentation provided).

450:17-15-5. Critical incident reporting
(a) The facility shall have written policies and procedures requiring documentation and reporting of critical incidents and analysis of the contributors to the incident, with attention to issues that may reflect opportunities for system level or program level improvement.
(b) The documentation for critical incidents shall minimally include:
(1) the facility, name and signature of the person(s) reporting the incident;
(2) the name(s) of the consumer(s), staff member(s) or property involved;
(3) the time, date and physical location of the critical incident;
(4) the time and date the incident was reported and name of the staff person within the facility to whom it was reported;
(5) a description of the incident;
(6) resolution or action taken, date action taken, and signature of appropriate staff; and
(7) severity of each injury, if applicable. Severity shall be indicated as follows:
(A) No off-site medical care required or first-aid care administered on-site;
(B) Medical care by a physician or nurse or follow-up attention required; or
(C) Hospitalization or immediate off-site medical attention was required;
(e) Critical incidents shall be reported to ODMHSAS with specific timeframes, as follows:
(1) Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax or mail to ODMHSAS Provider Certification within twenty-four (24) hours of the incident being documented.
(2) Critical incidents involving allegations constituting a sentinel event or consumer abuse shall be reported to ODMHSAS immediately via telephone or fax, but not more than twenty-four (24) hours of the incident. If reported by telephone, the report shall be followed with a written report within twenty-four (24) hours.
(3) Sentinel events shall have a root cause analysis completed no later than 30 days after the event occurred with a copy of the completed report sent to ODMHSAS.
(d) Compliance with 450:17-15-5 shall be determined by a review of facility policy and procedures; critical incident reports at the facility and those submitted to ODMHSAS, performance improvement program documents and reports, and staff interviews.

In addition to the requirements set forth in OAC 450:1-9-5.3(f), sentinel events shall have a root cause analysis completed no later than 30 days after the event occurred with a copy of the completed report sent to ODMHSAS.

SUBCHAPTER 19. HUMAN RESOURCES [REVOKED]

450:17-19-1. Personnel policies and procedures [REVOKED]

(a) The facility shall have written personnel policies and procedures approved by the governing authority.
(b) All employees shall have access to personnel policies and procedures, as well as other Rules and Regulations governing the conditions of their employment.
(c) The facility shall develop, adopt, and maintain policies and procedures at each provider location to promote the objectives of the center and provide for qualified personnel during all hours of operation to support the functions of the facility and the provision of quality care.
(d) Compliance with 450:17-19-1 shall be determined by a review of written personnel policies and procedures, and other supporting documentation provided.

(a) There shall be job descriptions for all positions setting forth minimum qualifications and duties of each position.
(b) All job descriptions shall include an expectation of core competencies in relation to individuals with co-occurring disorders.
(c) Compliance with 450:17-19-2 shall be determined by a review of written job descriptions for all facility positions, and other supporting documentation provided.

(a) In facilities where volunteers are utilized, specific policies and procedures shall be in place to define the purpose, scope, and training, supervision and operations related to the use of volunteers.
(b) A qualified staff member shall be assigned the role of, or responsibility as, the volunteer coordinator.
(c) Volunteer policies and procedures shall be reviewed by the governing authority upon revision.
(d) There shall be documentation to verify orientation of each volunteer which shall enable him or her to have knowledge of program goals and familiarity with routine procedures.
(e) Volunteers are required to receive in-service training pursuant to 17-21-3.
(f) Compliance with 450:17-19-3 shall be determined by a review of volunteer policies and procedures; designation of a volunteer coordinator; written orientation plan; orientation program; written goals and objectives; volunteer personnel files; and volunteer records.

SUBCHAPTER 21. STAFF DEVELOPMENT AND TRAINING [REVOKED]

450:17-21-1. Staff qualifications [REVOKED]
(a) All staff who provide clinical services shall have documented qualifications or training specific to the clinical services they provide within the CMHC.
(b) Staff qualifications for contracted entities shall be in compliance with 450:1-1-1.1 and 450:1-3-5.
(c) Compliance with 450:17-21-1 shall be determined by a review of staff personnel files and other supporting documentation provided.
(d) Failure to comply with 450:17-21-1 will result in the initiation of procedures to deny, suspend and/or revoke certification.
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450:17-21-2. Staff development [REVOKED]
(a) The CMHC shall have a written plan for the professional growth and development of all administrative, professional and support staff.
(b) This plan shall include, but not be limited to:
(1) orientation procedures;
(2) in-service training and education programs;
(3) availability of professional reference materials; and
(4) mechanisms for insuring outside continuing educational opportunities for staff members.
(c) The results of performance improvement activities, accrediting and audit findings and recommendations shall be addressed by and documented in the staff development and clinical privileging processes.
(d) Staff competency development shall be aligned with the organization’s goals related to co-occurring capability, and incorporate a training plan, training activities, and supervision designed to improve co-occurring core competencies of all staff.
(e) Staff education and in-service training programs shall be evaluated by the CMHC at least annually.
(f) Compliance with 450:17-21-2 shall be determined by a review of the staff development plan, clinical privileging processes; documentation of in-service training programs; and other supporting documentation provided.

450:17-21-3. Annually required in-service training for all employees and volunteers [REVOKED]
(a) In-service presentations shall be conducted each calendar year and are required upon hire and annually thereafter for all employees on the following topics:
(1) Fire and safety;
(2) AIDS and HIV precautions and infection control;
(3) Consumer’s rights and the constraints of the Mental Health Patient’s Bill of Rights;
(4) Confidentiality;
(5) Oklahoma Child Abuse Reporting and Prevention Act, 10 O.S. §§ 7101-7115; and
(6) Facility policy and procedures;
(7) Cultural Competence (including military culture if active duty or veterans are being served);
(8) Co-occurring disorder competency and treatment principles;
(9) Trauma informed; and
(10) Age and developmentally appropriate trainings, where applicable.
(b) All clinical staff and/or volunteers shall have non-physical intervention training in techniques and philosophies addressing appropriate non-violent interventions for potentially physical interpersonal conflicts, staff attitudes which promote dignity and enhanced self-esteem, keys to effective communication skills, verbal and non-verbal interaction and non-violent intervention within three (3) months of being hired with annual updates thereafter.
(c) The local facility Executive Director shall designate which positions, employees, including temporary employees, will be required to successfully complete physical intervention training. An employee or volunteer shall not provide direct care services to consumers until completing this training.
(d) The training curriculum for 450:17-21-3 (b) and (c) must be approved by the ODMHAS commissioner or designee in writing prior to conducting any training pursuant to this provision.
(e) Compliance with 450:17-21-3 shall be determined by a review of in-service training records, personnel records, and other supporting written information provided.

450:17-21-4. First Aid and CPR training [REVOKED]
(a) The CMHC shall have staff during all hours of operation at each program site who maintains current certification in basic first aid and Cardiopulmonary Resuscitation (CPR).
(b) Compliance with 450:17-21-4 shall be determined by a review of staff training records and other supporting written information, including, but not limited to staff schedules to assure all program sites are continuously staff with staff trained in Item (a) above.

450:17-21-6. Clinical supervision [REVOKED]
(a) Clinical supervision is a vital component of the provision of quality treatment. Clinical supervision shall be provided for those delivering direct services and shall be provided by persons knowledgeable of clinical services as determined by the program.
(b) All facilities shall have written policies and procedures, operational methods, and documentation of the provision of clinical supervision for all direct treatment and service staff. For facilities that employ only one service provider, supervision will be in the form of clinical consultation from a qualified service provider in the same field. These policies shall include, but are not limited to:
(1) Credentials required for the clinical supervisor;
(2) Specific frequency for case reviews with treatment and service providers;
(3) Methods and time frames for supervision of individual, group, and educational treatment services; and
(4) Written policies and procedures defining the program’s plan for appropriate counselor to consumer ratio, and a plan for how exceptions may be handled.
(c) Ongoing clinical supervision should address:
(1) The appropriateness of treatment selected for the consumer;
(2) Treatment effectiveness as reflected by the consumers meeting their individual goals; and
(3) The provision of feedback that enhances the clinical skills of service providers.
(d) Compliance with this Section may be determined by a review of the following:
(1) Policies and procedures;
(2) Clinical services manuals;
(3) Clinical supervision manuals;
(4) Documentation of clinical supervision;
(5) Personnel records;
(6) Interviews with staff; and
(7) Other facility documentation.

(2) Failure to comply with this Section will result in the initiation of procedures to deny, suspend and/or revoke certification.

SUBCHAPTER 23. FACILITY ENVIRONMENT [REVOKED]

450:17-23-1. Facility environment [REVOKED]

(a) The CMHC shall obtain an annual fire and safety inspection from the State Fire Marshall or local authorities which documents approval for continued occupancy.

(b) CMHC staff shall know the exact location, contents and use of first aid supply kits and fire fighting equipment. First aid supplies and fire fighting equipment shall be maintained in appropriately designated areas within the facility. Fire alarm systems shall have visual signals suitable for the deaf and hearing-impaired.

(c) There shall be posted written plans and diagrams noting emergency evacuation routes in case of fire, and shelter locations in case of severe weather.

(d) Facility grounds shall be maintained in a manner to provide a safe environment for consumers, personnel, and visitors.

(e) The director of the CMHC or designee shall appointment of a safety officer.

(f) The facility shall have an emergency preparedness program designed to provide for the effective utilization of available resources so that consumer care can be continued during a disaster. The emergency preparedness program is evaluated annually and is updated as needed.

(g) Policies for the use and control of personal electrical equipment shall be developed and implemented.

(h) There shall be an emergency power system to provide lighting throughout the facility.

(i) The CMHC director shall ensure there is a written plan to cope with internal and external disasters. External disasters include, but are not limited to, tornadoes, explosions, and chemical spills.

(j) Compliance with 450:17-23-1 shall be determined by visual observation; posted evacuation plans; a review of the CMHC's annual fire and safety inspection report; and a review of policy, procedures, and other supporting documentation provided.

450:17-23-2. Technology [REVOKED]

(a) The CMHC shall have a written plan regarding the use of technology and systems to support and advance effective and efficient service and business practices. The plan shall include, but not be limited to:

(1) Hardware and software.

(2) Security.

(3) Confidentiality.

(4) Backup policies.

(5) Assistive technology.

(6) Disaster recovery-preparedness.

(7) Virus protection.

(b) Compliance with this Section shall be determined by a review of the facility policies, performance improvement plans and technology and system plan.

450:17-23-3. Tobacco-free campus [REVOKED]

(a) The CMHC shall provide a tobacco-free campus for its employees, consumers and visitors. Possession and use of any tobacco product is prohibited on the grounds of the CMHC by employees, consumers, volunteers and visitors.

(b) Facility will visibly post signs on the property notifying consumers, employees and visitors that the visible possession and use of tobacco products is prohibited.

(c) CMHC employees shall not share tobacco or tobacco replacement products with consumers.

(d) The CMHC shall offer assistance to employees who are tobacco users while he or she is employed by the CMHC. The assistance shall include but is not limited to, the provision of information on the health impact of continued tobacco use; the integrated assessment of consumer's tobacco use into standard practice; referrals to tobacco cessation programs such as the Oklahoma Tobacco Helpline; the provision of or access to FDA approved prescription and/or non-prescription medications for the treatment of nicotine dependence when available; the delivery of evidence-based behavioral interventions for tobacco use cessation by counselors and other clinicians; and provision of appropriate follow-up to facilitate cessation intervention and prevent relapse.

(e) The CMHC shall always inquire of the consumers' tobacco use status and be prepared to offer treatment upon request of the consumer.

(f) Compliance with this Section shall be determined by visual observation; posted signs; consumer and staff interviews; and a review of the CMHC's policy, procedures and other supporting documentation provided.

SUBCHAPTER 25. GOVERNING AUTHORITY

450:17-25-1. Documents of authority [REVOKED]

(a) There shall be a duly constituted authority and governance structure for ensuring legal responsibility and for requiring accountability for performance and operation of the facility (including all components and satellites).

(b) The governing authority shall have written documents of its source of authority, which shall be available to the public upon request.

(c) In accordance with governing body bylaws, rules and regulations, the chief executive officer is responsible to the governing body for the overall day-to-day operation of the facility, including the control, utilization, and conservation of its physical and financial assets and the recruitment and direction of the staff.

(d) The source of authority document shall state:

(A) The eligibility criteria for governing body membership;

(B) The number and types of membership;

(C) The method of selecting members.
(D) The number of members necessary for a quorum;
(E) Attendance requirements for governing body membership;
(F) The duration of appointment or election for governing body members and officers; and
(G) The powers and duties of the governing body and its officers and committees or the authority and responsibilities of any person legally designated to function as the governing body.

(2) There shall be an organizational chart setting forth the operational components of the facility and their relationship to one another.

(d) Compliance with 450:17-25-1 shall be determined by a review of the following: bylaws, articles of incorporation, written document of source of authority, minutes of governing board meetings, job description of the CEO, and the written organizational chart.

SUBCHAPTER 27. SPECIAL POPULATIONS [REVOKED]


(a) Under Titles 11 and 111 of the ADA, the CMHCs shall comply with the "Accessibility Guidelines for Buildings and Facilities (ADAG) for alterations and new construction." United States government facilities are exempt for the ADA as they shall comply with the "Uniform Federal Accessibility Standards (UFAS)", effective August 7, 1984. Also available for use in assessing quality design and accessibility is the American National Standards Institute (ANSI) A117.1 "American National Standard for Accessible and Usable Buildings and Facilities."

(b) State and local standards for accessibility and usability may be more stringent than ADA, UFAs, or ANSI A 117.1. The CMHC shall assume responsibility for verification of all applicable requirements and comply with the most stringent standards.

(c) The CMHC shall have written policy and procedures providing or arranging for services for persons who fall under the protection of the Americans With Disabilities Act of 1990 and provide documentation of compliance with applicable federal, state, and local requirements. A recommended reference is the "Americans With Disabilities Handbook" published in U.S. Equal Employment Opportunities Commission and the U.S. Department of Justice.

(d) Compliance with 450:17-27-1 shall be determined through a review of facility written policy and procedure; and any other supporting documentation.

450:17-27-2. Human Immunodeficiency Virus (HIV), and Acquired Immunodeficiency Syndrome (AIDS) [REVOKED]

(a) The facility shall have a policy of non-discrimination against persons with HIV infection or AIDS.
This chapter sets forth the standards and criteria used in the certification of facilities and organizations providing treatment services for consumers with substance-related and addictive disorders and implements 43A O.S. §§ 3-403, 3-415, 3-416, 3-417, 3-417.1, 3-601, 3-602 and 3-603. The rules regarding the certification processes, including, but not limited to, the application process, fees, and administrative sanctions are found in OAC 450:1, Subchapters 5 and 9. Regulations governing the certification processes, including, but not limited to, the application process, fees, and administrative sanctions are found in OAC 450:1, Subchapters 5 and 9. The rules establishing the Certificate of Need assessment process applicable to certain treatment services for consumers with substance-related and addictive disorders and implements 43A O.S. §§ 3-403, 3-415, 3-416, 3-417, 3-417.1, 3-601, 3-602 and 3-603. The rules regarding the Certificate of Need assessment process applicable to certain treatment services for consumers with substance-related and addictive disorders and implements 43A O.S. §§ 3-403, 3-415, 3-416, 3-417, 3-417.1, 3-601, 3-602 and 3-603.

**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., sections 250.3(5) and 308(E), with an effective date of September 15, 2021:**

**SUBCHAPTER 1. GENERAL PROVISIONS**

450:18-1-1. Purpose

This chapter sets forth the standards and criteria used in the certification of facilities and organizations providing treatment services for consumers with substance-related and addictive disorders and implements 43A O.S. §§ 3-403, 3-415, 3-416, 3-417, 3-417.1, 3-601, 3-602 and 3-603. The rules regarding the certification processes, including, but not limited to, the application process, fees, and administrative sanctions are found in OAC 450:1, Subchapters 5 and 9. Rules outlining general certification qualifications applicable to facilities and organizations certified under this Chapter are found in OAC 450:1-9-5 through OAC 450:1-9-5.3.

450:18-1-2. Definitions

The following words or terms, when used in this chapter, shall have the following meaning, unless the context clearly indicates otherwise:
"Abuse" means the causing or permitting of harm or threatened harm to the health, safety, or welfare of a consumer by a staff responsible for the consumer’s health, safety, or welfare, including but not limited to: non-accidental physical injury or mental anguish; sexual abuse; sexual exploitation; use of mechanical restraints without proper authority; the intentional use of excessive or unauthorized force aimed at hurting or injuring the resident; or deprivation of food, clothing, shelter, or healthcare by a staff responsible for providing these services to a consumer.

"Acute intoxication" or "withdrawal potential" means one dimension to be considered in consumer placement, continued stay, and discharge and is an evaluation of the consumer’s withdrawal patterns and current level of intoxication and potential for withdrawal complications as it impacts level of care decision making.

"Admission" means the acceptance of a consumer by a treatment program to receive services at that program.

"Admission criteria" means those criteria which shall be met for admission of a consumer for services.

"Adult" means any individual eighteen (18) years of age or older.

"ASAM" means the American Society of Addiction Medicine.

"ASAM levels of care" means the different options for treatment as described in the current edition of the ASAM criteria that vary according to the intensity of the services offered. Each treatment option is a level of care.

"ASAM criteria" or—means the most current edition of the American Society of Addiction Medicine’s published criteria for admission to treatment, continued services, and discharge.

"ASAM level 1" means Outpatient Services for adolescents and adults. This level of care typically consists of less than nine (9) hours of services per week for adults or less than six (6) hours of services per week for adolescents. Services may be delivered in a wide variety of settings.

"ASAM level 3" means residential and inpatient services and encompasses ASAM levels 3.1, 3.3, 3.5 and 3.7.

"ASAM level 3.1" means Clinically Managed Low-Intensity Residential Services for adolescents and adults. This level of care typically provides at least five (5) hours of clinical services a week and provides a twenty-four (24) hour living support and structure with trained personnel. The corresponding service description for this level of care is Halfway House Services.

"ASAM level 3.3" means Clinically Managed Population-Specific High-Intensity Residential Services. This level of care is for adults only and typically offers twenty-four (24) hour care with trained personnel and is designed to accommodate individuals with cognitive or other impairments, including co-occurring disorders. The corresponding service description for this level of care is Residential Treatment for Adults with Co-Occurring Disorders.

"ASAM level 3.5" means Clinically Managed Medium-Intensity Residential Services for adolescents and Clinically Managed High-Intensity Residential Services for adults. This level of care provides twenty-four (24) hour care and offers a wide range of therapeutic services. The corresponding service descriptions for this level of care are Residential Treatment and Intensive Residential Treatment.

"ASAM level 3.7" means Medically Monitored High-Intensity Inpatient Services for adolescents and Medically Monitored Intensive Inpatient Withdrawal Management for adults. This level of care provides twenty-four (24) hour nursing care with physician supervision and medication availability. This level of care is appropriate for individuals withdrawing from alcohol or other drugs with subacute biomedical and emotional, behavioral, or cognitive problems severe enough to require inpatient treatment but for whom hospitalization is not necessary. The corresponding service description for this level of care is Medically Supervised Withdrawal Management.

"Assessment" means those procedures by which a program provides an on-going evaluation process with the consumer as outlined in applicable rules throughout OAC 450 to collect pertinent information needed as prescribed in applicable rules and statutes to determine courses of actions or services to be provided on behalf of the consumer. Assessment may be synonymous with the term evaluation.

"Behavioral health services" means a wide range of diagnostic, therapeutic, and rehabilitative services used in the treatment of mental illness, substance use disorders, and co-occurring disorders.

"Biomedical condition and complications" means one dimension to be considered in placement, continued stay, and discharge and is an evaluation of the consumer's current physical condition and history of medical and physical functioning as it impacts level of care decision making.

"Biopsychosocial assessment" means face-to-face interviews conducted by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate designed to elicit historical and current information regarding the behaviors, experiences, and support systems of a consumer, and identify the consumer's strengths, needs, abilities, and preferences for the purpose of guiding the consumer's recovery plan.

"Care management" means a type of case management in residential substance use disorder (ASAM Level 3) treatment settings that includes assessment, development of a care plan, and referral and linkage to community supports and community-based or lower level of care services to promote continued recovery after the individual discharges from the treatment facility.

"Case management—services" means planned referral, linkage, monitoring, support, and advocacy provided in partnership with a consumer to assist that consumer with self-sufficiency and community tenure and take place in the individual's home, in the community, or in the facility, in accordance with a service plan developed with and approved by the consumer and qualified staff.

"Certified Gambling Addiction Treatment" or "CGAT" means programs certified by ODMHSAS to provide treatment to individuals diagnosed with a gambling disorder. "Child" or "Children" means any individuals under eighteen (18) years of age.

"Client" See "Consumer".
"Clinical supervision" means an organized process by which knowledgeable and skilled supervisors systematically and routinely provide ongoing and in-depth review of direct service providers' performance which leads to professional growth, clinical skills development, and increased self-awareness.

"Community-based Structured Crisis Center" or "CBSCC" means a program of non-hospital emergency services for mental health and substance use disorder crisis stabilization as authorized by 43A O.S. §3-317 including, but not limited to, observation, evaluation, emergency treatment, and referral, when necessary, for inpatient psychiatric or substance use disorder treatment services. This service is limited to CMHCs who are certified by the Department of Mental Health and Substance Abuse Services or facilities operated by the Department of Mental Health and Substance Abuse Services.

"Community education information, consultation, and outreach" means services designed to reach the facility's target population, to promote available services, and to give information on substance-related and addictive disorders, domestic violence, sexual assault, and other related issues to the general public, the target population, or to other agencies serving the target population. These services include presentations to human services agencies, community organizations, and individuals, other than individuals in treatment, and staff. These services may take the form of lecture presentations, films or other visual displays, and discussions in which factual information is disseminated. The presentations may be made by staff or trained volunteers.

"Community mental health center" or "CMHC" means a facility offering a comprehensive array of community-based mental health services including, but not limited to, inpatient treatment, outpatient treatment, partial hospitalization, emergency care, consultation and education, and certain services at the option of the center including, but not limited to, prescreening, rehabilitation services, pre-care and aftercare, training programs, and research and evaluation.

"Consultation" means the act of providing information or technical assistance to a particular group or individual seeking resolution of specific problems. A documented process of interaction between staff members or between facility staff and unrelated individuals, groups, or agencies for the purpose of problem solving or enhancing their capacities to manage consumers or facilities.

"Consumer" means an individual, adult, adolescent, or child who has applied for, is receiving or has received evaluation or treatment services from a facility operated or certified by ODMHSAS or with which ODMHSAS contracts and includes all persons referred to in OAC Title 450 as client(s) or patient(s) or resident(s) or a combination thereof.

"Consumer advocacy" means all activities on behalf of the consumer to assist with or facilitate resolution of problems in the acquisition of resources or services needed by the consumer.

"Consumer record" means the collection of written information about a consumer's evaluation or treatment that includes the admission data, evaluation, treatment or service plan, description of treatment or services provided, continuing care plan, and discharge information on an individual consumer.

"Continuing care" means providing a specific period of structured therapeutic involvement designed to enhance, facilitate, and promote transition from a current level of services to support ongoing recovery.

"Contract" means a document adopted by the governing authority of a treatment facility and any other organization, facility, or individual, which specifies services, personnel, or space to be provided by the program, as well as the monies to be expended in exchange.

"Co-occurring disorder" (COD) means any combination of mental health symptoms and substance use disorder symptoms or diagnoses that affect a consumer and are typically determined by the current Diagnostic and Statistical Manual of Mental Disorders.

"Co-occurring disorder capability" means the organized capacity within any type of program to routinely screen, identify, assess, and provide properly matched interventions to consumer's with co-occurring disorders.

"Co-occurring disorder enhanced" means that the program (or subunit of the program) provides a specialized service designed for individuals with co-occurring disorders, usually with a higher level of available service capacity or intensity for the co-occurring substance use disorder than would be the case in a comparable co-occurring disorder capable program.

"Correctional institution" means any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program operated by, or under contract to, the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense, or other persons held in lawful custody. Other persons held in lawful custody include juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial. Programs which are providing treatment services within a correctional facility may be exempt from certain services described in this chapter which cannot be provided due to circumstance.

"Crisis Diversion" means an 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.

"Crisis intervention" means actions taken and services provided to address emergency psychological, physiological, and safety aspects of alcohol, drug-related, and mental health crises.

"Critical incident" means an occurrence or set of events inconsistent with the routine operations of a facility, service setting, or otherwise routine care of a consumer. Critical incidents specifically include, but are not necessarily limited to the following: adverse drug events, self-destructive behavior, deaths and injuries to consumers, staff, and visitor; medication errors; residential consumers that have absent without leave (AWOL); neglect or abuse of a consumer; fire; unauthorized
disclosure of information; damage to or theft of property belonging to consumers or the facility; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or results.

"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs, and values that reflect an individual's racial, ethnic, religious, sexual orientation, and/or social group.

"Day school" means the provision of therapeutic and accredited academic services on a regularly scheduled basis.

"Department" or "ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"Detoxification" means the process of eliminating the toxic effects of drugs and alcohol from the body. Supervised detoxification methods include social detoxification and medical monitoring or medical management and are intended to avoid withdrawal complications.

"DHS" or "OKDHS" means the Oklahoma Department of Human Services.

"Diagnosis" means the determination of a disorder as defined by current DSM criteria and in accordance with commonly accepted professional practice standards.

"Dietitian" or "Dietician" means an individual trained and licensed in the development, monitoring, and maintenance of food and nutrition in accordance with the Oklahoma State Board of Medical Licensure and Supervision.

"Discharge criteria" means individualized measures by which a program and the consumer determine readiness for discharge or transition from services being provided by that facility. These may reference general guidelines as specified in facility policies or procedures and/or in published guidelines including, but not limited to, the current ASAM criteria for individuals with substance use disorders, but should be individualized for each consumer and articulated in terms of consumer behaviors, resolutions of specific problems, and attainment of goals developed in partnership with the participant and the provider.

"Discharge planning" or "transition planning" means the process, begun at admission, of determining a consumer's continued need for treatment services and of developing a plan to address ongoing consumer post-treatment and recovery needs. Discharge planning may or may not include a document identified as a discharge plan.

"Discharge summary" means a clinical document in the treatment record summarizing the consumer's progress during treatment, with goals reached, continuing needs, and other pertinent information including documentation of linkage to aftercare.

"DOC" or "ODOC" means the Oklahoma Department of Corrections.

"Documentation" means the provision of written, dated, and authenticated evidence to substantiate compliance with standards, e.g., minutes of meetings, memoranda, schedules, notices, logs, records, policies, procedures, and announcements.

"DSM" means the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"Education" means the dissemination of relevant information specifically focused on increasing the awareness of the community and the receptivity and sensitivity of the community concerning mental health, substance-related and addictive disorders, or other related problems and services related to the specific focus of treatment.

"Educational group" means groups in which information is provided to consumers or consumers in a teaching or instructional format and typically related to the current focus of treatment, designated to positively impact a consumer's recovery. Topics should be gender and age specific and should include, but not be limited to, information regarding their diagnosis or identified problems on their treatment plan. This service may involve teaching skills in communication, self-care, and social skills to promote recovery. Paraprofessionals and/or professionals in fields related to the education topic may facilitate education groups.

"Efficiency" means a program's measure of cost benefit or cost effectiveness through a comparison to some alternative method.

"Emergency services" means a twenty-four (24) hour capability for assessment, intervention, and resolution of a consumer's crisis or emergency provided in response to unanticipated, unscheduled emergencies requiring prompt intervention to resolve immediate, overwhelming problems that severely impair the individual's ability to function or remain in the community and may include placement of the individual in a protective environment, withdrawal management, individual and group consultation, and medical assessment.

"Emotional, behavioral or cognitive conditions and complications" means one dimension to be considered in consumer placement, continued stay, and discharge and is an evaluation of the consumer's historical and current emotional, behavioral, or cognitive status including the presence and severity of any diagnosed mental illnesses, as well as, the level of anxiety, depression, impulsivity, guilt, and behavior that accompanies or follows these emotional states and historical information, as it impacts on level of care decision making.

"Evaluation" See "Assessment."

"Evidence based practice" means programs or practices that are supported by research methodology and have produced consistently positive patterns of results when replicated within the intent of the published guidance.

"Executive director" means the person hired by the governing authority to direct all the activities of the organization; may be used synonymously with administrative director, administrator, chief executive officer, and director.

"Face-To-Face" for the purposes of the delivery of behavioral health care, means a face-to-face physical contact and in-person encounter between the health care provider and the consumer, including the initial visit. The use of telemedicine shall be considered a face-to-face encounter.

"Facilities" or "facility" means entities as described in Title 43A O.S. § 1-103(7), community mental health centers,
residential mental health facilities, community-based structured crisis centers, certified services for the alcohol and drug dependent, programs of assertive community treatment, eating disorder treatment, gambling disorder treatment, and narcotic treatment programs.

"Family" means the parents, brothers, sisters, other relatives, foster parents, guardians, and others who perform the roles and functions of family members in the lives of consumers.

"Follow-up" means the organized method of systematically determining the status of consumers after they have been discharged to determine post-treatment outcomes and utilization of post-treatment referrals.

"Gambling disorder treatment services" means treatment activities for consumers by a gambling treatment professional that include, but are not limited to, the following:

(A) Assessment and diagnostic impression, ongoing;
(B) Treatment planning and revision, as necessary;
(C) Individual, group and family therapy;
(D) Case management;
(E) Psychosocial rehabilitation; and
(E) Discharge planning.

"Gambling treatment professional: means an individual holding a valid NCGC I or II certification or has documented completion of at least thirty hours of ODMHSAS recognized core problem gambling training requirements and documented completion of ten hours of problem gambling specific continuing education every twelve months, and is either a Licensed Behavioral Health Professional or Licensure Candidate.

"Gambling related disorders/problems" means persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as defined by the most recent edition of the DSM.

"Goals" means broad general statements of purpose or intent that indicates the general effect the facility or service is intended to have.

"Governing authority" means the individual or group of people who serve as the treatment facility's board of directors and who are ultimately responsible for the treatment facility's activities and finances.

"Guardian" means an individual who has been given the legal authority for managing the affairs of another individual.

"Halfway house" means low intensity substance use disorder treatment in a supportive living environment to facilitate the individual's reintegration into the community, most often following completion of primary treatment. Corresponding ASAM Treatment Level: Level III.1, Clinically managed Low Intensity Residential Services.

"Halfway house for persons with children" means a halfway house that includes services for the recovering person's children who will reside with him or her in the house. Corresponding ASAM Treatment Level: Level III.1, Clinically managed Low Intensity Residential Services.

"Infant" means any child from birth up to 3 years of age.

"Initial contact" means a person's first contact with the facility, e.g., a request for information or service by telephone or in person.

"Inpatient services" means the process of providing care to persons who require twenty-four (24) hour supervision in a hospital or other suitably equipped medical setting as a result of acute or chronic medical or psychiatric illnesses and professional staff providing medical care according to a treatment plan based on documentation of need.

"Intervention" means a process or technique intended to facilitate behavior change.

"Length of stay" means the number of days or number of sessions attended by consumers in the course of treatment.

"Licensed Behavioral Health Professional" or "LBHP" means:

(A) An Allopathic or Osteopathic Physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry;
(B) An Advanced Practice Registered Nurse 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 certified in a psychiatric mental health specialty;
(C) A Clinical Psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists;
(D) A Physician Assistant who is licensed in good standing in Oklahoma and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions;
(F) A Practitioner with a license to practice in the state in which services are provided by one of the following licensing boards:
(i) Psychology;
(ii) Social Work (clinical specialty only);
(iii) Professional Counselor;
(iv) Marriage and Family Therapist;
(v) Behavioral Practitioner; or
(vi) Alcohol and Drug Counselor.
(C) 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.
(D) A Physician Assistant who is licensed in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

"Licensed physician" means an individual with an M.D. or D.O. degree who is licensed in the State of Oklahoma to practice medicine.

"Licensed practical nurse" means an individual who is a graduate of an approved school of nursing and is licensed in the State of Oklahoma to provide practical nursing services.

"Licensure" means the process by which an agency of government grants permission to persons or health facilities
meeting qualifications to engage in a given occupation or business or use a particular title.

"Licensure Candidate" means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:

(A) Psychology;
(B) Social Work (clinical specialty only);
(C) Professional Counselor;
(D) Marriage and Family Therapist;
(E) Behavioral Practitioner; or
(F) Alcohol and Drug Counselor.

"Life skills" means abilities and techniques necessary to function independently in society.

"Medical care" means those diagnostic and treatment services which, under the laws of the jurisdiction in which the facility is located, can only be provided or supervised by a licensed physician.

"Medical withdrawal management" means diagnostic and treatment services performed by licensed facilities for acute alcohol or drug intoxication, delirium tremens, and physical and neurological complications resulting from acute intoxication. Medical withdrawal management includes the services of a physician and attendant medical personnel including nurses, interns, and emergency room personnel, the administration of a medical examination and a medical history, the use of an emergency room and emergency medical equipment if warranted, a general diet of three meals each day, the administration of appropriate laboratory tests, and supervision by properly trained personnel until the person is no longer medically incapacitated by the effects of alcohol or drugs. [43 A.O.S. § 3-403(5)] It is an organized service delivered by medical and nursing professionals that provides for twenty-four (24)-hour medically directed evaluation and withdrawal management in an acute care inpatient setting. Services are delivered under a defined set of physician-approved policies and physician-managed procedures or medical protocols. Corresponding ASAM Service Level: Level 4-WM, Medically Managed Intensive Inpatient Withdrawal Management.

"Medical services" means the administration of medical procedures by a physician, registered nurse, nurse practitioner, physician's assistant, or dentist and in accordance with a documented treatment plan and medical supervision available to provide the consumer with the service necessitated by the prevalent problem identified and includes physical examinations, withdrawal management from alcohol or drugs, methadone maintenance, dental services, or pharmacy services, etc.

"Medically supervised withdrawal management" means withdrawal management outside of a medical setting, directed by a physician who has attendant medical personnel including nurses for intoxicated consumers, and consumer's withdrawing from alcohol and other drugs, presenting with no apparent medical or neurological symptoms as a result of their use of substances that would require hospitalization as determined by an examining physician. Corresponding ASAM Service Level: Level 3.7-WM, Medically Monitored Inpatient Withdrawal Management. Withdrawal management is intended to stabilize and prepare consumers in accessing treatment.

"Medication" means any prescription or over-the-counter drug that is taken orally, injected, inserted, applied topically, or otherwise administered by staff or self-administered by the consumer for the appropriate treatment or prevention of medical or psychiatric issues.

"Medication assisted treatment" means the use of medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders.

"Medication error" means an error in prescribing, dispensing, or administration of medication, regardless if the error reached the consumer, e.g., omission of prescribed drugs, giving drugs not prescribed, prescribing inappropriate drugs, prescribing or administering incorrect dosages, incorrectly filling or labeling prescriptions, or incorrectly transcribing medication orders.

"Medication-self administration" means the consumers administer their own medication to themselves, or their children, with staff observation.

"Minutes" means a record of business introduced, transactions and reports made, conclusions reached, and recommendations made during a meeting.

"NCGC" means Nationally Certified Gambling Counselor, offered at levels I or II through the National Council on Problem Gambling.

"Neglect" means:

(A) the failure of staff to provide adequate food, clothing, shelter, medical care or supervision which includes, but is not limited to, lack of appropriate supervision that results in harm to a consumer;
(B) the failure of staff to provide special care made necessary by the physical or mental condition of the consumer;
(C) the knowing failure of staff to provide protection for a consumer who is unable to protect his or her own interest; or
(D) staff knowingly causing or permitting harm or threatened harm through action or inaction that has resulted or may result in physical or mental injury.

"Non-medical withdrawal management" means withdrawal management services for intoxicated consumers and consumers withdrawing from alcohol or other drugs presenting with no apparent medical or neurological symptoms as a result of their use of substances. Corresponding ASAM Service Level: Level 3.2-WM, Clinically managed Residential Withdrawal Management Withdrawal management is intended to stabilize and prepare consumers in accessing treatment.

"Objectives" means a specific statement of planned accomplishments or results that are specific, measurable, attainable, realistic, and time-limited.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"Oklahoma Administrative Code" or "OAC" means the publication authorized by 75 O.S. § 256 known as The Oklahoma Administrative Code or, prior to its publication,
the compilation of codified rules authorized by 75 O.S. § 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"OSDH" means the Oklahoma State Department of Health.

"Outpatient services" means an organized, nonresidential treatment service in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimens. For substance use disorder treatment services, the corresponding ASAM Treatment Level is Level I, Outpatient Treatment.

"Outreach" means the process of reaching into a community systematically for the purposes of identifying persons in need of services, alerting persons and their families to the availability of services, locating needed services, and enabling persons to enter into and accept the service delivery system.

"Paraprofessional" means a person who does not have an academic degree related to the scope of treatment or support services being provided, but performs prescribed functions under the general supervision of that discipline.

"Peer Recovery Support Specialist" or "PRSS" means an individual who meets the qualifications and is certified as a PRSS pursuant to OAC 450:53.

"Performance Improvement" or "PI" means an approach to the continuous study and improvement of the processes of providing health care services to meet the needs of consumers and others. Synonyms, and near synonyms, include continuous quality improvement, continuous improvement, organization-wide quality improvement, and total quality management.

"Personnel record" means a chart or file containing the employment history and actions relative to individual employee or volunteer activities within an organization and may contain application, evaluation, salary data, job description, citations, credentials, etc.

"PICIS" is a comprehensive management information system based on national standards for mental health and substance abuse databases. It is a repository of diverse data elements that provide information about organizational concepts, staffing patterns, consumer profiles, program or treatment focus, and many other topics of interest to clinicians, administrators, and consumers. It includes unique identifiers for agencies, staff, and consumers that provide the ability to monitor the course of consumer services throughout the statewide ODMHSAS network. PICIS collects data from hospitals, community mental health centers, substance abuse agencies, community residential mental health facilities, prevention programs, and centers for the homeless which are operated or funded in part by ODMHSAS.

"Play therapy" means a form of action therapy that uses, but is not limited to, sand play, fairy tales, art and puppetry to encourage communication in children who have inadequate or immature verbalization skills or who verbalize excessively due to defensiveness.

"Policy" means statements of facility intent, strategy, principle, or rules in the provision of services; a course of action leading to the effective and ethical provision of services.

"Prevention" means the assessment, development, and implementation of strategies designed to prevent the adverse effects of mental illness, substance use disorders, addiction, and trauma.

"Procedures" means the written methods by which policies are implemented.

"Process" means information about what a program is implementing and the extent to which the program is being implemented as planned.

"Program" means a structured set of activities designed and structured to achieve specific objectives relative to the needs of the consumers or patients.

"Program effectiveness outcome" means a written plan and operational methods of determining the effectiveness of services provided that objectively measures facility resources, activities, and consumer outcomes.

"Progress notes" means a chronological written description of services provided to a consumer, resident, client, or patient that documents, utilizing acceptable documentation practices, the consumer's response related to the intervention plan or services provided.

"Psychiatrist" means a licensed physician who specializes in the assessment and treatment of individuals having psychiatric disorders and who is fully licensed to practice medicine in the state in which he or she practices and is certified in psychiatry by the American Board of Psychiatry and Neurology or has equivalent training or experience.

"Psychological Social evaluations" are in person interviews conducted by professionally trained personnel designed to elicit historical and current information regarding the behavior and experiences of an individual and are designed to provide sufficient information for problem formulation and intervention.

"Psychotherapy" or "Therapy" means a goal directed process using generally accepted clinical approaches provided face-to-face by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate with consumers in individual, group, or family settings to promote positive, emotional, or behavioral change.

"Readiness to change" means one dimension to be considered in consumer placement, continued stay, and transition and is an evaluation of the consumer's current emotional and cognitive awareness of the need to change, coupled with a commitment to change.

"Recovery" means an ongoing process of discovery and/or rediscovery that must be self-defined, individualized, and may contain some, if not all, of the fundamental components of recovery as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA).

"Recovery/living environment" means one dimension to be considered in consumer placement, continued stay, and discharge and is an evaluation of the consumer’s current recovery environment, current relationships, degree of support for recovery, current housing, employment situation, availability of alternatives, and historical information as it impacts on level of care decision making.
"Registered nurse" means an individual who is a graduate of an approved school of nursing and is licensed in the State of Oklahoma to practice as a registered nurse.

"Rehabilitation services" means face-to-face individual or group services provided by qualified staff to develop skills necessary to perform activities of daily living and successful integration into community life. Rehabilitation services for substance use disorders are also referred to as skill development services.

"Relapse" means the process which may result in the return to the use of substances after a period of abstinence.

"Relapse potential, continued use, or continued problem potential" means one dimension to be considered in consumer placement, continued stay, and discharge and is an evaluation of the consumer's attitudes, knowledge, and coping skills, as well as the likelihood that the consumer will relapse from a previously achieved and maintained abstinence and/or stable and healthy mental health function. If an individual has not yet achieved abstinence and/or stable and healthy mental health function, this dimension assesses the likelihood that the individual will continue to use alcohol or other drugs and/or continue to have mental health problems.

"Residential treatment-substance abuse" means treatment for a consumer in a live-in setting which provides a regimen consisting of twenty-four (24) treatment hours per week. This level of care should correspond with the ASAM Service Level: Level 3.5, Clinically managed High-Intensity Residential Services.

"Residential treatment for persons with children-substance abuse" means a residential treatment facility that includes services for the recovering person's children who will reside with him or her in the residential facility. Corresponding ASAM Service Level (Parent Only): Level 3.5 Clinically Managed High-Intensity Residential Services.

"Safety officer" means the individual responsible for ensuring the safety policies and procedures are maintained and enforced within the facility.

"Screening" means the process to determine whether the person seeking assistance needs further comprehensive assessment.

"Sentinel event" is a type of critical incident that is an unexpected occurrence involving the death or serious physical or psychological injury to a consumer or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a consumer. These events signal the need for immediate investigation and response. Sentinel events include, but are not limited to suicide, homicide, criminal activity, assault and other forms of violence, including domestic violence or sexual assault, and adverse drug events resulting in serious injury or death.

"Service plan" or "Treatment plan" means the document used during the process by which a LBHP or a Licensure Candidate and the consumer together and jointly identify and rank problems, establish agreed-upon immediate short-term and long-term goals, and decide on the treatment process and resources to be utilized.

"Service Provider" means a person who is allowed to provide treatment services within the regulation and scope of their certification level or license.

"Significant others" means those individuals who are, or have been, significantly involved in the life of the consumer.

"Socialization" means all activities, which encourage interaction and the development of communication, interpersonal, social, and recreational skills and can include consumer education.

"Staff privileging" means an organized method for treatment facilities to authorize an individual permission to provide specific care and treatment services to consumers within well-defined limits, based on the evaluation of the individual's license, education, certification, training, experience, competence, judgment, and other credentials.

"Substance-related and addictive disorders" means a substance-related disorder involving problems related to the use of ten distinct classes of drugs: alcohol; caffeine; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics and anxiolytics; stimulants; tobacco; and other (unknown) substances. Substance-related disorders fall into one of two categories, substance use disorders and substance induced disorders. A substance use disorder is a cluster of cognitive, behavioral and physiological symptoms indicating the consumer continues using the substance(s) despite significant substance-related problems. A substance-induced disorder is a reversible substance-specific syndrome due to the recent ingestion of a substance. Addictive disorders involve repetitive clusters of behaviors that activate reward systems similar to those activated by drugs and create behavioral symptoms comparable to those produced by substance use disorders such as compulsive gambling.

"Substance use disorder treatment services" means the coordination of treatment activities for consumers by service provider that includes, but is not limited to, the following:
(A) Screenin, diagnostic impression, and assessment.
(B) Treatment planning and revision, as necessary.
(C) Continuing care review to assure continuing stay and discharge criteria are met.
(D) Case management services.
(E) Reports and record keeping of consumer related data.
(F) Consultation that facilitates necessary communication in regard to consumers.
(G) Discharge planning that assists consumers in developing continuing care plans and facilitates transition into post-treatment recovery.
(H) Group and individual therapy, Individual, group, and family therapy.
(I) Education, as necessary.
(J) Rehabilitation services.
(K) Peer recovery support services.
(L) Crisis intervention services.

"Substance-use disorders" means alcohol or drug dependence or psychoactive substance use disorder as defined by current DSM criteria or by other standardized and widely accepted criteria.
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"Substance withdrawal" means a state of being in which a group of symptoms of variable clustering and degree of severity occur on cessation or reduction of use of a psychoactive substance that has been taken repeatedly, usually for a prolonged period and/or in high doses. The syndrome may be accompanied by signs of physiological disturbance. Onset and course of the withdrawal state are time-limited and are related to the type of substance and the dose being used immediately before abstinence.

"Supportive services" refers to assistance with the development of problem-solving and decision making skills to maintain or achieve optimal functioning within the community and can include consumer education.

"Therapeutic hours(s)" means the amount of time in which the consumer is engaged with a service provider identifying, addressing, and/or resolving issues that are related to the consumer's treatment plan.

"Tobacco" means any nicotine delivery product or device that is not approved by the U.S. Food and Drug Administration (FDA) for the purpose of nicotine dependence treatment, including, but not limited to cigarettes, cigars, snuff, chewing tobacco, electronic cigarettes and vaping devices.

"Trauma informed capability" means the capacity for a facility and all its programs to recognize and respond accordingly to the presence of the effects of past and current traumatic experiences in the lives of its consumers.

"Treatment" means the broad range of emergency, inpatient, intermediate and outpatient services and care including diagnostic evaluation, medical, psychiatric, psychological and social service care, vocational rehabilitation, and career counseling. [43A O.S. § 3-403(11)].

"Treatment hours - residential" means the structured hours in which a consumer is involved in receiving professional services to assist in achieving recovery.

"Treatment session-outpatient" means each face-to-face contact with a consumer in a therapeutic setting whether individually or in a group.

"Volunteer" means any person who is not on the program's payroll, but provides services and fulfills a defined role within the program and includes interns and practicum students.

"Walk through" means an exercise in which staff members of a facility walk through the program's treatment process as a consumer. The goal is to view the agency processes from the consumer's perspective for the purpose of removing barriers and enhancing treatment.

"Wellness" means the condition of good physical, mental, and emotional health, especially when maintained by an appropriate diet, exercise, and other lifestyle modifications.

"Withdrawal Management" means the process of eliminating the toxic effects of substances from the body. Withdrawal management methods include social detoxification and medical monitoring or medical management and are intended to avoid withdrawal complications.

450:18-1-9. Staff qualifications [REVOKED]
(a) All staff who provide clinical services shall have documented qualifications or training specific to the clinical services they provide.
(b) Staff qualifications for contracted entities shall be in compliance with 450:1-1-1.1 and 450:1-3-5.
(c) Compliance with 450:18-1-9 shall be determined by a review of staff personnel files and other supporting documentation provided.
(d) Failure to comply with 450:18-1-9 will result in the initiation of procedures to deny, suspend and/or revoke certification.

450:18-1-10. Volunteers [REVOKED]
(a) If volunteers are utilized, the program will have specific policies and procedures to define the purpose, scope, training, supervision related to the use of volunteers.
(b) A qualified staff member shall be assigned as the volunteer coordinator.
(c) Policies and procedures for volunteers and the services they perform shall be initially approved by the governing authority and upon revision.
(d) Compliance with this Section shall be determined by a review of volunteer policies and procedures; designation of a volunteer coordinator; written orientation plan; orientation program; volunteer personnel files; and volunteer records.

SUBCHAPTER 5. ORGANIZATIONAL AND FACILITY MANAGEMENT

450:18-5-2.1. Organizational and facility description [REVOKED]
(a) The facility shall have a written organizational description, which is reviewed annually and minimally includes:
   (1) Target population to be served;
   (2) The overall mission statement of the program which shall address the manner in which the facility welcomes all consumer with substance related and addictive disorders, including those with co-occurring mental health conditions; and
   (3) The annual facility goals and objectives, including the goal of continued progress for the agency in providing recovery oriented, culturally competent, trauma informed, and co-occurring capable services.
(b) The facility’s governing authority shall review and approve the mission statement and annual goals and objectives and document its approval.
(c) The facility shall make the organizational description, mission statement, and annual goals available to staff.
(d) The facility shall make the organizational description, mission statement, and annual goals available to the general public upon request.
(e) Each facility shall have in writing, by program component or service, the following:

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(1) Philosophy and description of services, including the philosophy of recovery-oriented and welcoming service delivery;
(2) Identity of the professional staff that provides these services;
(3) Admission and exclusionary criteria that identifies the type of consumers for whom the services are primarily intended;
(4) Goals and objectives, including making progress toward co-occurring capable, trauma-informed, and culturally competent service delivery; and
(5) Delineation of processes to assure welcoming, accessible, integrated, and co-occurring capable services and a plan for how each program component will address the needs of individuals with co-occurring disorders.
(f) The facility shall have a written statement of the quality improvement processes, procedures, and plans for attaining the organization's goals and objectives. These procedures and plans shall define specific tasks, including actions regarding the organization's co-occurring capability, set target dates, and designate staff responsible for carrying out the procedures and plans.
(g) Compliance with this Section shall be determined by a review of the facility's target population definition; facility policy and procedures; mission statement; written plan for professional services; other stated required documentation; and any other supporting documentation.

450:18-5-2.2. Information analysis and planning

(a) The facility shall have a defined and written plan for conducting an organizational needs assessment which specifies the methods and data to be collected to include, but not limited to, information from:
(1) Consumers;
(2) Governing Authority;
(3) Staff;
(4) Stakeholders;
(5) Outcomes management processes;
(6) Quality record review; and
(7) Self-assessment tools to determine progress toward co-occurring recovery, oriented, trauma-informed, and consumer driven capability.
(b) The facility shall have a defined ongoing system to collect data and information on a quarterly basis to manage the organization.
(c) Information collected shall be analyzed to improve consumer services and organizational performance.
(d) The facility shall prepare an end of year management report which shall include, but not be limited to:
(1) An analysis of the needs assessment process;
(2) Performance improvement program findings; and
(3) Claims and accomplishments by facilities, including but not limited to consumer count and success rates, which may be verified by the ODMHSAS Board.
(e) The management report shall be communicated and made available to, among others:
(1) Governing authority;
(2) Facility staff; and
(3) ODMHSAS, as requested.
(f) Compliance with OAC 450:18-5-2.2 shall be determined by a review of the written program evaluation plan; written annual program evaluations; special or interim program evaluations; program goals and objectives; and other supporting documentation provided.

450:18-5-2.3. Performance improvement program

(a) The facility shall have an ongoing performance improvement program designed to objectively and systematically monitor, evaluate and improve the quality of consumer care.
(b) The performance improvement program shall also address the fiscal management of the facility.
(c) The facility shall have an annual written plan for performance improvement activities. The plan shall include, but not be limited to:
(1) Outcomes management specific to each program;
(2) A quarterly quality consumer record review to evaluate the quality of service delivery;
(3) Staff privileging;
(4) Review of critical and unusual incidents and consumer grievances and complaints; and
(5) Improvement in the following:
(A) Co-occurring capability;
(B) Provision of trauma-informed services;
(C) Provision of culturally competent services; and
(D) Provision of consumer driven services.
(d) Activities to improve access and retention within the treatment program, including an annual "walk through" of the intake and admission process.
(e) The facility shall identify a performance improvement officer.
(f) The facility shall monitor the implementation of the performance improvement plan on an annual basis and shall make adjustments as needed.
(g) Performance improvement findings shall be communicated and made available to, among others:
(1) Governing authority;
(2) Facility staff;
(3) Consumers;
(4) Stakeholders; and
(5) ODMHSAS, as requested.
(h) Compliance with 450:18-5-2.3 shall be determined by a review of the written program evaluation plan; written program evaluations (annual and/or special or interim; program goals and objectives; and other supporting documentation provided).

450:18-5-3. Physical facility environment and safety

(a) All facilities providing any service to persons, groups, or the community shall have written policy and procedures intended to ensure the safety and protection of all persons within the facility's physical environment (property and buildings, leased or owned).
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(h) These policies and procedures shall include, but are not limited to:

(1) Meeting all fire and safety regulations, code, or statutory requirements of federal, state, or local government.
(2) All facilities shall have an annual fire and safety inspection from the State Fire Marshal or local authorities, and shall maintain a copy of said inspection and attendant correspondence regarding any deficiency.
(3) An emergency preparedness plan to provide effective utilization of resources to best meet the physical needs of consumers, visitors, and staff during any disaster (including, but not limited to, fire, flood, tornado, explosion, prolonged loss of heat, light, water, and/or air conditioning). This plan shall be evaluated annually and revised as needed.
(4) Facilities shall have a designated Safety Officer.
(5) Staff training and orientation regarding the location and use of all fire extinguishers and first aid supplies and equipment.
(6) Emergency evacuation routes and shelter areas shall be prominently posted in all areas.
(7) Fire alarm systems shall have visual signals suitable for the deaf and hearing-impaired.
(8) There shall be emergency power to supply lighting to pre-selected areas of the facility.
(9) The maintenance of facility grounds to provide a safe environment for consumers (specific to age group[s] served), staff and visitors.
(10) Storage of dangerous substances (toxic or flammable substances) in locked, safe areas or cabinets.
(11) There shall be a written plan for the protection and preservation of consumer records in the event of a disaster.

(c) If the facility serves children or adolescents in any form of residential care, there shall be outside play and recreational space and equipment provided which:

(1) Is protected and free from hazards;
(2) Is safely accessible from indoors;
(3) Has supplies and equipment maintained safely; and
(4) Has some shade provided.

(d) Compliance with 450:18-5-3 may be determined by a review of facility policy and procedures, fire and safety inspection reports and correspondence, disaster plan, any other supporting facility documentation, and interviews with staff and consumers.

450:18-5-3.1. Hygiene and sanitation [REVOKED]

(a) Residential facilities shall provide the following services and applicable supporting documentation:

(1) Lavatories in a minimum ratio of one per each eight resident beds.
(2) Toilet facilities in a minimum ratio of one per eight resident beds. Each toilet room shall include a lavatory in the same room or immediately adjacent thereto.
(3) Bathing facilities in a minimum ratio of one tub or shower per each eight resident beds.

(4) Sewage discharge into a municipal sewerage system or collected, treated, and disposed of in an independent sewerage system.
(5) The facility shall have proof of regular inspections and treatment by a licensed pest control operator.
(6) Solid waste disposal through public systems or in a manner approved by the local agency having jurisdiction and the OSDH or Department of Environmental Quality (DEQ), as necessary.
(7) Water obtained from an approved public water supply or tested at least quarterly and treated as necessary, thereby maintaining a determination as an approved water supply by the authority having jurisdiction and the OSDH or DEQ, as necessary.
(8) Linen in quantities adequate to provide at least two changes of bedding each week.
(9) Housekeeping services so that a hygienic environment is maintained in the facility.

(b) Outpatient treatment facilities shall provide:

(1) Lavatories and toilet facilities in a minimum ratio of one (1) per twenty (20) persons.
(2) Water and sewerage in the same manner as prescribed for residential facilities.
(3) Housekeeping services so that a hygienic environment is maintained in the facility.

450:18-5-3.3. Tobacco-free campus [REVOKED]

(a) The facility shall provide a tobacco-free campus for its employees, consumers and visitors. Possession and use of any tobacco product is prohibited on the grounds of the facility by employees, consumers, volunteers and visitors.

(b) Facility will visibly post signs on the property notifying consumers, employees and visitors that the visible possession and use of tobacco products is prohibited.

(c) Facility employees shall not share tobacco or tobacco replacement products with consumers.

(d) The facility shall offer assistance to employees who are tobacco users while he or she is employed by the facility. The assistance shall include, but is not limited to, the provision of information on the health impact of continued tobacco use; the integrated assessment of consumer’s tobacco use into standard practice; referrals to tobacco cessation programs such as the Oklahoma Tobacco Helpline; the provision of or access to FDA-approved prescription and/or non-prescription medications for the treatment of nicotine dependence when available; the delivery of evidence-based behavioral interventions for tobacco use cessation by counselors and other clinicians; and provision of appropriate follow-up to facilitate cessation intervention and prevent relapse.

(e) The facility shall always inquire of the consumers’ tobacco use status and be prepared to offer treatment upon request of the consumer.

(f) Compliance with this Section shall be determined by visual observation; posted signs; consumer and staff interviews; and a review of the facility’s policy, procedures and other supporting documentation provided.
450:18-5-5.1. Medication assisted treatment
Providers of residential treatment, medically supervised withdrawal management, or halfway house services shall provide access to medication assisted treatment (MAT) medications to all consumers for whom MAT is determined to be appropriate. Access to MAT medications shall be provided either directly from the residential treatment, medically supervised withdrawal management, or halfway house provider; or provided through a formal agreement with a separate MAT provider.

450:18-5-8. Critical incident reporting [REVOKED]
(a) The facility shall have written policies and procedures requiring documentation and reporting of critical incidents and analysis of the contributors to the incident with attention given to issues that may reflect opportunities for system level or program level improvement.
(b) The documentation of critical incidents shall include, but not be limited to the following:
   (1) The facility name and signature of the persons reporting the incident;
   (2) The names of the consumers, staff members or property involved;
   (3) The time, date, and physical location of the incident;
   (4) The time and date the incident was reported and the name of the staff person within the facility to whom it was reported;
   (5) A description of the incident;
   (6) Resolution or action taken, date resolution or action was taken, and signature of appropriate staff members; and
   (7) Severity of each injury, if applicable. Severity shall be indicated as follows:
      (A) No off-site medical care required or first-aid care administered on-site;
      (B) Medical care by a physician or nurse or follow-up attention required; or
      (C) Hospitalization or immediate off-site medical attention required.
(e) Critical incidents shall be reported to ODMHSAS with specific timeframe, as follows:
   (1) Critical incidents requiring medical care by a physician, nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax or mail to ODMHSAS Provider Certification within twenty-four (24) hours of the incident being documented;
   (2) Critical incidents involving allegations constituting a sentinel event or consumer abuse shall be reported to ODMHSAS immediately via telephone or fax, but not more than twenty-four (24) hours after the incident. If reported by telephone, the report shall be followed with a written report within twenty-four (24) hours.
(d) Compliance with 450:18-5-8 shall be determined by a review of facility policies and procedures, critical incident reports at the facility, and those submitted to ODMHSAS, performance improvement program documents and reports, staff interviews, and any other relevant documentation of the facility or ODMHSAS.

450:18-5-11. Technology [REVOKED]
(a) The facility shall have a written plan regarding the use of technology and systems to support and advance effective and efficient service and business practices. The plan shall include, but not be limited to:
   (1) Hardware and software.
   (2) Security.
   (3) Confidentiality.
   (4) Backup policies.
   (5) Assistive technology.
   (6) Disaster recovery preparedness.
   (7) Virus protection.
(b) Compliance with 450:18-5-11 shall be determined by a review of the facility policies, performance improvement plans and technology and system plan.

(a) Under Titles I and I-I of the ADA, the CCARC’s shall comply with the “Accessibility Guidelines for Buildings and Facilities (ADAAG) for alterations and new construction.” United States government facilities are exempt for the ADA as they shall comply with the “Uniform Federal Accessibility Standards (UFAS)”, effective August 7, 1984. Also available for use in ensuring quality design and accessibility is the American National Standards Institute (ANSI) A117.1 “American National Standard for Accessible and Usable Buildings and Facilities.”
(b) State and local standards for accessibility and usability may be more stringent than ADA, UFAS, or ANSI A 117.1. The CCARC shall assume responsibility for verification of all applicable requirements and comply with the most stringent standards.
(c) The CCARC shall have written policy and procedures providing or arranging for services for persons who fall under the protection of the Americans With Disabilities Act of 1990 and provide documentation of compliance with applicable Federal, state, and local requirements. A recommended reference is the “Americans With Disabilities Handbook” published by the U.S. Equal Employment Opportunities Commission and the U.S. Department of Justice.
(d) Compliance with 450:24-25-1 shall be determined through a review of facility written policy and procedure, and any other supporting documentation.

450:18-5-13. Human Immunodeficiency Virus (HIV), and Acquired Immunodeficiency Syndrome (AIDS) [REVOKED]
(a) The facility shall have a policy of non-discrimination against persons with HIV infection or AIDS.
(b) All facilities shall observe the Universal Precautions For Transmission of Infectious Diseases as set forth in, “Occupational Exposure to Bloodborne Pathogens” published by the
(U.S.) Occupations Safety Health Administration [OSHA]; and
(1) There shall be written documentation the aforesaid Universal Precautions are the policy of the facility;
(2) In-service training regarding the Universal Precautions shall be a part of employee orientation and, at least once per year, is included in employee in-service training.
(c) Compliance with 450:24-25-2 is determined by reviews of facility policy and procedure and in-service training records, schedules, or other documentation.

450:18-5-14. Non-medical withdrawal management
(a) Providers of residential treatment services (ASAM Level 3.3 and ASAM Level 3.5) shall provide non-medical withdrawal management as part of their regular service delivery program and facility environment.
(b) Non-medical withdrawal management shall be provided for intoxicated consumers and consumers withdrawing from alcohol and other drugs who present with no apparent medical or neurological symptoms as a result of their substance use disorder.
(c) The facility shall maintain written programmatic descriptions and policy and procedures addressing the following:
   (1) Environment: The facility shall monitor and document vital signs, and food and liquids intake.
   (2) Staff:  
      (A) Staff providing non-medical withdrawal management shall be knowledgeable about the physical signs of withdrawal, the taking of vital signs, the implication of those vital signs, and emergency procedures. Service providers shall be trained and competent to implement physician-approved protocols for consumer observation and supervision, determination of appropriate level of care, and facilitation of the consumer's transition to continuing care.
      (B) The facility shall document in personnel records all education, training, and experience stated in (A) above prior to staff providing direct care services.
   (3) Treatment services: Daily (twenty-four [24] hours a day, seven [7] days a week) substance use disorder withdrawal management treatment services shall be provided, to include oral intake of fluids, three (3) meals a day, and the taking of vital signs (temperature, pulse, respiration rate, blood pressure), and fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the consumer's condition.

SUBCHAPTER 7. FACILITY CLINICAL RECORDS

PART 1. RECORD SYSTEM

450:18-7-11. Consumer record system [REVOKED]
(a) Each facility shall maintain an organized system for the content, confidentiality, storage retention, and disposition of consumer case records.
(b) The facility shall have written policies and procedures concerning consumer records which define required documentation within the case record.
(c) Consumer records shall be contained within equipment which shall be maintained under locked and secured measures.
(d) The facility shall maintain identification and filing systems which enable prompt record location and accessibility by the service providers.
(e) Consumer records shall be maintained in the facility where the individual is being treated or served. In the case of temporary office space and in-home treatment services, records may be maintained in the main (permanent) office and transported in secured lock boxes or vehicle trunks to and from temporary offices and homes, when necessary.
Consumer records may be permanently maintained at the facility's administrative offices; however, a working copy of the consumer record for the purposes of documentation and review of services provided must be maintained at the site in which the consumer is receiving treatment.
(f) The facility shall have policies which govern the storage, retention, and disposition of consumer case records, including electronic records. These policies shall be compatible with protection of consumer's rights against confidential information disclosure at a later date. ODMHAS operated facilities shall comply with Records Disposition Schedule 82-17 as approved by the Oklahoma Archives and Records Commission.
(g) Compliance with 450:18-7-1.1 may be determined by a review of policies and procedures, treatment records, performance improvement guidelines, interviews with staff, and other facility documentation.

450:18-7-3.1. Confidentiality of substance-related and addictive disorder treatment information [REVOKED]
Confidentiality policies, procedures, and practices must comply with federal and state law, guidelines, and standards.

PART 3. SCREENING AND ASSESSMENT

450:18-7-21. Clinical record content, screening and assessment
(a) All facilities shall complete a face-to-face screening with each individual to determine appropriateness of further assessment.
(b) The facility shall maintain written screening policies and procedures that, at a minimum include: (1) how the screening is to be conducted; (2) that the screening conducted is an integrated screening to identify both immediate and ongoing needs, which includes screening for whether the consumer is a risk to self or others, including suicide risk factors; and (3) how the consumer is assisted with admission for services, and/or with accessing other appropriate services.
(c) All facilities shall assess each consumer for appropriateness of admission to the treatment program. Each presenting consumer for substance use disorder treatment shall be assessed, according to ASAM criteria, which includes a list of symptoms for all six dimensions and each level of care to determine a clinically appropriate placement in the least restrictive level of care. The Oklahoma Determination of ODMHSAS designated ASAM Service Level (ODASL) instrument must be completed when determining to determine clinically appropriate residential/inpatient level of care (ASAM Level 3) treatment placement prior to admission into the treatment facility. Facilities offering gambling disorder treatment services, each presenting consumer for gambling disorder treatment shall be assessed using the Southern Oaks Gambling Screen (SOGS). Facilities must ensure that a consumer's refusal of a particular service does not preclude the consumer from accessing other needed mental health or substance-related or addictive disorder treatment services. Should the service provider determine the consumer’s needs cannot be met within the facility, clinical assessments and referrals for the consumer shall be documented.

(d) Any consumer seeking admission to inpatient or residential services, including medically-supervised withdrawal management and non-medical withdrawal management, while under the influence or undergoing withdrawal of alcohol or drugs, shall be assessed prior to admission for medical needs. The written criteria to be used for medical needs assessment of persons under the influence or undergoing withdrawal of alcohol or drugs, and the protocols for determining when physician review of the assessment is needed, shall be approved by the facility's consulting physician.

(e) Upon determination of appropriate admission, consumer assessment demographic information shall contain, but not be limited to, the following:

1. Date of initial contact requesting services;
2. Date of the screening and/or assessment;
3. Consumer's name;
4. Gender;
5. Birthdate;
6. Home address;
7. Telephone number;
8. Referral source;
9. Reason for referral;
10. Significant other to be notified in case of emergency; and
11. PICIS-data core content, if the facility reports on PICIS.

(f) Compliance with 450:18-7-21 may be determined by a review of the following:

1. Policies and procedures;
2. Intake protocols;
3. Assessment instruments;
4. Treatment records;
5. Interviews with staff and consumers; and
6. Other facility documentation.

450:18-7-23. Biopsychosocial assessment

(a) All programs shall complete a biopsychosocial assessment using the Addiction Severity Index (ASI) for adults or the Teen Addiction Severity Index (T-ASI) for adolescents, which gathers sufficient information to assist the consumer in developing an individualized service plan. The assessment must also list the client's past and current psychiatric medications. The assessment must be completed by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing.

(b) Compliance with 450:18-7-23 may be determined by a review of the following:

1. Policy and procedures;
2. Biopsychosocial assessment instruments;
3. Consumer records;
4. Case management assessments;
5. Interviews with staff and consumers; and
6. Other facility documentation.

450:18-7-24. Biopsychosocial assessment, time frame

(a) The assessment shall be completed during the admission process and within specific timelines established by the facility but no later than the following time frames:

1. Residential services: The assessment shall be completed during the admission process, not to exceed fourteen (14) days after admission procedures are initiated; seven (7) days [48 hours];
2. Halfway house services: The assessment shall be completed during the admission process, not to exceed fourteen (14) days after admission procedures are initiated; seven (7) days [48 hours];
3. Intensive outpatient services: The assessment shall be completed by the fourth visit;
4. Outpatient services: The assessment shall be completed by the end of the fourth visit.

(b) In the event of a consumer re-admission after one (1) year of the last biopsychosocial assessment, a new biopsychosocial assessment shall be completed. If readmission occurs within one (1) year after the last biopsychosocial assessment, an update shall be completed.

(c) Compliance with 450:18-7-24 may be determined by a review of the following:

1. Policies and procedures;
2. Biopsychosocial assessment instruments;
3. Treatment records;
4. Case management assessments;
5. Interviews with staff and consumers; and
6. Other facility documentation.

450:18-7-25. Biopsychosocial assessments of children accompanying a parent into treatment

(a) All programs shall document biopsychosocial assessments for the parent and for children accompanying their parent into treatment who are receiving services from the facility.
(1) Assessments of children (including infants) accompanying their parent into treatment (residential or halfway house levels of care) who are receiving services from the facility shall include the following items in addition to the requirements in 450:18-7-23:
   (A) parent-child relationship;
   (B) physical and psychological development;
   (C) educational needs;
   (D) parent related issues; and
   (E) family issues related to the child.

(2) Assessments of the parent bringing their children into treatment (residential or halfway house levels of care) shall include the following items, in addition to the requirements of 450:18-7-23:
   (A) parenting skills (especially in consideration of the child's issues);
   (B) knowledge of age appropriate behaviors;
   (C) parental coping skills;
   (D) personal issues related to parenting; and
   (E) family issues as related to the child.

(b) Compliance with 450:18-7-25 may be determined by a review of the following:
   (1) Policy and procedure;
   (2) Biopsychosocial assessment instruments;
   (3) Treatment records;
   (4) Case management assessments;
   (5) Interviews with staff and consumers; and
   (6) Other facility documentation.

450:18-7-26. Biopsychosocial assessments of children accompanying a parent into treatment, time frame

(a) The assessment shall be completed as soon as possible after admission and within specific timelines established by the facility but no later than:
   (1) Residential: The assessment shall be completed during the admission process, not to exceed forty-eight (48) hours after admission procedures are initiated [seven (7) days [168 hours]].
   (2) Halfway house: The assessment shall be completed during the admission process, not to exceed forty-eight (48) hours after admission procedures are initiated [seven (7) days [168 hours]].

(b) In the event of a consumer readmission within one (1) year of the last biopsychosocial assessment, a photocopy of the latest biopsychosocial assessment and a biopsychosocial update will suffice.
(c) Compliance with 450:18-7-26 may be determined by a review of the following:
   (1) Policies and procedures;
   (2) Biopsychosocial assessment instruments;
   (3) Treatment records;
   (4) Case management assessments;
   (5) Interviews with staff and consumers; and
   (6) Other facility documentation.

PART 9. SERVICE PLANNING

450:18-7-81. Service Plan

(a) A service plan shall be completed for each adult and child consumer, including dependent children receiving services from a residential or halfway house facility. The service plan is performed with the active participation of the consumer and a support person or advocate, if requested by the consumer. In the case of children under the age of eighteen (18), sixteen (16), it is performed with the participation of the parent or guardian, if allowed by law, and the child as age and developmentally appropriate. The service plan shall provide the formation of measurable service objectives and reflect ongoing changes in goals and objectives based upon consumer's progress or preference or the identification of new needs, challenges, and problems. The service plan shall be completed by a LBHP or Licensure Candidate.

(b) The service plan is developed and supported based on information obtained in the assessment and includes the evaluation of the assessment information by the clinician and the consumer.

(c) The service plan must have an overall general focus on recovery which, for adults, may include goals like employment, independent living, volunteer work, or training, and for children, may include areas like school and educational concerns and assisting the family in caring for the child in the least restrictive level of care.

(d) Comprehensive service plan contents shall address the following:
   (1) Consumer strengths, needs, abilities, and preferences;
   (2) Identified presenting challenges, needs, and diagnosis;
   (3) Goals for treatment with specific, measurable, attainable, realistic, and time-limited objectives;
   (4) Type and frequency of services to be provided;
   (5) Description of consumer's involvement in, and response to, the service plan;
   (6) The service provider who will be rendering the services identified in the service plan; and
   (7) Discharge criteria that are individualized for each consumer and beyond that which may be stated in the ASAM criteria.

(e) Service plan updates shall address the following:
   (1) Progress on previous service plan goals and/or objectives;
   (2) A statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
   (3) Change in goals and/or objectives based upon consumer's progress or identification of new needs and challenges;
   (4) Change in frequency and/or type of services provided;
   (5) Change in staff who will be responsible for providing services on the plan; and
   (6) Change in discharge criteria.

(f) Service plan updates should occur at a minimum of every six (6) months during which outpatient services are provided. Service plan updates shall occur at a minimum of once
every thirty (30) days during which services are provided for levels of care with ASAM Level 3 (residential and inpatient services).

(g) Service plans, both comprehensive and update, must include dated signatures for the consumer (if over age 14), the parent/guardian (if under age sixteen (16) and allowed by law), and the primary service practitioner/LBHP or Licensure Candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. Signatures must be obtained after the service plan is completed.

(h) Compliance with 450:18-7-81 shall be determined by a review of the clinical records, interviews with staff and consumers, and other facility documentation.

**450:18-7-82. Comprehensive Service plans, time frames**

(a) Comprehensive service plans shall be completed according to the time frames outlined by the facility, but no later than:

1. Residential services, eight (8) four (4) days;
2. Halfway house services, eight (8) four (4) days;
3. Intensive outpatient services, sixth (6th) visit;
4. Outpatient services, sixth (6th) visit.

(b) Compliance with 450:18-7-82 may be determined by a review of the following:

1. Policies and procedures;
2. Treatment protocols;
3. Clinical services manuals;
4. Service plan forms;
5. Consumer records;
6. Interviews with staff and consumers; and
7. Other facility documentation.

**PART 13. DISCHARGE PLANNING**

**450:18-7-122. Continuing care Transition/discharge plan**

(a) The facility shall assist the consumer to obtain services that are needed, but not available within the facility, and/or in transitioning from one level of care to another, and/or discharging from a facility. A written plan of recommendations and specific referrals for implementation of continuing care services, including medications, shall be prepared for each consumer who meets the ASAM dimensional continued service criteria, in each level of care. Continuing care Transition/discharge plans shall be developed with the knowledge and cooperation of the consumer. The continuing care plan may be included in the discharge summary. The consumer's response to the continuing care plan shall be noted in the plan or a note shall be made that the consumer was not available and why. In the event of the death of a consumer, a summary statement including this information shall be documented in the record.

(b) A written plan of recommendations and specific referrals for implementation of continuing care services, including medications, shall be prepared for each consumer who meets the ASAM dimensional continued service criteria, in each level of care. The discharge plan is to include, at a minimum, recommendations for continued treatment services and other appropriate community resources. Appointments for outpatient therapy and other services, as applicable, should be scheduled prior to discharge from residential service settings. Development of the transition/discharge plan shall begin no later than two (2) weeks after admission into residential/inpatient level of care (ASAM Level 3) service settings.

(c) The consumer's response to the transition/discharge plan shall be noted in the plan or a note shall be made that the consumer was not available and why. In the event of the death of a consumer, a summary statement including this information shall be documented in the record.

(d) The transition/discharge plan shall be included in the discharge summary.

(bg) Compliance with 450:18-7-122 may be determined by a review of the following:

1. Policies and procedures;
2. Continuing care plans;
3. Discharge assessments;
4. Discharge summaries;
5. Progress notes;
6. Consumer records;
7. Interviews with staff and consumers; and
8. Other facility information.

**450:18-7-123. Discharge summary [REVOKED]**

(a) The discharge summary shall document the consumer's progress made in treatment and response to services rendered.

(b) A completed discharge summary shall be entered in each consumer's record within fifteen (15) days of the consumer completing, transferring, or discontinuing services. The summary must be signed and dated by the staff member completing the summary. Consumers who have received no services for one hundred eighty (180) days shall be discharged if it is determined that services are no longer needed or desired.

(c) In the event of death of a consumer. A summary statement including this information shall be documented in the record, and

(d) Compliance with 450:247-13 may be determined by a review of closed consumer records.

**SUBCHAPTER 9. SERVICES SUPPORT AND ENHANCEMENT**

**PART 1. STAFF SUPPORT**

**450:18-9-2. Clinical supervision [REVOKED]**

(a) Clinical supervision is a vital component of the provision of quality treatment. Clinical supervision shall be provided for those delivering direct services and shall be provided by persons knowledgeable of clinical services as determined by the program.

(b) All facilities shall have written policies and procedures, operational methods, and documentation of the provision of clinical supervision for all direct treatment and service staff.
For facilities that employ only one service provider, supervision will be in the form of clinical consultation from a qualified service provider in the same field. These policies shall include, but are not limited to:

1. Credentials required for the clinical supervisor;
2. Specific frequency for case reviews with treatment and service providers;
3. Methods and time frames for supervision of individual, group, and educational treatment services; and
4. Written policies and procedures defining the program’s plan for appropriate counselor to consumer ratio, and a plan for how exceptions may be handled.

(c) Ongoing clinical supervision should address:

1. The appropriateness of treatment selected for the consumer;
2. Treatment effectiveness as reflected by the consumers meeting their individual goals; and
3. The provision of feedback that enhances the clinical skills of service providers.

(d) Compliance with 450:18-9-2 may be determined by a review of the following:

1. Policies and procedures;
2. Clinical services manuals;
3. Clinical supervision manuals;
4. Documentation of clinical supervision;
5. Personnel records;
6. Interviews with staff; and
7. Other facility documentation.

(e) Failure to comply with 450:18-9-2 will result in the initiation of procedures to deny, suspend and/or revoke certification.

450:18-9-3. Staff privileging [REVOKED]

(a) Each facility shall have policies and procedures for documenting and verifying the training, experience, education, and other credentials of service providers prior to their providing treatment services for which they were hired.

(b) Each facility shall have written policies and procedures and operational methods for evaluating the professional qualifications of service providers providing treatment services, including those who perform these evaluations and the verification process and the granting of privileges.

(c) All service providers shall be documented as privileged prior to performing treatment services.

(d) The evaluation and verification of professional qualifications includes, but is not limited to, the review and verification of:

1. Professional licensure;
2. Professional certifications; and
3. Other qualifications as set forth in the position’s job description.

(e) Each facility shall minimally perform an annual review of current licensure, certifications, and current qualifications for privileges to provide specific treatment services.

(f) Initial in-service training and annual in-service training updates for all personnel employed by the treatment facility, as well as volunteers, shall cover, at a minimum:

1. Most current version of the ODMHSAS Bill of Rights;
2. Person and family centered services;
3. The prevention of violence in the workplace;
4. Confidentiality requirements;
5. Cultural competency; and
6. Expectations regarding professional conduct.
7. Fire and safety;
8. AIDS and HIV precautions and infection control;
9. Oklahoma Child Abuse Reporting and Prevention Act, 10 O.S. §§ 7101-7115;
10. Trauma informed; and
11. Age- and developmentally-appropriate trainings, where applicable.

(g) Compliance with 450:18-9-3 may be determined by a review of the following:

1. Policies and procedures;
2. Clinical supervision manuals;
3. Minutes of privileging meetings;
4. Personnel records;
5. Interviews with staff; and
6. Other facility documentation.

SUBCHAPTER 13. SUBSTANCE USE DISORDER TREATMENT SERVICES

PART 1. LEVELS OF CARE

450:18-13-1. Levels of Care and optional programs

Facilities shall document the provision of one or more of the following levels of care and/or optional programs in policies and procedures. All facilities shall include the requirements found in Subchapter 7, Facility Clinical Records.

1. Outpatient services;
2. Medically supervised withdrawal management;
3. Non-medical withdrawal management;
4. Residential treatment for adults;
5. Residential treatment for persons with dependent children;
6. Residential treatment for adults with co-occurring disorders;
7. Residential treatment for adolescents;
8. Halfway house services;
9. Halfway house services for persons with dependent children;
10. Halfway house services for adolescents; and
11. Outpatient services, ASAM Level 1
12. Residential services, ASAM Level 3

(A) Halfway house services, ASAM Level 3.1, which includes:

1. Adult halfway house services;
2. Halfway house services for persons with dependent children and pregnant women; and
3. Adolescent halfway house services.

(B) Residential treatment services for adults with co-occurring disorders, ASAM Level 3.3
Permanent Final Adoptions

(C) Residential treatment services, ASAM Level 3.5, which includes:
   (i) Residential treatment for adults;
   (ii) Intensive residential treatment for adults;
   (iii) Residential treatment for persons with dependent children and pregnant women;
   (iv) Intensive residential treatment for persons with dependent children and pregnant women;
   (v) Residential treatment for adolescents; and
   (vi) Intensive residential treatment for adolescents.

(D) Medically supervised withdrawal management, ASAM Level 3.7

PART 3. OUTPATIENT SERVICES, ASAM LEVEL 1

PART 7. MEDICALLY SUPERVISED WITHDRAWAL MANAGEMENT, ASAM LEVEL 3.7

450:18-13-61. Medically-supervised withdrawal management

(a) Medically supervised withdrawal management shall be provided outside a medical facility, but under the direction of a licensed physician and a licensed registered nurse supervisor, for consumers who are withdrawing or are intoxicated from alcohol or other drugs. Presenting consumers shall be assessed as currently experiencing no apparent medical or neurological symptoms as a result of their substance use that would require hospitalization.

(b) The facility shall maintain written programmatic descriptions and operational methods addressing the following:

   (1) Environment: The facility shall provide for beds, food service, monitoring/documenting vital signs, food, and liquids. The facility shall provide a safe, welcoming, and culturally/age appropriate environment. If the facility provides services to consumers under the age of eighteen (18), it shall be licensed by the Oklahoma State Department of Human Services (OKDHS) as a "Residential Child Care Facility".

   (2) Support system:

      (A) A licensed physician providing supervision of withdrawal management shall be on site or on call twenty-four (24) hours per day, seven (7) days per week;
      (B) The facility shall maintain a written plan for emergency procedures which shall be approved by a licensed physician; and
      (C) The facility shall have supplies, as designated in the written emergency procedures, which shall be accessible to the staff.

   (3) Staff:

      (A) Staff members shall be knowledgeable about the physical signs of withdrawal, the taking of vital signs, the implication of those vital signs, and emergency procedures.
      (B) Oklahoma licensed nurses shall provide twenty-four (24) hour monitoring, and statutorily approved personnel shall administer medications in accordance with physician's orders;
      (C) Staff shall be knowledgeable regarding facility-required education, evidenced based practices, training, and policies; and
      (D) The facility shall document in personnel records all education, training, and experience stated in (A), (B), and (C) above prior to staff providing direct care services.

      (E) The facility shall have a minimum of two (2) staff members on site twenty-four (24) hours per day, seven (7) days per week. If consumers under eighteen (18) are on site, staffing ratios shall not exceed those specified in OAC 340:110-3-153.2.

   (4) Treatment services:

      (A) Daily (twenty-four [24] hours a day, seven [7] days a week) substance use disorder withdrawal management treatment services shall be provided which shall include, but are not limited to, oral intake of fluids, three (3) meals a day, taking of vital signs (temperature, pulse, respiration rate, blood pressure), documentation of fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the consumer's condition.
      (B) Medications are to be prescribed if needed during withdrawal management. The medications are to include those needed for physical health issues and mental impairment if acquired during the withdrawal process.

   (5) Assessment:

      (A) An individualized case management plan shall be developed for each consumer prior to discharge;
      (B) A medical assessment for appropriateness of placement shall be completed and documented by a licensed physician during the admission process to the program.

   (c) Compliance with 450:18-13-61 may be determined by a review and/or observation of facility documentation and operations, including but not limited to the following:

      (1) Licenses;
      (2) Policies and procedures;
      (3) Treatment protocols;
      (4) Personnel records, documentation of professional licensure, certification or licensure as an alcohol and drug counselor, documentation of professional work experience, and ongoing in-service trainings;
      (5) Treatment records;
      (6) Interviews with staff; and
      (7) Other supporting facility documentation

PART 9. NON-MEDICAL WITHDRAWAL MANAGEMENT [REVOKED]
450:18-13-81. Non-medical withdrawal management

(a) Non-medical withdrawal management shall be provided in a non-medical setting, with trained paraprofessionals, for intoxicated consumers and consumers withdrawing from alcohol and other drugs, who present with no apparent medical or neurological symptoms as a result of their substance use disorder.

(b) The facility shall maintain written programmatic descriptions and policy and procedures addressing the following:

1. Environment: The facility shall provide beds, food service, and monitor/document vital signs, and food and liquids intake. The facility shall provide a safe, welcoming, and culturally/age appropriate environment.

2. Support system:

   (A) A licensed physician shall be on call twenty-four (24) hours per day, seven (7) days per week;
   (B) The facility shall have a written plan for emergency procedures approved by a licensed physician; and
   (C) Supplies, as designated by the written emergency procedures, shall be available and accessible to the staff.

3. Staff:

   (A) The service provider assigned shall be knowledgeable about the physical signs of withdrawal, the taking of vital signs, the implication of those vital signs, and emergency procedures. Service providers shall be trained and competent to implement physician-approved protocols for consumer observation and supervision, determination of appropriate level of care, and facilitation of the consumer’s transition to continuing care;
   (B) The staff shall be knowledgeable regarding facility-required education, evidenced based practices, training, and policies; and
   (C) The facility shall document in personnel records all education, training, and experience stated in (A) and (B) above prior to staff providing direct care services.

4. Treatment services: Daily (twenty-four [24] hours a day, seven [7] days a week) substance use disorder withdrawal management treatment services shall be provided, to include oral intake of fluids, three (3) meals a day, and the taking of vital signs (temperature, pulse, respiration rate, blood pressure), and fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the consumer's condition.

5. Assessment:

   (A) The consumer shall have an addiction-focused history, obtained as part of the initial assessment and reviewed with a physician during the admission process if physician-developed protocols indicate concern; and

   (B) An individualized case management plan shall be developed prior to discharge to the appropriate level of care.

(c) Compliance with 450:18-13-81 may be determined by a review of the following:

1. Licenses;
2. Policies and procedures;
3. Treatment protocols;
4. Physician-approved withdrawal management procedures;
5. Personnel records, documentation of professional licensure or certification, documentation of professional work experience, and ongoing-in service trainings;
6. Treatment records; and
7. Interviews with staff.

450:18-13-82. Non-medical withdrawal management, admission criteria [REVOKED]

(a) Admission to non-medical withdrawal management shall be determined according to 450:18-7-21. These criteria shall be a part of the program’s written policy and procedures.

(b) Compliance with 450:18-13-82 may be determined by a review of the following:

1. Policies and procedures;
2. Admission assessment instruments;
3. Medical evaluations;
4. Admission protocols;
5. Treatment records;
6. Interviews with staff and consumers; and
7. Publicly posted information and other facility documentation.

450:18-13-83. Non-medical withdrawal management, discharge criteria [REVOKED]

(a) Programmatic discharge from non-medical withdrawal management shall be determined according to 450:18-7-121. These criteria shall be a part of the program’s written policy and procedures.

(b) Compliance with 450:18-13-83 may be determined by a review of the following:

1. Policies and procedures;
2. Discharge evaluation assessment instruments;
3. Medical evaluations;
4. Consumer records and discharge summaries;
5. Continuing care plans;
6. Interviews with staff and consumers; and
7. Other facility documentation.

PART 11. RESIDENTIAL TREATMENT, ASAM LEVEL 3.5


(a) Substance use disorder treatment in a residential setting shall provide a planned regimen of twenty-four (24) hours a day, seven (7) days a week of professionally directed evaluation, care, and treatment in a permanent program location.
Consumers shall participate in at least twenty-four (24) treatment hours of substance use disorder treatment services per week. The facility shall provide beds, food service, and a safe, welcoming, and culturally/age appropriate environment.

(b) The facility shall maintain written programmatic descriptions and operational methods addressing the following:

(1) Support system:
   (A) A licensed physician shall be available, at least by telephone, twenty-four (24) hours per day, seven (7) days per week;
   (B) The facility shall maintain written policy and procedures for handling medical emergencies which are approved by the licensed physician; and an emergency medical number shall be conspicuously posted for staff use; and
   (C) The facility shall maintain written policies and procedures for the handling of clinical issues during times in which clinical staff are not at the facility.

(2) Staff:
   (A) The facility shall maintain documentation that service providers are knowledgeable regarding the biopsychosocial dimensions of substance use disorders, evidenced-based practices, cultural, age, and gender specified issues, and co-occurring disorder issues.
   (B) Staff shall be at least eighteen (18) years of age.
   (C) The facility shall document in personnel records all education, training, and experience stated above prior to the provision of direct care services.
   (D) The facility shall have staff members on site twenty-four (24) hours per day, seven (7) days per week.

(3) Treatment services. Daily (twenty-four [24] hours a day, seven [7] days a week) substance use disorder treatment services shall be provided to assess and address individual needs of each consumer. Services shall include, but are not limited to:
   (A) Therapy. Therapy including individual, family, and group therapy, must be provided by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate who must use and document a generally accepted clinical approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. The therapy must be goal directed utilizing techniques appropriate to the individual consumer's service plan and the consumer's developmental and cognitive abilities. This service does not include social skill development or daily living skill activities. For adults, group therapy is limited to a total of eight adult individuals. For all children under the age of eighteen, the total group size is limited to six. Therapy must be provided at least one (1) hour per week.
   (B) Rehabilitation services. Rehabilitation services must be provided by a LBHP, Licensure Candidate, Certified Alcohol and Drug Counselor (CADC) or Certified Behavioral Health Case Manager II (CM II). These services include educational and supportive services regarding independent living, self-care, social skills regarding development, lifestyle changes and recovery principles and practices (including relapse prevention). Services provided typically take the form of curriculum based education and skills practice, and should be goal specific in accordance with an individualized service plan. Rehabilitation services must be provided at least seven (7) hours per week. The maximum staffing ratio for group rehabilitation services is fourteen members for each qualified provider for adults and eight to one for children under the age of eighteen.
   (C) Peer Recovery Support Services. Peer recovery support services must be provided by Peer Recovery Support Specialists. Peer recovery support services may be offered to adult consumers with substance use disorders, including co-occurring disorders. Services shall be provided in accordance with OAC 450:18-13-221. A maximum of seven (7) hours per week of peer recovery support services may count toward the weekly required treatment hours.

(ED) Case Care Management. Case Care management must be provided by a LBHP, Licensure Candidate, CADC, CM II or CM I as clinically indicated. Case management is case management provided in residential settings that includes assessment, development of a care plan, and referral and linkage to community supports and community-based or lower level of care services to promote continued recovery after the individual discharges from the treatment facility.

(FF) Crisis Intervention. Crisis intervention services must be provided by a LBHP or Licensure Candidate. Crisis intervention services are provided as needed for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress, and/or imminent danger of substance relapse. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented in the consumer's record.

(4) Treatment documentation:
   (A) All documentation for therapy, crisis intervention and case management must be documented in an individual note and reflect the content of each session provided. Documentation must include, at a minimum, the following:
      (i) Date;
(ii) start and stop time for each session;
(iii) Specific problems, goals, and objectives addressed;
(iv) type of service and method(s) used to address problems;
(v) Summary of progress made toward goals and objectives, or lack of;
(vi) Consumer response to overall treatment services;
(vii) Any new problems, goals, or objectives identified during the session;
(viii) dated signature and credentials of the service provider completing the documentation; and
(ix) Consumer's name.

(B) Documentation for rehabilitation and peer recovery support services and education groups must include daily member sign-in/sign-out record of member attendance (including date, time, type of service and service focus), and a daily progress note or a summary progress note weekly.

(C) Documentation shall reflect each consumer has received a minimum of twenty four (24) hours of treatment services each week, including the treatment services required in 18-13-101(b)(3), in addition to life skills, recreational, and self-help supportive meetings.

(5) The program provides documentation of the following community living components:

(A) A written daily schedule of activities.

(B) Quarterly meetings between consumers and the program personnel.

(C) Recreational activities to be utilized on personal time.

(D) Personal space for privacy.

(E) Security of consumer's property.

(F) A clean, inviting, and comfortable setting.

(G) Evidence of individual possessions and decorations.

(H) Daily access to nutritious meals and snacks.

(I) Policy addressing separate sleeping areas for the consumers based on:

(i) Gender;
(ii) Age; and
(iii) Needs.

(c) Compliance with 450:18-13-101 may be determined by a review and/or observation of facility documentation and operations, including but not limited to the following:

(1) Licenses;
(2) Policies and procedures;
(3) Treatment protocols;
(4) Personnel record, documentation of professional licensure or certification, documentation of professional work experience, and ongoing in-service trainings;
(5) Treatment records; and
(6) Interviews with staff and consumers.

450:18-13-101.1. Intensive residential treatment for adults
(a) Intensive substance use disorder treatment in a residential setting shall provide a planned regimen of twenty-four (24) hours a day, seven (7) days a week of professionally directed evaluation, care, and treatment in a permanent program location. Consumers shall participate in at least thirty-seven (37) treatment hours of substance use disorder treatment services per week. The facility shall provide beds, food service, and a safe, welcoming, and culturally/age appropriate environment.

(b) The facility shall maintain written programmatic descriptions and operational methods addressing the following:

(1) Support system:

(A) A licensed psychiatrist shall be available, at least by telephone, twenty-four (24) hours per day, seven (7) days per week;

(B) The facility shall maintain written policy and procedures for handling medical emergencies which are approved by the licensed psychiatrist; and an emergency medical number shall be conspicuously posted for staff use; and

(C) The facility shall maintain written policies and procedures for the handling of clinical issues during times in which clinical staff are not at the facility.

(2) Staff:

(A) The facility shall maintain documentation that service providers are knowledgeable regarding the biopsychosocial dimensions of substance use disorders, evidenced-based practices, cultural, and gender specific related issues, and co-occurring disorder issues.

(B) Staff shall be at least eighteen (18) years of age.

(C) The facility shall document in personnel records all education, training, and experience stated above prior to the provision of direct care services.

(D) The facility shall have staff members on site twenty-four (24) hours per day, seven (7) days per week.

(3) Treatment services. Daily (twenty-four [24] hours a day, seven [7] days a week) substance use disorder treatment services shall be provided to assess and address individual needs of each consumer. Services shall include, but are not limited to:

(A) Therapy. Therapy, including individual, family, and group therapy, must be provided by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate who must use and document a generally accepted clinical approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. The therapy must be goal directed utilizing techniques appropriate to the individual consumer's service plan and the consumer's developmental and cognitive abilities. This service does not include social skill development or daily living skill activities. For adults, group therapy is limited to a total of eight adult individuals. For all children under the age of eighteen,
the total group size is limited to six. Therapy must be provided at least four (4) hours per week.

(B) **Rehabilitation services.** Rehabilitation services must be provided by a LBHP, Licensure Candidate, Certified Alcohol and Drug Counselor (CADC) or Certified Behavioral Health Case Manager II (CM II). These services include educational and supportive services regarding independent living, self-care, social skills regarding development, lifestyle changes and recovery principles and practices (including relapse prevention). Services provided typically take the form of curriculum based education and skills practice, and should be goal specific in accordance with an individualized service plan. Rehabilitation services must be provided at least seven (7) hours per week. The maximum staffing ratio for group rehabilitation services is fourteen members for each qualified provider for adults and eight to one for children under the age of eighteen.

(C) **Educational groups.** Only eleven (11) hours per week of education group may be counted toward the required treatment hours. Education groups may include but are not limited to learning experiences regarding living skills, budgeting, educational/vocational skills, etc.

(C) **Peer Recovery Support Services.** Peer recovery support services must be provided by Peer Recovery Support Specialists. Peer recovery support services may be offered to adult consumers with substance use disorders, including co-occurring disorders. Services shall be provided in accordance with OAC 450:18-13-221. A maximum of eleven (11) hours per week of peer recovery support services may count toward the weekly required treatment hours.

(D) **Case Management.** Case management must be provided by a LBHP, Licensure Candidate, CADC, CM II or CM I as clinically indicated. Case management is case management in residential settings that includes assessment, development of a care plan, and referral and linkage to community supports and community-based or lower level of care services to promote continued recovery after the individual discharges from the treatment facility.

(E) **Crisis Intervention.** Crisis intervention services must be provided by a LBHP or Licensure Candidate. Crisis intervention services are provided as needed for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress, and/or imminent danger of substance relapse. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented in the consumer's record.

(4) **Treatment documentation:**

(A) All documentation for therapy, case management and crisis intervention must be documented in an individual note and reflect the content of each session provided. Documentation must include, at a minimum, the following:

1. Date;
2. Start and stop time for each session;
3. Specific problems, goals, and objectives addressed;
4. Type of service and method(s) used to address problems;
5. Summary of progress made toward goals and objectives, or lack of;
6. Consumer response to overall treatment services;
7. Any new problems, goals, or objectives identified during the week;
8. Dated signature and credentials of the service provider completing the documentation; and
9. Consumer's name.

(B) Documentation for rehabilitation and peer recovery support services and education groups must include daily member sign-in/sign-out record of member attendance (including date, time, type of service and service focus), and a daily progress note or a summary progress note weekly.

(C) Documentation shall reflect each consumer has received a minimum of thirty-seven (37) hours of treatment services each week, including the treatment services required in 18-13-101.1(b)(3), in addition to life skills, recreational, and self-help supportive meetings.

(5) The program provides documentation of the following community living components:

(A) A written daily schedule of activities.
(B) Quarterly meetings between consumers and the program personnel.
(C) Functional activities to be utilized on personal time.
(D) Personal space for privacy.
(E) Security of consumer's property.
(F) A clean, inviting, and comfortable setting.
(G) Evidence of individual possessions and decorations.
(H) Daily access to nutritious meals and snacks.
(I) Policy addressing separate sleeping areas for the consumers based on:

1. Gender;
2. Age; and

(c) Compliance with 450:18-13-101.1 may be determined by a review and/or observation of facility documentation and operations, including but not limited to the following:

1. Licenses;
2. Policies and procedures;
3. Treatment protocols;
4. Personnel record, documentation of professional licensure or certification, documentation of professional work experience, and ongoing in-service trainings;
5. Treatment records; and
(6) Interviews with staff and consumers.

PART 13. RESIDENTIAL TREATMENT FOR PERSONS WITH DEPENDENT CHILDREN AND PREGNANT WOMEN, ASAM LEVEL 3.5

450:18-13-121. Residential treatment for persons with dependent children and pregnant women

(a) Substance use disorder treatment shall be provided in a residential setting offering a planned regimen of twenty-four (24) hours a day, seven (7) days a week, for adults. [Exception: (1) TANF recipients with Oklahoma Department of Human Services (OKDHS) approved documentation shall participate in at least twenty-one (21) hours of treatment; documentation should be reflected in consumer record, and treatment services per week, for adults. (2) unless clinically indicated, structured services may be reduced to six (6) hours per week for children attending school.]

(b) Each facility shall maintain written programmatic descriptions and operational methods addressing the following:

1. Environment: The facility shall provide family-style living arrangements, indoor recreational space for children and families, and safe, protected outdoor recreational and leisure space. The facility shall provide for materials and space appropriate for ages and development of children receiving services. (43A O.S. §3-417). The facility shall provide beds, food service, and a safe, welcoming, and culturally/age appropriate environment.

2. Support system:
   (A) A licensed physician shall be available, at least by telephone, twenty-four (24) hours per day, seven (7) days per week.
   (B) The facility shall promote and facilitate children's access to the fullest possible range of medical services available such as health screening, well-child health care, screening in speech, language, hearing, and vision, and verify immunization records.
   (C) Access to emergency health care shall be provided as necessary.
   (D) The facility shall maintain written policy and procedures for handling medical emergencies which are approved by the licensed physician, and an emergency medical number shall be conspicuously posted for staff use.

3. Staff:
   (A) The facility shall maintain documentation that service providers are knowledgeable regarding biopsychosocial dimensions of substance use disorder, evidenced based practices, cultural, age and gender-specific related issues, co-occurring disorder issues and treatment of infants, toddlers, preschool children, and school-age children.
   (B) The facility shall document that service providers have training in the following:
      (i) trauma issues, identification of domestic violence, spousal or partner abuse, and child abuse and neglect, with special emphasis on failure to thrive, and sexual abuse of children;
      (ii) child development and age appropriate behaviors;
      (iii) parenting skills appropriate to infants, toddlers, preschool, and school age children; and
      (iv) the impact of substances and substance use disorders on parenting and family units.
   (C) The facility shall document that staff working with children shall have ongoing training in the following and demonstrate job appropriate functional comprehension of:
      (i) the impact of prenatal drug and alcohol exposure on child development;
      (ii) the effect of substance use disorders on parenting children and families;
      (iii) parenting skills appropriate to infants, toddlers, preschool, and school age children;
      (iv) common children's behavioral and developmental problems;
      (v) appropriate play activities according to developmental stage;
      (vi) recognition of sexual acting-out behavior; and
      (vii) the substance use disorder recovery process, especially as related to family units.
   (D) The facility shall document that staff are knowledgeable regarding facility-required education, and training requirements and policies;
   (E) The facility shall have staff on site twenty-four (24) hours a day;
   (F) Staff shall be at least eighteen (18) years of age; and
   (G) The facility shall document in personnel records, all education, training, and experience stated above prior to the provision of services.

4. Treatment services:
   (A) The facility shall provide (twenty-four [24] hours a day, seven [7] days a week) substance use disorder treatment services to assess and address individual needs of each consumer. Treatment services shall include, but are not limited to: therapy, rehabilitation services, educational groups, case management services, and crisis intervention, parenting, and child development; and
   (i) Therapy. Therapy, including individual, family, and group therapy, must be provided by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate who must use and document a generally accepted clinical approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy
or another widely accepted theoretical framework for treatment. The therapy must be goal directed utilizing techniques appropriate to the individual consumer's service plan and the consumer's developmental and cognitive abilities. This service does not include social skill development or daily living skill activities. For adults, group therapy is limited to a total of eight adult individuals. For all children under the age of eighteen, the total group size is limited to six. Therapy must be provided at least one (1) hour per week.

(ii) **Rehabilitation services.** Rehabilitation services must be provided by a LBHP, Licensure Candidate, Certified Alcohol and Drug Counselor (CADC) or Certified Behavioral Health Case Manager II (CM II). These services include educational and supportive services regarding independent living, self-care, social skills regarding development, lifestyle changes and recovery principles and practices (including relapse prevention). Services provided typically take the form of curriculum based education and skills practice, and should be goal specific in accordance with an individualized service plan. Rehabilitation services must be provided at least seven (7) hours per week. The maximum staffing ratio for group rehabilitation services is fourteen members for each qualified provider for adults and eight to one for children under the age of eighteen.

(iii) **Peer Recovery Support Services.** Peer recovery support services must be provided by Peer Recovery Support Specialists. Peer recovery support services may be offered to consumers age sixteen (16) and older with substance use disorders, including co-occurring disorders. Services shall be provided in accordance with OAC 450:18-13-221. A maximum of seven (7) hours per week of peer recovery support services may count toward the weekly required treatment hours.

(iv) **Care Management.** Care management must be provided by a LBHP, Licensure Candidate, CADC, CM II or CM I as clinically indicated. Care management is case management in residential settings that includes assessment, development of a care plan, and referral and linkage to community supports and community-based or lower level of care services to promote continued recovery after the individual discharges from the treatment facility.

(v) **Crisis Intervention.** Crisis intervention services must be provided by a LBHP or Licensure Candidate. Crisis intervention services are provided as needed for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress, and/or imminent danger of substance relapse. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented in the consumer's record.

(B) Services may be provided to dependent children by providers certified under this Chapter when provided to address the impacts related to the parent's addiction. Compliance with separate provider qualifications is required for other treatment services provided to dependent children in accordance with OAC 450 and Title 43A of the Oklahoma Statutes. The facility shall provide treatment services for children ages four (4) to twelve (12) years in accordance with the child's service plan, including a minimum of twelve (12) structured hours per week for each child (see 450:18-13-121 (a), Exception #2), including, but not limited to, assessment and age appropriate individual, family and group therapy (topics can include, but are not limited to, poor impulse control, anger management, peer interaction, understanding feelings, problem/conflict resolution), education groups (topics can include, but are not limited to, effects of alcohol on the body, roles of the family, safety planning, grief and loss), recreational activities, prevention techniques, and support groups, according to the development of the child. Structured activities do not include time spent watching television and watching videos. Special attention shall be given to the high risk of sexual abuse, sexual acting-out by children, suicide risk, and the treatment of toddlers and preschool children; and

(C) Children's services, excluding infants, shall address the significant issues and needs documented in the child's and/or parent's assessment utilizing both structured and unstructured therapeutic activity. Services shall create and enhance positive self-image and feelings of self-worth, promote family unity, teach personal body safety, and positive school interactions, and to prevent alcohol, tobacco, and other drug use; and

(D) Services for infants (ages birth to three [3] years of age) shall include, at a minimum, developmentally appropriate parent-child interactive activities and developmentally appropriate structured activities that promote and nurture the growth and well being of the infant; and

(E) Case management services for each adult and each child that include assessment of and planning and arranging for recovery needs.

(5) Treatment documentation:

(A) All documentation for therapy, case management and crisis intervention must be documented in an individual note and reflect the content of each session provided. Documentation must include, at a minimum, the following:

(i) Date;

(ii) start and stop time for each session;

(iii) Specific problems, goals, and objectives addressed;
(iv) type of service and method(s) used to address problems;
(v) Summary of progress made toward goals and objectives, or lack of;
(vi) Consumer response to overall treatment services;
(vii) Any new problems, goals, or objectives identified during the week;
(viii) Dated signature and credentials of the service provider completing the documentation; and
(ix) Consumer's name.
(B) Documentation for rehabilitation and peer recovery support services and education groups must include daily member sign-in/sign-out record of member attendance (including date, time, type of service and service focus), and a daily progress note or a summary progress note weekly.
(C) Documentation shall reflect that each adult consumer with dependent children and/or consumer who is pregnant has received a minimum of twenty-four (24) hours of treatment services each week, unless the woman is pregnant and the consumer record contains physician-approved permission for less than twenty-four (24) hours of service, or as permitted in 450:18-13-121 (a). Exception #1. Should the consumer be unable to participate in twenty-four (24) treatment hours for two (2) or more weeks, a review of appropriate placement shall be conducted weekly and documented by the executive director of the facility and shall include observations of parent and child interactions, especially those indicative of therapeutic need or progress.
(D) Documentation shall reflect each child has received services in accordance with the child’s service plan if services are provided by the facility a minimum of twelve (12) structured hours of service each week addressing needs and issues documented in either, or both, the child’s or parent’s assessments, the child’s response to those services, and an assessment and planning of recovery needs. Exception: As few as six (6) hours each week as permitted by 450:18-13-121(a).
(6) The program provides documentation of the following community living components:
(A) A written daily schedule of activities.
(B) Quarterly meetings between consumer and the program personnel.
(C) Recreational activities to be utilized on personal time.
(D) Personal space for privacy.
(E) Security of consumer’s property.
(F) A clean, inviting, and comfortable setting.
(G) Evidence of individual possessions and decorations.
(H) Daily access to nutritious meals and snacks.
(I) Policy addressing separate sleeping areas for the consumers based on:
   (i) Gender;
   (ii) Age; and
   (iii) Needs.
(c) Compliance with 450:18-13-121 may be determined by a review and/or observation of facility documentation and operations, including but not limited to the following:
   (1) Licenses;
   (2) Policies and procedures;
   (3) Treatment protocols;
   (4) Personnel record, documentation of professional licensure, certification or licensure as an alcohol and drug counselor, documentation of professional work experience, ongoing in-service trainings;
   (5) Records;
   (6) Interviews with staff; and
   (7) Other facility documentation.

450:18-13-122. Residential treatment for persons with dependent children and pregnant women, admission criteria

(a) Admission to residential treatment for persons with dependent children and pregnant women shall be determined according to 450:18-7-21. These criteria shall be a part of the program’s written policies and procedures. Admission of the parent's children shall depend upon the program's ability to provide and/or coordinate the needed services.
(b) Compliance with 450:18-13-122 may be determined by a review of the following:
   (1) Policies and procedures;
   (2) Admission assessment instruments and protocols;
   (3) Medical assessments;
   (4) Consumer records;
   (5) Brochures;
   (6) Posted public information; and
   (7) Interviews with staff and consumers.

450:18-13-123. Residential treatment for persons with dependent children and pregnant women, discharge criteria

(a) Programmatic discharge from residential treatment for persons with dependent children and pregnant women shall be determined according to 450:18-7-121; and the children shall have been linked with needed educational, therapy, and medical services in the planned community of residence. These criteria and the requirements for children shall be included in the program's written policies and procedures.
(b) Compliance with 450:18-13-123 may be determined by a review of the following:
   (1) Policies and procedures;
   (2) Discharge evaluation assessment instruments;
   (3) Medical evaluations;
   (4) Discharge protocols;
   (5) Continuing care plans;
   (6) Discharge summaries;
   (7) Treatment records;
   (8) Interviews with staff and consumers; and
   (9) Other facility documentation.
Permanent Final Adoptions

(a) Substance use disorder treatment shall be provided in a residential setting offering a planned regimen of twenty-four (24) hours a day, seven (7) days a week of professionally directed evaluation, care, and treatment in a permanent setting and under a defined set of policies and procedures. Adult consumers shall participate in at least thirty-five (35) treatment hours of substance use disorder treatment services per week.

(1) **Therapy.** Therapy, including individual, family, and group therapy, must be provided by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate who must use and document a generally accepted clinical approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. The therapy must be goal directed utilizing techniques appropriate to the individual consumer's service plan and the consumer's developmental and cognitive abilities. This service does not include social skill development or daily living skill activities. For adults, group therapy is limited to a total of eight adult individuals. For all children under the age of eighteen, the total group size is limited to six. Therapy must be provided at least four (4) hours per week.

(2) **Rehabilitation services.** Rehabilitation services must be provided by a LBHP, Licensure Candidate, Certified Alcohol and Drug Counselor (CADC) or Certified Behavioral Health Case Manager II (CM II). These services include educational and supportive services regarding independent living, self-care, social skills regarding development, lifestyle changes and recovery principles and practices (including relapse prevention). Services provided typically take the form of curriculum based education and skills practice, and should be goal specific in accordance with an individualized service plan. Rehabilitation services must be provided at least seven (7) hours per week. The maximum staffing ratio for group rehabilitation services is fourteen members for each qualified provider for adults and eight to one for children under the age of eighteen.

(3) **Peer Recovery Support Services.** Peer recovery support services must be provided by Peer Recovery Support Specialists. Peer recovery support services may be offered to consumers age sixteen (16) and older with substance use disorders, including co-occurring disorders. Services shall be provided in accordance with OAC 450:18-13-221. A maximum of eleven (11) hours per week of peer recovery support services may count toward the weekly required treatment hours.

(4) **Care Management.** Care management must be provided by a LBHP, Licensure Candidate, CADC, CM II or CM I as clinically indicated. Care management is case management in residential settings that includes assessment, development of a care plan, and referral and linkage to community supports and community-based or lower level of care services to promote continued recovery after the individual discharges from the treatment facility.

(5) **Crisis Intervention.** Crisis intervention services must be provided by a LBHP or Licensure Candidate. Crisis intervention services are provided as needed for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress, and/or imminent danger of substance relapse. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented in the consumer's record.

(b) Documentation shall reflect that each consumer with dependent children and/or consumer who is pregnant has received a minimum of thirty-five (35) hours of treatment services each week.

(c) If services to dependent children are provided by the facility, documentation shall reflect each child has received services in accordance with the child's service plan that address the needs and issues documented in either, or both, the child's or parent's assessments; the child's response to those services; and an assessment and planning of recovery needs.

(d) A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week.

(e) Facilities shall otherwise comply with all requirements within 450:18-13-121, 450:18-13-122, and 450:18-13-123.

PART 15. RESIDENTIAL TREATMENT FOR ADULTS WITH CO-OCCURRING DISORDERS, ASAM LEVEL 3.3

450:18-13.141. Adult residential treatment for consumers with co-occurring disorders
(a) Substance use disorder and mental health treatment shall be provided in a residential setting offering a planned regimen of twenty-four (24) hour structured evaluation, care, and treatment, under a defined set of policy and procedures, and shall have a permanent setting. Consumers shall participate in at least twenty-four (24) treatment hours of mental health or substance use disorder treatment services per week, including medication therapy, case management services that address medical and/or dental needs, or any other service identified on the consumer's service plan, excluding community support groups. The facility shall provide beds, food service, and a safe, welcoming, and culturally/age appropriate environment.

(b) The facility shall maintain written programmatic descriptions and operational methods addressing the following:

(1) **Support system:**

   (A) The facility shall maintain availability of a licensed physicians, who is knowledgeable in substance use disorders and mental health issues to provide evaluation, treatment and follow-up; and a licensed psychiatrist will be available by telephone twenty-four (24) hours per day, seven (7) days per week;

   (B) The facility shall make available medication evaluation, administration, or monitoring, and staff
shall be available to monitor medications as needed; and
(C) The facility shall provide case management services.
(D) The facility shall maintain written policy and
procedures for handling medical emergencies which are
approved by the licensed psychiatrist, and an
emergency medical number shall be conspicuously
posted for staff use.
(2) Staff:
(A) Service providers shall be knowledgeable
regarding substance use disorders, mental health,
evidenced based practices, co-occurring issues, cul-
tural culture, age, and gender specificrelated issues.
(B) All staff shall be knowledgeable regarding
facility-required education, training, and policies;
(C) Staff shall be at least eighteen (18) years of age;
and
(D) The facility shall document in personnel
records, prior to the provision of treatment services,
all education, training, and experience stated above.
(3) Treatment services:
(A) Daily treatment service shall be provided to
assess and address individual needs of each consumer.
These services shall include, but not limited to:
(i) Medication monitoring.
(ii) Therapy. See 18-13-101(b)(3)(A) for re-
quirements.
(iii) Rehabilitation services. See 18-13-
101(b)(3)(B) for requirements.
(iv) Educational groups. See 18-13-101(b)(3)(C) for re-
quirements.
(v) Case management services. See 18-
3-101(b)(3)(D) for requirements.
(vi) Crisis intervention. See 18-
13-101(b)(3)(E) for requirements.
(B) Psychiatric and/or psychological and/or
mental health evaluations shall be completed on all
consumers;
(C) Medication monitoring shall be provided.
(4) Treatment documentation:
(A) All documentation for therapy, case manage-
ment and crisis intervention must be documented
in an individual note and reflect the content of each
session provided. Documentation must include, at a
minimum, the following:
(i) Date;
(ii) start and stop time for each session;
(iii) Specific problems, goals, and objectives
addressed;
(iv) type of service and method(s) used to ad-
dress problems;
(v) Summary of progress made toward goals
and objectives, or lack of;
(vi) Consumer response to overall treatment
services;
(vii) Any new problems, goals, or objectives
identified during the week;
(viii) Dated signature and credentials of the ser-
vice provider completing the documentation; and
(ix) Consumer's name; and
(x) Consumer's medication and response to
medication therapy, if used, shall be documented.
(B) Documentation for rehabilitation and peer
recovery support services and education groups
must include daily member sign-in/sign-out record
of member attendance (including date, time, type of
service and service focus), and a daily progress note
or a summary progress note weekly.
(C) The service plan shall address the consumer's
mental health needs and related medications. The
consumer's medications shall be re-assessed a mini-
um of once every thirty (30) days.
(5) The program provides documentation of the follow-
ing community living components:
(A) A written daily schedule of activities.
(B) Quarterly meetings between consumers and the
program personnel.
(C) Recreational activities to be utilized on per-
sonal time.
(D) Personal space for privacy.
(E) Security of consumer's property.
(F) A clean, inviting, and comfortable setting.
(G) Evidence of individual possessions and decora-
tions.
(H) Daily access to nutritious meals and snacks.
(I) Policy addressing separate sleeping areas for
the consumers based on:
(i) Gender;
(ii) Age; and
(iii) Needs.
(c) Compliance with 450:18-13-141 may be determined by a
review and/or observation of facility documentation and oper-
ations, including but not limited to the following:
(1) Licenses;
(2) Policies and procedures;
(3) Treatment protocols;
(4) Personnel record, documentation of professional
license or certification, documentation of professional
work experience and ongoing in-service trainings;
(5) Treatment records;
(6) Interviews with staff; and
(7) Other facility documentation.

PART 17. RESIDENTIAL TREATMENT FOR
ADOLESCENTS, ASAM LEVEL 3.5

450:18-13-161. Residential treatment for adolescents
(a) Residential treatment for adolescents ages thirteen
(13) to seventeen (17) shall provide a planned regimen of
twenty-four (24) hour, seven (7) days a week, professionally
directed evaluation, care, and treatment for chemically de-
pendent adolescents, under written policies and procedures
in a permanent facility. Adolescents not attending academic training shall participate in at least twenty-one (21) twenty-four (24) substance use disorder treatment related hours per week. Adolescents attending academic training shall participate in at least fifteen (15) hours of substance use disorder treatment related hours per week. At a minimum, ten (10) hours shall be devoted to therapeutic treatment services including, but not limited to, group, individual, and family therapy provided by a qualified service provider. The remaining hours shall be devoted to life skills, pro-social skills, and recreational activities. Other activities such as self-help support groups, meetings, and religious participation shall be in addition to required hours.

(b) The residential treatment program shall maintain written programmatic descriptions and operational methods addressing the following:

(1) Environment:
(A) The facility shall maintain an environment which is supportive of physical and emotional growth and development which is appropriate to the needs of adolescents;
(B) The facility shall provide space, both indoor and outdoor, for the recreational and social needs of adolescents;
(C) The facility shall group consumers appropriately by age, developmental level, gender, and treatment needs;
(D) The program may provide transportation to activities in the community as appropriate. Vehicles used for transportation should not be labeled in any way that calls attention to the facility or the vehicle's occupants;
(E) The program shall provide study areas within the facility and shall provide ancillary study materials such as encyclopedias, dictionaries, and educational resource texts and materials; and
(F) The facility shall provide a safe, welcoming, and culturally/age appropriate environment;

(G) The facility shall be licensed by the Oklahoma State Department of Human Services (OKDHS) as a "Residential Child Care Facility".

(2) Support systems:
(A) The facility shall make available a licensed physician by telephone twenty-four (24) hours per day, seven (7) days per week;
(B) The facility shall have specialized professional consultation or supervision available;
(C) The facility shall provide clinically appropriate public educational services in compliance with applicable Oklahoma laws; and
(D) The facility shall provide emergency services and crisis interventions.

(E) The facility shall maintain written policy and procedures for handling medical emergencies which are approved by the licensed physician, and an emergency medical number shall be conspicuously posted for staff use.

(3) Staff:

(A) The facility shall document that service providers are knowledgeable regarding the biopsychosocial aspects of substance use disorder, cultural, gender, and age specific issues, co-occurring disorder issues, child and adolescent development and, evidenced based practices.
(B) Maintain documentation that service providers are knowledgeable regarding the identification of violence and domestic violence, spousal or partner abuse, child abuse and neglect, parent and sibling abuse, normal and abnormal adolescent development, and family dynamics;
(C) Ensure at least two (2) staff members are awake and on duty twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2.
(D) If educational services are provided, the facility shall maintain documentation to verify that providing staff meets all state requirements for education or special education;
(E) Staff shall be knowledgeable regarding the facility required education, and training requirements and policies;
(F) Staff shall be at least eighteen (18) years of age; and

(G) The facility shall document in personnel records all education training and experience stated in above prior to the provision of direct care service.

(4) Treatment services:

(A) A multidisciplinary team approach shall be utilized in providing daily substance use disorder treatment services to assess and address the individual needs of each adolescent;
(B) Services shall include, but not be limited to:

(i) **Therapy.** Therapy, including individual, family, and group therapy, must be provided by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate who must use and document a clinical approach generally accepted as reliable in the relevant clinical community, such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. The therapy must be goal directed utilizing techniques appropriate to the individual consumer's service plan and the consumer's developmental and cognitive abilities. This service does not include social skill development or daily living skill activities. For all children under the age of eighteen, the total group size is limited to six. Therapy must be provided at least one (1) hour per week.

(ii) **Rehabilitation Services.** Rehabilitation services must be provided by a LBHP, Licensure Candidate, Certified Alcohol and Drug Counselor (CADC) or Certified Behavioral Health Case Manager II (CM II). This service includes these services include educational and supportive services regarding independent living, self-care,
social skills regarding development, lifestyle changes and recovery principles and practices (including relapse prevention). Services provided typically take the form of curriculum based education and skills practice, and should be goal specific in accordance with an individualized service plan. The maximum staffing ratio for group rehabilitation services is eight to one for children under the age of eighteen. Rehabilitation services must be provided at least seven (7) hours per week.

(iii) **Educational groups.** Education groups must be conducted by a LBHP, Licensure Candidate, CADC, CM II or Peer Recovery Support Specialist (PRSS).

(iii) **Peer Recovery Support Services.** Peer recovery support services must be provided by Peer Recovery Support Specialists. Peer recovery support services may be offered to consumers age sixteen (16) and older with substance use disorders, including co-occurring disorders. Services shall be provided in accordance with OAC 450:18-13-221. A maximum of seven (7) hours per week of peer recovery support services may count toward the weekly required treatment hours.

(iv) **Case Care Management.** CaseCare management must be provided by a LBHP, Licensure Candidate, CADC, CM II or CM I as clinically indicated. Case care management is case management in residential settings that includes assessment, development of a care plan, and referral and linkage to community supports and community-based or lower level of care services to promote continued recovery after the individual discharges from the treatment facility.

(v) **Crisis intervention.** Crisis intervention services must be provided by a LBHP or Licensure Candidate. Crisis intervention services are provided as needed for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress, and/or danger of substance relapse. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented in the consumer's record.

(C) Services shall be provided in appropriate groups according to age, gender, developmental level, treatment status, and individual needs;

(D) The facility shall provide clinically appropriate public educational services in compliance with applicable Oklahoma law;

(E) Consumers shall participate in educational programs within the community, when clinically indicated, including extracurricular activities; and

(F) Service providers shall confer on a regular basis with school personnel, including the provision of necessary information, when appropriate, on the educational progress of the consumer, and shall assess and respond to the needs for changes in the educational plans.

(5) **Assessments:**

(A) A physical examination shall be conducted by a licensed physician, to include physical assessment, health history, immunization status, and evaluation of motor development and function, speech, hearing, visual, and language functioning; and

(B) The facility shall facilitate and document the involvement and participation of family members or significant others in the assessment, treatment, rehabilitation, and continuing treatment needs of each consumer;

(6) **Treatment documentation:**

(A) All documentation for therapy, case management and crisis intervention must be documented in an individual note and reflect the content of each session provided. Documentation must include, at a minimum, the following:

(i) Date;

(ii) start and stop time for each session;

(iii) Specific problems, goals, and objectives addressed;

(iv) type of service and method(s) used to address problems;

(v) Summary of progress made toward goals and objectives, or lack of;

(vi) Consumer response to overall treatment services;

(vii) Any new problems, goals, or objectives identified during the week;

(viii) Dated signature and credentials of the service provider completing the documentation; and

(ix) Consumer's name.

(B) Documentation for rehabilitation and peer recovery supports services and education groups must include daily member sign-in/sign-out record of member attendance (including date, time, type of service and service focus), and a daily progress note or a summary progress note weekly.

(C) Documentation shall reflect that each consumer receives a minimum of twenty-one (21) twenty-four (24) hours of treatment-related hours each week or fifteen (15) or more treatment-related hours if participating in academic training.

(7) **Documentation of the following community living components:**

(A) A written daily schedule of activities.

(B) Quarterly meetings between consumers and the program personnel.

(C) Recreational activities to be utilized on personal time.

(D) Personal space for privacy.

(E) Security of consumer's property.

(F) A clean, inviting, and comfortable setting.

(G) Evidence of individual possessions and decorations.

(H) Daily access to nutritious meals and snacks.
Permanent Final Adoptions

(I) Policy addressing separate sleeping areas for the consumers based on:
    (i) Gender;
    (ii) Age; and
    (iii) Needs.
(c) Compliance with 450:18-13-161 may be determined by a review and/or observation of facility documentation and operations, including but not limited to the following:
   (1) Licenses;
   (2) Policies and procedures;
   (3) Treatment and service protocols;
   (4) Personnel records, documentation of professional licensure, certification or licensure as an alcohol and drug counselor, documentation of professional work experience, ongoing in-service training(s);
   (5) Treatment records;
   (6) Interviews with staff and consumers; and
   (7) Other facility documentation.

450:18-13-161.1. Intensive residential treatment for adolescents
(a) Intensive substance use disorder treatment in a residential setting for adolescents ages thirteen (13) to seventeen (17) shall provide a planned regimen of twenty four (24) hours a day, seven (7) days a week of professionally directed evaluation, care, and treatment in a permanent program location. Consumers shall participate in at least thirty-seven (37) treatment hours of substance use disorder treatment services per week. The facility shall provide beds, food service, and a safe, welcoming, and culturally/age appropriate environment.
(b) The facility shall maintain written programmatic descriptions and operational methods addressing the following:
   (1) Environment. The facility shall comply with requirements within OAC 450:18-13-161(b)(1).
   (2) Support system:
      (A) A licensed psychiatrist shall be available, at least by telephone, twenty-four (24) hours per day, seven (7) days per week;
      (B) The facility shall maintain written policy and procedures for handling medical emergencies which are approved by the licensed psychiatrist, and an emergency medical number shall be conspicuously posted for staff use;
      (C) The facility shall maintain written policies and procedures for the handling of clinical issues during times in which clinical staff are not at the facility;
      (D) The facility shall have specialized professional consultation or supervision available;
      (E) The facility shall provide clinically appropriate public educational services in compliance with applicable Oklahoma laws; and
      (F) The facility shall provide emergency services and crisis interventions.
   (3) Staff:
      (A) The facility shall maintain documentation that service providers are knowledgeable regarding the biopsychosocial dimensions of substance use disorders, evidenced-based practices, culture, age, and gender related issues, and co-occurring disorder issues.
      (B) Staff shall be at least eighteen (18) years of age.
      (C) The facility shall document in personnel records all education, training, and experience stated above prior to the provision of direct care services.
      (D) The facility shall ensure at least two (2) staff members are awake and on duty twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3.153.2.
   (4) Treatment services. Daily (twenty-four [24] hours a day, seven [7] days a week) substance use disorder treatment services shall be provided to assess and address individual needs of each consumer. Services shall include, but are not limited to:
      (A) Therapy. Therapy, including individual, family, and group therapy, must be provided by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate who must use and document a generally accepted clinical approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. The therapy must be goal directed utilizing techniques appropriate to the individual consumer's service plan and the consumer's developmental and cognitive abilities. This service does not include social skill development or daily living skill activities. For adults, group therapy is limited to a total of eight adult individuals. For all children under the age of eighteen, the total group size is limited to six. Therapy must be provided at least four (4) hours per week.
      (B) Rehabilitation services. Rehabilitation services must be provided by a LBHP, Licensure Candidate, Certified Alcohol and Drug Counselor (CADC) or Certified Behavioral Health Case Manager II (CM II). These services include educational and supportive services regarding independent living, self-care, social skills regarding development, lifestyle changes and recovery principles and practices (including relapse prevention). Services provided typically take the form of curriculum based education and skills practice, and should be goal specific in accordance with an individualized service plan. Rehabilitation services must be provided at least seven (7) hours per week. The maximum staffing ratio for group rehabilitation services is fourteen members for each qualified provider for adults and eight to one for children under the age of eighteen.
      (C) Peer Recovery Support Services. Peer recovery support services must be provided by Peer Recovery Support Specialists. Peer recovery support services may be offered to consumers age sixteen (16) and older with substance use disorders, including co-occurring disorders. Services shall be provided in accordance with OAC 450:18-13-221. A maximum
of eleven (11) hours per week of peer recovery support services may count toward the weekly required treatment hours.

(D) **Care Management.** Care management must be provided by a LBHP, Licensure Candidate, CADC, CM II or CM I as clinically indicated. Care management is case management in residential settings that includes assessment, development of a care plan, and referral and linkage to community supports and community-based or lower level of care services to promote continued recovery after the individual discharges from the treatment facility.

(E) **Crisis Intervention.** Crisis intervention services must be provided by a LBHP or Licensure Candidate. Crisis intervention services are provided as needed for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress, and/or imminent danger of substance relapse. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented in the consumer's record.

(5) Treatment documentation:

(A) All documentation for therapy, case management and crisis intervention must be documented in an individual note and reflect the content of each session provided. Documentation must include, at a minimum, the following:

(i) Date;
(ii) Start and stop time for each session;
(iii) Specific problems, goals, and objectives addressed;
(iv) Type of service and method(s) used to address problems;
(v) Summary of progress made toward goals and objectives, or lack of;
(vi) Consumer response to overall treatment services;
(vii) Any new problems, goals, or objectives identified during the week;
(viii) Dated signature and credentials of the service provider completing the documentation; and
(ix) Consumer's name.

(B) Documentation for rehabilitation and peer recovery support services must include daily member sign-in/sign-out record of member attendance (including date, time, type of service and service focus), and a daily progress note or a summary progress note weekly.

(C) Documentation shall reflect each consumer has received a minimum of thirty-seven (37) hours of treatment services each week, in addition to life skills, recreational, and self-help supportive meetings.

(6) The program provides documentation of the following community living components:

(A) A written daily schedule of activities.

(B) Quarterly meetings between consumers and the program personnel.

(C) Recreational activities to be utilized on personal time.

(D) Personal space for privacy.

(E) Security of consumer's property.

(F) A clean, inviting, and comfortable setting.

(G) Evidence of individual possessions and decorations.

(H) Daily access to nutritious meals and snacks.

(I) Policy addressing separate sleeping areas for the consumers based on:

(i) Gender;
(ii) Age; and
(iii) Needs.

(c) Compliance with 450:18-13-161.1 may be determined by review and/or observation of facility documentation and operations, including but not limited to the following:

(1) Licenses;
(2) Policies and procedures;
(3) Treatment protocols;
(4) Personnel record, documentation of professional licensure or certification, documentation of professional work experience, and ongoing in-service trainings;
(5) Treatment records; and
(6) Interviews with staff and consumers.

**PART 19. HALFWAY HOUSE SERVICES, ASAM LEVEL 3.1**

450:18-13-181. Adult Halfway/halfway house services

(a) Halfway house services shall provide low intensity treatment in a supportive living environment to facilitate reintegration into the community. Major emphasis shall be on continuing substance use disorder care and follow-up, and community ancillary services in an environment supporting continued abstinence. Consumers shall participate in a minimum of six (6) hours of structured substance use disorder treatment per week.

(b) Each facility shall maintain written programmatic descriptions and operational methods addressing the following:

(1) Environment: The facility shall be a freestanding facility or portion of a related healthcare facility having at least one (1) each of toilet, lavatory, and bathing facilities for each eight (8) residents. The facility shall provide a safe, welcoming, and culturally/age appropriate environment.

(2) Support system:

(A) A licensed physician shall be available, by telephone twenty-four (24) hours a day, seven (7) days a week;

(B) The facility shall have a written plan for emergency procedures, approved by a licensed physician;

(C) The facility shall have supplies, as designated by the written emergency procedures plan, which shall be accessible to staff at all times; and
(D) Specialized professional consultation or professional supervision shall be available.

(3) Staff:
   (A) Service providers shall be knowledgeable regarding biopsychosocial dimensions of substance use disorders, evidenced based practices, co-occurring disorder issues, gender, cultural, and age specific issues, culture, age, and gender related issues, and co-occurring disorder issues;
   (B) Staff shall be knowledgeable regarding facility-required education, training, and policies;
   (C) Staff shall be knowledgeable about emergency procedures as specified in the emergency procedures plan;
   (D) The facility shall have staff members on site twenty-four (24) hours per day, seven (7) days per week;
   (E) Staff shall be at least eighteen (18) years of age; and
   (F) The facility shall document in personnel records all education, training, and experience stated above prior to the provision of direct care services.

(4) Treatment services. The facility shall have scheduled rehabilitation services to assess and address the individual needs of each consumer. Such services shall include, but not limited to:
   (A) Therapy. Therapy, including individual, family, and group therapy, must be provided by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate who must use and document a clinical approach generally accepted as reliable in the relevant community, such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. The therapy must be goal directed utilizing techniques appropriate to the individual consumer's service plan and the consumer's developmental and cognitive abilities. This service does not include social skill development or daily living skill activities. For adults, group therapy is limited to a total of eight adult individuals. For all children under the age of eighteen, the total group size is limited to six.
   (B) Rehabilitation Services. Rehabilitation services must be provided by a LBHP, Licensure Candidate, Certified Alcohol and Drug Counselor (CADC) or Certified Behavioral Health Case Manager II (CM II). This service includes educational and supportive services regarding independent living, self-care, social skills regarding development, lifestyle changes and recovery principles and practices (including relapse prevention). Services provided typically take the form of curriculum based education and skills practice, and should be goal specific in accordance with an individualized service plan. The maximum staffing ratio for group rehabilitation services is fourteen members for each qualified provider for adults and eight to one for children under the age of eighteen.
   (C) Educational Groups. Education groups must be conducted by a LBHP, Licensure Candidate, CADC, CM II or Peer Recovery Support Specialist (PRSS).
   (C) Peer Recovery Support Services. Peer recovery support services must be provided by Peer Recovery Support Specialists. Peer recovery support services may be offered to adult consumers with substance use disorders, including co-occurring disorders. Services shall be provided in accordance with OAC 450:18-13-221.
   (D) Case Care Management. Case Care management must be provided by a LBHP, Licensure Candidate, CADC, CM II or CM I as clinically indicated. Care management is a type of case management that includes assessment, development of a care plan, and referral and linkage to community supports and community-based or lower level of care services to promote continued recovery after the individual discharges from the treatment facility.
   (E) Crisis Intervention. Crisis intervention services must be provided by a LBHP or Licensure Candidate. Crisis intervention services are provided as needed for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress, and/or imminent danger of substance relapse. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented in the consumer's record.
   (F) Vocational services. Any level of provider can provide vocational services (Employment consultants, or other staff who have completed some form of job coach training, are preferred). Vocational services include the process of developing or creating appropriate employment situations for individuals who desire employment to include, but not be limited to: the identification of employment positions, conducting job analysis, matching individuals to specific jobs, facilitating job expansion or advancement and communicating with employers about training needs.

(5) Treatment documentation:
   (A) All documentation for therapy, case management and crisis intervention must be documented in an individual note and reflect the content of each session provided. Documentation must include, at a minimum, the following:
      (i) Date;
      (ii) start and stop time for each session;
      (iii) Specific problems, goals, and objectives addressed;
      (iv) type of service and method(s) used to address problems;
      (v) Summary of progress made toward goals and objectives, or lack of;
(vi) Consumer response to overall treatment services;
(vii) Any new problems, goals, or objectives identified during the week;
(viii) Dated signature and credentials of the service provider completing the documentation; and
(ix) Consumer's name.
(B) Documentation for rehabilitation and peer recovery support services and education groups must include daily member sign-in/sign-out record of member attendance (including date, time, type of service and service focus), and a daily progress note or a summary progress note weekly.
(C) Documentation shall reflect that the consumer works or attempts to find work while receiving halfway house services.
(c) Compliance with 450:18-13-181 may be determined by a review and/or observation of facility documentation and operations, including but not limited to the following:
(1) Licenses;
(2) Policies and procedures;
(3) Treatment protocols;
(4) Personnel records, documentation of professional licensure, certification or licensure as an alcohol and drug counselor, documentation of professional work experience, ongoing in-service trainings;
(5) Treatment records;
(6) Interviews with staff and consumers; and
(7) Other facility records.

450:18-13-182. Adult Halfway House Services, admission criteria
(a) Admission to halfway house services shall be determined according to 450:18-7-21. These criteria shall be a part of the program's written policies and procedures.
(b) Compliance with 450:18-13-182 may be determined by a review of the following:
(1) Policies and procedures;
(2) Admission protocols;
(3) Consumer records;
(4) Posted public information;
(5) Interviews with staff and consumers; and
(6) Other facility information.

450:18-13-183. Adult Halfway House Services, discharge criteria
(a) Programmatic discharge from halfway house services shall be determined according to 450:18-7-121. These criteria shall be a part of the program’s written policy and procedures.
(b) Compliance with 450:18-13-183 may be determined by a review of the following:
(1) Policies and procedures;
(2) Discharge assessment instruments;
(3) Discharge summaries;
(4) Continuing care plans;
(5) Consumer records;
(6) Progress notes;
(7) Interviews with staff and consumers; and
(8) Other facility documentation.

PART 20. ADOLESCENT HALFWAY HOUSE SERVICES, ASAM LEVEL 3.1

450:18-13-190. Adolescent halfway house services
(a) Adolescent halfway house treatment for adolescents ages thirteen (13) to seventeen (17) shall provide low intensity substance use disorder treatment in a supportive living environment to facilitate reintegration into the home or community. Emphasis shall be on applying recovery skills, relapse prevention, independent living skills, and educational and vocational skills. Consumers shall participate in at least six (6) hours of structured substance use disorder treatment and rehabilitation services weekly. Self-help meetings are not included in the required hours.
(b) Each facility shall maintain written programmatic descriptions and operational methods addressing the following:
(1) Environment:
   (A) The facility shall be a freestanding facility or portion of a related healthcare facility having at least one (1) each of toilet, lavatory, and bathing facilities for each eight (8) residents;
   (B) The facility shall maintain an environment supportive of physical and emotional growth and development, and appropriate to the needs of adolescents;
   (C) The facility shall provide space, both indoor and outdoor. In co-ed treatment, the facility shall maintain separate sleeping quarters for males and females;
   (D) The program may provide transportation to activities in the community as appropriate. Vehicles used for transportation should not be labeled in any way that calls attention to the facility or the vehicle's occupants;
   (E) The program shall provide study areas within the facility, and shall provide ancillary study materials, such as encyclopedias, dictionaries, and educational resource texts and materials;
   (F) The facility shall be licensed by the Oklahoma State Department of Human Services (OKDHS) as a "Residential Child Care Facility"; and
   (G) The facility shall provide a safe, welcoming, and culturally/age appropriate environment.
(2) Support systems:
   (A) A licensed physician shall be available by telephone twenty-four (24) hours per day, seven (7) days a week;
   (B) Specialized professional consultation or supervision, emergency services, and crisis intervention shall be available;
   (C) The facility shall provide clinically appropriate public educational services in compliance with applicable Oklahoma laws; and
(D) The facility shall have a written plan for emergency procedures approved by the licensed physician, and staff shall have access to supplies as designated in this plan.

(3) Staff:
(A) Service providers shall be knowledgeable regarding the biopsychosocial aspects of substance use disorders, evidenced based practices, co-occurring disorders, and gender, cultural, and age-specific culture, age, and gender related issues.
(B) Service providers shall be knowledgeable regarding the identification of violence and domestic violence, spousal or partner abuse, child abuse and neglect, parent and sibling abuse, normal and abnormal adolescent development, and family dynamics;
(C) The facility shall have a minimum of two (2) staff members on duty twenty-four (24) hours per day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2.
(D) Staff shall be knowledgeable about emergency procedures as specified in the emergency procedures plan;
(E) If educational services are provided, documentation shall be maintained to verify providing staff meet all state requirements for education or special education;
(F) Staff shall be knowledgeable regarding the facility-required education, training requirements, and policies;
(G) Staff shall be at least eighteen (18) years of age; and
(H) The facility shall document in personnel records all education, training, and experience stated above prior to the provision of direct care services.

(4) Treatment services:
(A) The facility shall provide substance use disorder treatment services to assess and address the individual needs of each adolescent, to include, but not be limited to:
(i) Therapy. Therapy, including individual, family, and group therapy, must be provided by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate who must use and document a clinical approach generally accepted as reliable in the relevant clinical community, such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. The therapy must be goal directed utilizing techniques appropriate to the individual consumer's service plan and the consumer's developmental and cognitive abilities. This service does not include social skill development or daily living skill activities. For all children under the age of eighteen, the total group size is limited to six.
(ii) Rehabilitation services. Rehabilitation services must be provided by a LBHP, Licensure Candidate, Certified Alcohol and Drug Counselor (CADC) or Certified Behavioral Health Case Manager II (CM II). This service includes educational and supportive services regarding independent living, self-care, social skills regarding development, lifestyle changes and recovery principles and practices (including relapse prevention). Services provided typically take the form of curriculum based education and skills practice, and should be goal specific in accordance with an individualized service plan. The maximum staffing ratio for group rehabilitation services is eight to one for children under the age of eighteen.

(iii) Educational groups. Education groups must be conducted by a LBHP, Licensure Candidate, CADC, CM II or Peer Recovery Support Specialist (PRSS).
(iv) Peer Recovery Support Services. Peer recovery support services must be provided by Peer Recovery Support Specialists. Peer recovery support services may be offered to consumers age sixteen (16) and older with substance use disorders, including co-occurring disorders. Services shall be provided in accordance with OAC 450:18-13-221.
(v) Case Care Management. Case Care management must be provided by a LBHP, Licensure Candidate, CADC, CM II or CM I as clinically indicated. Case management case management in residential settings that includes assessment, development of a care plan, and referral and linkage to community supports and community-based or lower level of care services to promote continued recovery after the individual discharges from the treatment facility.
(vi) Crisis intervention. Crisis intervention services must be provided by a LBHP or Licensure Candidate. Crisis intervention services are provided as needed for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress, and/or imminent danger of substance relapse. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented in the consumer's record.
(B) The facility shall provide services in appropriate groups according to age, gender, developmental level, and individual needs;
(C) The facility shall provide for clinically appropriate public educational services in compliance with applicable Oklahoma law;
(D) Consumers may participate in educational programs in the community, when clinically indicated, including extracurricular activities; and
(E) Service providers shall confer on a regular basis with school personnel, including the provision of
necessary information when appropriate, on the educational progress of the consumer and shall assess and respond to the needs for changes in the educational plans.

(5) Assessment;
(A) A physical examination shall be conducted by a licensed physician to include physical assessment, health history, immunization status, and evaluation of motor development and functioning, speech, hearing, visual and language functioning, if no records are available on admission reflecting such examination within the previous year; and
(B) The facility shall facilitate involvement and participation of family members or significant others in the assessment, treatment, rehabilitation, and continuing treatment needs of each consumer.

(6) Treatment documentation:
(A) All documentation for therapy, case management and crisis intervention must be documented in an individual note and reflect the content of each session provided. Documentation must include, at a minimum, the following:
   (i) Date;
   (ii) start and stop time for each session;
   (iii) Specific problems, goals, and objectives addressed;
   (iv) type of service and method(s) used to address problems;
   (v) Summary of progress made toward goals and objectives, or lack of;
   (vi) Consumer response to overall treatment services;
   (vii) Any new problems, goals, or objectives identified during the week;
   (viii) Dated signature and credentials of the service provider completing the documentation; and
   (ix) Consumer's name.
(B) Documentation for rehabilitation and peer recovery support services and education groups must include daily member sign-in/sign-out record of member attendance (including date, time, type of service and service focus), and a daily progress note or a summary progress note weekly.

(c) Compliance with the above may be determined by a review and/or observation of facility documentation and operations, including but not limited to the following:
   (1) Licenses;
   (2) Policies and procedures;
   (3) Treatment protocols;
   (4) Personnel records, documentation of professional licensure, certification or licensure as an alcohol and drug counselor, documentation of professional work experience, ongoing in-service trainings;
   (5) Treatment records;
   (6) Interviews with staff and consumers; and
   (7) Other facility records.

PART 21. HALFWAY HOUSE SERVICES FOR PERSONS WITH DEPENDENT CHILDREN AND PREGNANT WOMEN, ASAM LEVEL 3.1

450:18-13-201. Halfway house services for persons with dependent children and pregnant women
(a) Halfway house services for persons with dependent children and pregnant women shall provide substance use disorder treatment services in a residential setting and shall include a planned regimen of twenty-four (24) hour, seven (7) days a week, supervised living arrangements, to include professionally directed evaluation, care, and treatment, under a defined set of policy and procedures, in a permanent setting. Consumers with dependent children and consumers who are pregnant shall participate in at least six (6) hours of treatment, supportive services, parenting, and child development services per week for adults, and (6) therapeutic hours of services for children, excluding infants.

(b) Each facility shall maintain written programmatic descriptions and operational methods addressing the following:
(1) Environment: The facility shall be a freestanding facility providing family-style living arrangements, indoor recreational space for children and families, and safe, protected outdoor recreational space. The facility shall provide materials and space appropriate for ages of children receiving services. The facility shall provide a safe, welcoming, and culturally/age appropriate environment.
(2) Support system:
   (A) A licensed physician shall be available by telephone twenty-four (24) hours per day, seven (7) days a week;
   (B) The facility shall ensure children's access to the fullest possible range of medical services available, such as health screening, well-child health care, screening in speech, language, hearing, and vision, and verification of immunization records;
   (C) The facility shall have access to emergency health care provided as necessary. The facility shall maintain written policy and procedures for handling medical emergencies which are approved by the licensed physician, and an emergency medical number shall be conspicuously posted for staff use;
   (D) The facility shall have access to public schools for school age children, and facilitation of the child's receiving the benefits of Public Laws 99-142; and
   (E) The facility staff shall document a liaison with the local Oklahoma Department of Human Service (OKDHS) offices to:
      (i) Promote preservation of families;
      (ii) In cases of investigation of abuse, provide instruction in positive parenting behavior, if requested by the Oklahoma Department of Human Services (OKDHS) and with parental consent, provide daily observations of parent-child interaction;
      (iii) Expedite investigations in a timely manner; and
      (iv) Ensure prompt facility response to situations which require immediate intervention.
(3) Staff:
(A) Service providers shall be knowledgeable regarding Biopsychosocial dimensions of substance use disorder, evidenced-based practices, cultural, age, and gender related issues, co-occurring disorder issues, and services for infants, toddlers, preschool, and school-age children.
(B) Service providers are minimally trained in:
   (i) The identification of domestic violence, spousal or partner abuse, and child abuse and neglect, with special emphasis on failure to thrive and sexual abuse of children.
   (ii) Child development and age appropriate behaviors.
   (iii) Parenting skills appropriate to infants, toddlers, pre-school, and school age children.
   (iv) The impact of substances and substance use disorders on parenting and family units.
(C) Service providers working with children shall be knowledgeable and demonstrate job appropriate functional comprehension of:
   (i) The impact of prenatal drug and alcohol exposure on child development.
   (iii) Parenting skills appropriate to infants, toddlers, pre-school, and school age children.
   (iv) Common child behavioral and developmental problems.
   (v) Appropriate play activities according to developmental stage.
   (vi) Recognition of sexual acting out behavior.
   (vii) The substance use disorder recovery process, especially as related to family units.
(D) The facility shall have staff members on site and awake twenty-four (24)–hours per day, seven (7) days per week;
(E) Staff shall be knowledgeable regarding facility-required education and training requirements and policies.
(F) Staff shall be at least eighteen (18) years of age; and
(G) The facility shall document in personnel records all education, training, and experience stated above prior to the provision of direct care services.

(4) Treatment services:
(A) Daily (twenty-four [24] hours a day, seven [7] days a week) substance use disorder services shall be provided to assess and address individual needs of each consumer. Services shall include, but are not limited to:
   (i) Therapy. Therapy, including individual, family, and group therapy, must be provided by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate who must use and document a clinical approach generally accepted as reliable in the relevant clinical community, such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. The therapy must be goal directed utilizing techniques appropriate to the individual consumer's service plan and the consumer's developmental and cognitive abilities. This service does not include social skill development or daily living skill activities. For adults, group therapy is limited to a total of eight adult individuals. For all children under the age of eighteen, the total group size is limited to six.
   (ii) Rehabilitation services. Rehabilitation services must be provided by a LBHP, Licensure Candidate, Certified Alcohol and Drug Counselor (CADC) or Certified Behavioral Health Case Manager II (CM II). This service includes educational and supportive services regarding independent living, self-care, social skills regarding development, lifestyle changes and recovery principles and practices (including relapse prevention). Services provided typically take the form of curriculum based education and skills practice, and should be goal specific in accordance with an individualized service plan. The maximum staffing ratio for group rehabilitation services is fourteen members for each qualified provider for adults and eight to one for children under the age of eighteen.
   (iii) Educational groups. Education groups must be conducted by a LBHP, Licensure Candidate, CADC, CM II or Peer Recovery Support Specialist (PRSS).
   (iii) Peer Recovery Support Services. Peer recovery support services must be provided by Peer Recovery Support Specialists. Peer recovery support services may be offered to consumers age sixteen (16) and older with substance use disorders, including co-occurring disorders. Services shall be provided in accordance with OAC 450:18-13-221.
   (iv) Crisis intervention. Crisis intervention services must be provided by a LBHP or Licensure Candidate. Crisis intervention services are provided as needed for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress, and/or imminent danger of substance relapse. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented in the consumer's record.
   (v) Case Management. Case management must be provided by a LBHP, Licensure Candidate, CADC, CM II or CM I as clinically indicated. Case management is a type of case management that includes assessment, development of a case plan, and referral and linkage to community supports and community-based or lower level of care services to promote continued
recovery after the individual discharges from the treatment facility.

(vi) **Vocational services.** Any level of provider can provide vocational services (Employment consultants, or other staff who have completed some form of job coach training, are preferred. Vocational services include the process of developing or creating appropriate employment situations for individuals who desire employment to include, but not be limited to: the identification of employment positions, conducting job analysis, matching individuals to specific jobs, facilitating job expansion or advancement and communicating with employers about training needs.

(vii) **Parenting and child development.**

(B) Services are may be provided to dependent children by providers certified under this Chapter when provided to address the impacts related to the parent's addiction. Compliance with separate provider qualifications is required for other treatment services provided to dependent children in accordance with OAC 450 and Title 43A of the Oklahoma Statutes. Services for children shall be provided in accordance with the child's service plan and include a minimum of six (6) hours per week of therapeutic units for each child consisting of, but not limited to, assessment, and therapy, via art and recreational activities, etc., according to the development of the child. Documentation of all needs identified for each child shall be identified on that child's case management service plan and/or service plan.

(C) Children's services, excluding infants, shall be provided which address the significant issues and needs documented in either or both the child's and the parent's assessment and shall utilize both structured and unstructured therapeutic activity. Services shall address the significant issues and needs documented in the parent's or child's assessment and create and enhance positive self image and feelings of self-worth, promote family unity, teach personal body safety and positive school interactions, and to prevent alcohol, tobacco, and other drug use;

(D) Infant services, ages birth to three (3) years of age, shall be provided and shall consist, at a minimum, of developmentally appropriate parent-child bonding (interactive) activities and play therapy as determined by mother's service plan; and

(E) Case management services for each adult and each child shall be provided, which include the assessment of and planning and arranging for recovery needs.

(5) **Treatment documentation:**

(A) All documentation for therapy, case management and crisis intervention must be documented in an individual note and reflect the content of each session provided. Documentation must include, at a minimum, the following:

(i) Date;

(ii) start and stop time for each session;

(iii) Specific problems, goals, and objectives addressed;

(iv) type of service and method(s) used to address problems;

(v) Summary of progress made toward goals and objectives, or lack of;

(vi) Consumer response to overall treatment services;

(vii) Any new problems, goals, or objectives identified during the week;

(viii) Dated signature and credentials of the service provider completing the documentation; and

(ix) Consumer's name.

(B) Documentation for rehabilitation and peer recovery support services and education groups must include daily member sign-in/sign-out record of member attendance (including date, time, type of service and service focus), and a daily progress note or a summary progress note weekly.

(C) Documentation shall reflect each consumer, adult, and child, with dependent children and/or consumer who is pregnant has received a minimum of six (6) hours of service each week. Documentation shall reflect each child has received services in accordance with the child's service plan that addressing needs and issues indicated in the assessments (parents or child), if services are provided by the facility.

(c) Compliance with 450:18-13-201 may be determined by a review and/or observation of facility documentation and operations, including but not limited to the following:

(1) Licenses;

(2) Policies and procedures;

(3) Treatment protocols;

(4) Personel records, documentation of professional licensure, certification or licensure as an alcohol and drug counselor, documentation of professional work experience, and ongoing in-service trainings;

(5) Treatment records;

(6) Interviews with staff and consumers; and

(7) Other facility documentation.

## SUBCHAPTER 17. CERTIFICATE OF NEED

### 450:18-17-1. Purpose

The purpose of this Subchapter is to set forth rules regulating Certificate of Need requirements for applicable facilities.

### 450:18-17-2. Applicability

The rules set forth in this Subchapter are applicable only to facilities that seek to obtain initial certification under this Chapter for residential substance use disorder services, medically supervised withdrawal management services, or halfway house services and that intend to enroll with the Oklahoma Health Care Authority as a Medicaid provider.
450:18-17-3. Certificate of Need requirements
(a) Facilities seeking initial certification for residential substance use disorder services, medically supervised withdrawal management services, or halfway house services that intend to enroll with the Oklahoma Health Care Authority shall be subject to a Certificate of Need evaluation completed by the Department. Such facilities will be required to provide a Certificate of Need from the Department to the Oklahoma Health Care Authority upon enrollment as a Medicaid provider, in accordance with 317:30-5:95.44(a)(3). In addition to the standard certification application, entities shall provide information requested by the Department on the Department-prescribed form. Such information shall include, but not be limited to, the following:
(1) Number of beds that are/will be in the facility;
(2) Number of beds that will be added, if any;
(3) Timeframe for the addition of new beds;
(4) Population(s) that will be served; and
(5) Type(s) of services that will be provided.
(b) The following factors shall be considered in determining whether a Certificate of Need shall be granted:
(1) Residential substance use disorder, medically supervised withdrawal management, and/or halfway house bed occupancy rates for the applicable population and geographic area;
(2) Residential substance use disorder, medically supervised withdrawal management, and/or halfway house bed occupancy rates for Medicaid beneficiaries within the geographic area;
(3) The estimated need that the population to be served has for the services proposed by the entity based on the following:
   (A) Current population estimates and demographics;
   (B) Population trends or projections; and
   (C) Substance use disorder service utilization trends
(4) The type and number of residential substance use disorder, medically supervised withdrawal management, and/or halfway house providers in the same geographic area; and
(5) Any extenuating circumstances or factors the Department considers substantial, such as anticipated increases in the need or demand for residential substance use disorder, medically supervised withdrawal management, or halfway house services.
(c) If the Department determines that, based upon these factors, a need for an additional residential substance use disorder, medically supervised withdrawal management, or halfway house facility and associated number of beds cannot be demonstrated, a Certificate of Need shall not be issued to the facility.
(d) Failure of a facility to obtain a Certificate of Need shall not prohibit the facility from obtaining certification from the Department.

[OAR Docket #21-432; filed 6-14-21]
conducting alcohol and drug assessments related to driver's license revocations.

450:21-1-2. Statutory authority
(a) Under 43A O.S. § 3-453(E), ODMHSAS has authority to certify Alcohol and Drug Substance Abuse Courses. Pursuant to 47 O.S. § 6-212.2, persons convicted of driving under the influence of alcohol or other intoxicating substances or receiving an alcohol or other drug related revocation or suspension of driving privileges must complete an Alcohol and Drug Substance Abuse Course as a requirement for reinstatement of Oklahoma driving privileges.
(b) Pursuant to 43A O.S. §§ 3-453, ODMHSAS is authorized to adopt rules governing:

1. Applications and certification of individuals, institutions and organizations to conduct an Alcohol or Drug Substance Abuse Course (ADSAC);
2. Denial, suspension or revocation of certification of individuals, institutions and organizations;
3. Minimum requirements for all ADSAC content and curricula;
4. Minimum qualifications for all ADSAC facilitators;
5. Enrollment fees for those attending an ADSAC course;
6. Facilities, equipment and instructional materials for ADSAC;
7. Minimum qualifications for facilitators of ADSAC facilitator training;
8. ADSAC participant attendance requirements;
9. Requirements for certifying to the Oklahoma Department of Mental Health and Substance Abuse Services and the Oklahoma Department of Public Safety successful course completion of ADSAC by a participant;
10. Operational and physical site requirements for all institutions and organizations offering ADSAC courses; and
11. Training requirements for ADSAC facilitators.
(c) Pursuant to 43A O.S. §§ 3-461, ODMHSAS is authorized to adopt rules governing:

1. Certification of individuals approved to provide assessment services;
2. Assessment standards;
3. Assessment responsibilities and activities of certified assessors; and
4. Requirements for reporting completed assessments to ODMHSAS.

450:21-1-3. Definitions
The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise.

"Abuse" means the causing or permitting of harm or threatened harm to the health, safety, or welfare of a participant by staff responsible for the participant's health, safety, or welfare, including, but not limited to: 
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(A) non-accidental physical injury or mental anguish;
(B) sexual abuse;
(C) sexual exploitation;
(D) use of mechanical restraints without proper authority;
(E) the intentional use of excessive or unauthorized force aimed at hurting or injuring the participant; or
(F) deprivation of food, clothing, shelter, or health care by staff responsible for providing these services to a participant.

"Action Code" means a numerical designation applied to ADSAC by the Oklahoma Department of Public Safety, and which will be provided by ODMHSAS to organizations and institutions conducting ADSAC, for use in completing the written verification of an individual's completion of an ADSAC.

"Administrator" means the person responsible for administering ADSAC courses within a certified institution or organization.

"ADSAC" means Alcohol and Drug Substance Abuse Course.

"ADSAC Facilitator" means an individual certified to teach both the ten (10) or the twenty-four (24) hour ADSAC courses.

"Administrator" means the person responsible for administrating ADSAC courses within a certified institution or organization.

"Action Code" means a numerical designation applied to ADSAC by the Oklahoma Department of Public Safety, and which will be provided by ODMHSAS to organizations and institutions conducting ADSAC, for use in completing the written verification of an individual's completion of an ADSAC.

"ASAM" means the American Society of Addiction Medicine.

"ASAM levels of care" means the different options for treatment as described in the current edition of the ASAM criteria that vary according to the intensity of the services offered. Each treatment option is a level of care.

"Assessment" means a face-to-face clinical interview evaluating an individual's need and receptivity to substance abuse treatment and his or her prognosis.

"Assessor" means an individual certified to conduct alcohol and other drug assessments related to driver's license revocations.

"Audit" means a systematic inspection of accounting records involving analyses, tests, and confirmations or the hearing or investigation by an auditor.

"Biopsychosocial Assessment" means a face-to-face clinical interview conducted by an ADSAC assessor designed to elicit historical and current information regarding the behavior and experiences of a participant, and is designed to provide sufficient information for problem formulation, intervention planning, and formulation of appropriate substance abuse-related clinical and/or educational interventions to reduce or eliminate recidivism.

"Certification" means an institution, organization, or individual approved by ODMHSAS to conduct ADSAC courses.

"Certified Alcohol and Drug Counselor" or "CADC" means any person who is certified through the State of Oklahoma pursuant to the provisions of the Licensed Alcohol and Drug Counselors Act.

"Commissioner" means the Commissioner of the Oklahoma Department of Mental Health and Substance Abuse Services.

"Conflict of interest" means a conflict between the private interests and public obligations of a certified organization, institution, or certified ADSAC Facilitator.

"Consumer" means an individual, adult or child, who is receiving services, evaluation or treatment, from an entity operated or certified by ODMHSAS or with which ODMHSAS contracts and includes all persons referred to in OAC Title 450 Chapters 16, 17, 18, 19 and 23 as client(s) or patient(s) or resident(s) or a combination thereof.

"Consumer" means an individual who has applied for, is receiving or has received evaluation or treatment services from a facility operated or certified by ODMHSAS or with which ODMHSAS contracts and includes all persons referred to in OAC Title 450 as client(s) or patient(s) or resident(s) or a combination thereof.

"Course" means multiple classes offering an approved ADSAC curriculum.

"Critical incident" means an occurrence or set of events inconsistent with the routine operation of an approved institution or organization approved to do ADSAC, or the routine work with a participant in an ADSAC course. Critical incidents specifically include, but are not limited to: self-destructive behavior; deaths and injuries to the participant, participant's family, staff or visitors; abuse of a participant, fire, unauthorized disclosure of information; damage to or theft of property belonging to a participant or an approved institution or organization; other unexpected occurrences; or events subject to litigation. A critical incident may involve multiple individuals or results.

"Curricula" (plural of Curriculum) See Curriculum.

"Curriculum" means a specific course of study in alcohol and drug substance abuse designed for ADSAC.

"Defendant Questionnaire" or "DQ" means an automated assessment or screening instrument used in assessing an offender with alcohol or other drug involvement. This instrument contains scales to measure truthfulness, stress coping ability, and severity of the alcohol or other drug use disorder diagnosis using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria.

"Denial" means a refusal to certify to conduct ADSAC courses.

"DOC" means the Oklahoma Department of Corrections.

"Documentation" means the provision of written, dated and authenticated evidence to substantiate compliance with standards.

"DPS" means Department of Public Safety.

"Driver Risk Inventory-II" or "DRI-II" means an assessment or screening instrument, which contains six scales.
measuring truthfulness, alcohol, drug, driver risk, stress management, and severity of alcohol or other drug abuse and classifies a participant as being either a substance abuser or substance dependent in compliance with current Diagnostic and Statistical Manual criteria.

"Equipment" means hardware, such as audio visual equipment, used as a tool to present material in an ADSAC course.

"Evidence based practice" means programs or practices that are proven to be successful through research methodology and have produced consistently positive patterns of results.

"Facilitator candidate" means an individual who has applied for and is in the process of being certified to conduct an ADSAC course as an ADSAC facilitator.

"Facility" means any ODMHSAS approved building in which ADSAC is conducted.

"Group counseling" means a method of using various commonly accepted treatment approaches provided face-to-face by a treatment professional with two (2) or more participants that does not consist of solely related individuals, to promote positive emotional or behavioral change. Services rendered in this setting should be guided by the participant's treatment goals and objectives, and does not include social or daily living skill development as described in educational group counseling.

"Guest instructor" means non-certified individual invited to discuss a specific portion of ADSAC curriculum under the direct supervision of a certified ADSAC facilitator.

"Independent practitioner" means any professional, appropriately licensed or certified as an alcohol and drug counselor through the State of Oklahoma, pursuant to state law, and certified by ODMHSAS to conduct ADSAC assessments who does so through the format of a private practice.

"Individual counseling" means a method of using various commonly accepted treatment approaches provided face-to-face by a treatment professional with one participant to promote positive emotional or behavioral change.

"Instructional material" means written or printed data distributed to the participant during an ADSAC course for informational or educational purposes.

"Intensive outpatient services" or "IOP" means an organized, non-residential outpatient treatment service with scheduled sessions that provide a range of nine (9) to fifteen (15) treatment hours per week. Intensive outpatient services may offer evening outpatient services several nights per week or be incorporated into an inpatient or residential treatment program in which the individual participates in daytime treatment services but goes home at night. Intensive Outpatient shall correspond to ASAM Patient Placement Criteria Treatment Level: Level II.1, Intensive outpatient.

"Intern facilitator" means a facilitator who has initial approval to conduct ADSAC courses under supervision, both ten (10) and twenty-four (24) hour, but who has not completed internship or training requirements, and is not certified.

"Lapse" means the expiration of an otherwise valid ADSAC certification due to the failure to timely complete and submit the required application for recertification.

"Licensed Alcohol and Drug Counselor" or "LADC" means any person who is licensed through the State of Oklahoma pursuant to the provisions of the Licensed Alcohol and Drug Counselors Act.

"Licensed Behavioral Health Professional" or "LBHP" means:
(A) An Allopathic or Osteopathic Physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry;
(B) An Advanced Practice Registered Nurse 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 certified in a psychiatric mental health specialty;
(C) A Clinical Psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists;
(D) A Physician Assistant who is licensed in good standing in Oklahoma and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions;
(E) A practitioner with a license to practice in the state in which services are provided issued by one of the following licensing boards:
(i) Social Work (clinical specialty only);
(ii) Professional Counselor;
(iii) Marriage and Family Therapist;
(iv) Behavioral Practitioner;
(v) Alcohol and Drug Counselor.

"Licencure Candidate" means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinical if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:
(A) Psychology;
(B) Social Work (clinical specialty only);
(C) Professional Counselor;
(D) Marriage and Family Therapist;
(E) Behavioral Practitioner;
(F) Alcohol and Drug Counselor.

"Mutual support group" means a non-professional, widely available, peer directed, system of support meetings, available at little or no charge to the participant, in a group format, dedicated to the support and teaching of the skills related to an alcohol and other drug free lifestyle.

"Needs assessment" or "NEEDS" means a one hundred and thirty (130) item comprehensive adult assessment instrument addressing attitude, emotional stability, employment, health, education, substance abuse, relationships, support systems, criminal history and supervision needs.

"Notes" means a complete, chronological written description of any intervention(s) provided to a participant requiring documentation. Notes may include the participant's response and are written by the ADSAC staff delivering the service.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.
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"Oklahoma Administrative Code" or "OAC" means the publication authorized by 75 O.S. § 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"OSBI" means the Oklahoma State Bureau of Investigation.

"Participant" means a person convicted of driving under the influence of alcohol or other intoxicating substances or who has received an alcohol or drug-related revocation or suspension of driving privileges in Oklahoma and who is involved in the ADSAC process.

"Professional setting" means a facility that is adequate and suitable for the purpose of providing adult education or assessment services, meeting all confidentiality requirements of 42 CFR, Part 2 and HIPAA, and without distraction or interruption from adjacent business or activities.

"Program" means a structured set of treatment activities designed to achieve specific objectives relative to the needs of individuals served by the facility and certified or recognized by ODMHSAS.

"Recertification" means the renewal of certification for an institution, or organization, or instructor to provide ADSAC courses.

"Residential treatment" means treatment for a participant in a live-in setting which provides a twenty-four (24) hour therapeutic regimen. Corresponding ASAM Patient Placement Criteria Treatment Level: Level III. 5. Clinically managed High-Intensity Residential Services.

"Revocation" means cancellation of an existing certification to conduct or instruct ADSAC courses.

"Sentinel event" is a type of critical incident that is an unexpected occurrence involving the death or serious physical or psychological injury to a participant, or risk thereof. Serious injury specifically includes loss of limb or limb function. The phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a participant. These events signal the need for immediate investigation and response. Sentinel events include, but are not limited to: suicide, homicide, criminal activity, assault and other forms or violence, including domestic violence or sexual assault, and adverse drug events resulting in serious injury or death.

"Suspend" means to temporarily cancel certified ADSAC services or certification for a designated period of time.

"TAAD" or "Triage Assessment for Addictive Disorders" means a very brief, structured interview covering current alcohol and drug problems related to DSM-IV criteria for substance abuse and dependeny. The TAAD is intended to be presented as an interview and not as a paper and pencil instrument.

"Transtheoretical Model of Change" or "TMC" means a model which identifies distinct stages of change existing for each individual involved in any educational or therapeutic process and enhances the ability to accurately assess the individual's readiness for clinical or educational engagement at the time of an assessment. This is also referred to as the "Stages of Change" model.

"Victims Impact Panel" or "VIP" means the two (2) hour presentation, identified statutorily, intended to enhance awareness of the participant regarding possible impact on others by the individual driving while impaired.

450:21-4. Meaning of verbs in rules
The attention of the facility and assessor is drawn to the distinction between the use of the words "shall," "should," and "may" in this Chapter:
(1) "Shall" is the term used to indicate a mandatory statement, the only acceptable method under the present standards.
(2) "Should" is the term used to reflect the most preferable procedure, yet allowing for the use of effective alternatives.
(3) "May" is the term used to reflect an acceptable method that is recognized, but not necessarily preferred.

450:21-5. Compliance with laws, rules [REVOKED]
(a) All institutions, organizations and facilitators certified by ODMHSAS to conduct ADSAC courses shall do so in accordance with all applicable laws of the State of Oklahoma and all applicable rules of Title 450 OAC.
(b) Each applicant for ADSAC facilitator shall declare in writing, in a format and manner prescribed by the Commissioner of ODMHSAS, or designee, that he or she has read and understands §§ 3.451 through 3.461 of Title 43A of the Oklahoma Statutes and this Chapter and agrees to abide by the terms thereof, along with future amendments thereto, as a condition for obtaining and retaining such approval or certification.
(c) ODMHSAS shall process all applications for certification and recertification and enforce these standards and criteria (rules) in this Chapter, and related laws.
(d) Approved institutions, organizations and facilitators shall not make reference to ODMHSAS or DPS in any advertisement regarding ADSAC. Advertising shall be truthful in all communication with prospective participants. Implication of exclusive services by any one organization is prohibited.
(e) All institutions, organizations and facilitators certified to conduct ADSAC courses must promptly notify ODMHSAS of a change of email, mailing or physical address within fourteen (14) days of said change.
(f) The fees for those attending a ten (10) hour ADSAC course shall be one hundred and fifty dollars ($150.00) per participant, and for persons attending the twenty-four (24) hour courses the fee shall be three hundred and sixty dollars ($360.00).
(g) The ADSAC institution or organization shall pay ODMHSAS ten percent (10%) of each ADSAC fee collected, which ODMHSAS shall remit to the Oklahoma State Treasurer to be credited to the ODMHSAS Revolving Fund.
(h) The payment from the fee collected for each ADSAC course participant shall be made to ODMHSAS within thirty (30) days of course completion.
(i) A check for the appropriate fee shall accompany the completion roster, unless otherwise stipulated in writing by ODMHSAS.

(j) Compliance with this chapter may be determined by a review of all ADSAC-related records, documents and reports; facilitator, staff and participant interviews; and any other relevant documentation of the institution, organization or facilitator.

450:21-1-6. Applications [REVOKED]

(a) Applications for certification of institutions, organizations or facilitators to conduct ADSAC courses shall be made to ODMHSAS in writing on a form and in a manner prescribed by the Commissioner of ODMHSAS or designee.

(b) ODMHSAS shall give each institution, organization and facilitator candidate requesting certification to conduct ADSAC courses the following:

(1) A copy of §§ 3-151 through 3-453 of Title 43A of the Oklahoma Statutes;

(2) A copy of these standards and criteria; and

(3) The appropriate application(s).

(c) An institution or organization applying for certification to conduct ADSAC shall provide to ODMHSAS for consideration:

(1) Completed application;

(2) Film approval form(s) for the ten (10) and twenty-four (24)-hour ADSAC;

(3) Instructional materials for the ten (10) and twenty-four (24)-hour ADSAC;

(4) Written verification the applicant is a nonprofit educational institution of higher learning, appropriately accredited pursuant to state law, a governmental entity, or a nonprofit corporation. If the applicant is a nonprofit corporation verification shall be a copy of the U.S. Internal Revenue Service Documents granting the corporation 501(c)(3) status;

(5) Completed certification applications and resumes of proposed facilitators;

(6) The physical address (street, building name and suite [if applicable], city and zip code) and description of all sites at which the ADSAC course(s) will be conducted; and

(7) Letters of support from at least two (2) of the following individuals who serve in the community in which each proposed site, including satellites, is located:

(A) District or Associate District Judge;

(B) County Sheriff;

(C) Municipal Judge;

(D) District or Assistant District Attorney; or

(E) Chief of Police.

(d) If the applicant is a non-profit corporation, the applicant shall submit evidence it was constituted, is operated, to provide substance abuse, mental health or educational services as its primary service and that the corporation is operated from a professional administrative office, which is open and operated during normal business hours.

(e) Requests from a certified ADSAC provider for additional or replacement course sites shall be submitted to the ODMHSAS and shall meet all requirements for initial applications, except the institution or organization need not submit items previously submitted that are currently applicable to the new site(s) and expressly stated as such in the application for new course site(s).

(f) Renewal of certification of ADSAC institutions or organizations shall be contingent upon submission of renewal application and programmatic history of compliance with Oklahoma Administrative Code, Title 450. The application for renewal shall include all items required for initial certification as well as any unpaid fees required by 450:21-1-5(g). Applications with outstanding unpaid fees will not be processed until a resolution is reached regarding payment of outstanding fees.

(g) In addition to submitting an application and fulfilling the renewal standards for certification per 21-1-6(d), a review of consumer and organization documentation shall be performed. A score of at least 75% on clinical standards must be achieved in order to move forward with certification. The process will follow that of agency certifications found in Title 450:1-9-7.3. All deficiencies must be resolved in order for certification to be renewed.

(h) An applicant for initial certification as a facilitator to conduct ADSAC courses shall provide to ODMHSAS for consideration:

(1) A letter of recommendation from an administrator of a certified institution or organization;

(2) A current resume, which shall include:

(A) Educational background including an official college transcript from an accredited college or university, and

(B) Employment history covering the previous ten (10) years to include name, complete address and telephone number of employer(s).

(3) A completed application.

(4) A one hundred dollar ($100.00) application fee for initial certification; and

(5) Upon initial application, a completed Oklahoma State Bureau of Investigation background check or a similar background check from any other state(s) of residence for the past five (5) years;

(6) Provide a current, recognizable, color, photographic image, in good condition, no smaller than two (2) inch by two (2) inches of the applicant every six (6) years, upon the anniversary of every second recertification beginning with any qualifying recertifications occurring on or after July 1, 2008; and

(7) A new OKSBI background check must be submitted every six (6) years, upon the anniversary of every second recertification beginning with any qualifying recertifications occurring on or after July 1, 2008. The results of the OKSBI background check must be submitted with the recertification application and any conviction may result in denial of certification. This will be required of all individuals who have been certified as ADSAC facilitators for six (6) years or more, recertifying after July 1, 2008.

(i) ODMHSAS shall consider each applicant for certification in accordance with these rules. The Commissioner of ODMHSAS or designee shall notify each applicant in writing...
of an approval or denial of certification. Certification shall be effective for three (3) years commencing with the date of issue. (j) Faxes will not be accepted as permanent copies for an applicant’s record. (k) Applications are good for one (1) year from approval. All requirements must be completed within the initial twelve (12) month period or a new application must be submitted. (l) Completed applications must be received by ODMHSAS twenty (20) days prior to the new facilitator training event. (m) A facilitator whose certification has been expired for less than twelve (12) months must make application for an initial certification as set forth in 450:21-1-10, with the exception of attending the initial ADSAC facilitator training, and successful completion of the training exam. (n) A facilitator whose certification has been expired for more than twelve (12) months must make application for an initial certification as set forth in 450:21-1-10, including attending the initial ADSAC facilitator training, and successful completion of the training exam. (o) Each facilitator shall notify ODMHSAS of any change of application information related to his or her email address, phone number, work or home address at least fifteen (15) days in advance of the change. In case of an emergency, the facilitator may notify ODMHSAS of any change up to thirty (30) days after a change has occurred.

450:21-1-7. Minimum curriculum requirements, ten (10) hour courses [REVOKED]
(a) The standardized ADSAC curriculum approved by ODMHSAS shall be utilized by all ADSAC institutions, organizations and facilitators for the ten (10) hour ADSAC course. Any additional materials must be consistent with the format of the main curricula, follow the Transtheoretical Model of Change and prior to implementation receive written approval from ODMHSAS.
(b) The ten (10) hour ADSAC Course shall at a minimum include instruction on:
(1) Legal aspects of drinking or using other drugs and driving;
(2) Physiological aspects of using alcohol and other drugs;
(3) Sociological aspects of using alcohol and other drugs;
(4) Effects and possible outcomes of drinking or using other drugs and driving;
(5) Scope of the problem of drinking or using other drugs and driving;
(6) The history/Origins of alcohol and other drugs;
(7) The effects of substance abuse on family and friends; and
(8) Alternative plans/strategies to using alcohol or other drugs and driving.
(c) Each curriculum shall provide for a full ten (10) hours of block-teaching classroom instruction, and shall be conducted in no fewer than three (3) sessions with each session no more than three and one half (3.5) hours in duration, and conducted on no fewer than three (3) separate days. These hours shall not be inclusive of:
(1) Meal or break times; or
(2) ADSAC administrative functions except for enrollment form completion and fee payment.
(d) Participants may be admitted for fifteen (15) minutes after the official starting time of the class without having to make up this time.
(e) Each curriculum shall provide for a discussion period following each audio-visual presentation. Audio-visual materials shall not comprise more than ten (10) percent of the class and must have been submitted and approved at the time of application for certification and at each six (6) year anniversary thereafter.
(f) Each ten (10) hour curriculum shall provide for a scored pre- and post-test. The pre-test shall be given during the first two (2) hours of the beginning of each course, and the post-test at the end of each course. The purpose is to determine participant gain in knowledge of the material based upon the scores of the pre- and post-tests.
(g) The ADSAC institution, organization or facilitator shall provide each participant a list of community referrals and resources approved by ODMHSAS.
(h) Class size shall not exceed twenty-four (24) participants.
(i) No ten (10) hour ADSAC course shall be combined with, or presented in conjunction with any other educational or clinical class, track, program or assessment process.

450:21-1-7.2. Minimum curriculum requirements, twenty-four (24) hour courses [REVOKED]
(a) The standardized ADSAC curriculum approved by ODMHSAS shall be utilized by all ADSAC institutions, organizations and facilitators for the twenty-four (24) hour ADSAC. Any additional materials must be consistent with the format of the main curricula, follow the Transtheoretical Model of Change and prior to implementation receive written approval from ODMHSAS.
(b) The minimum curriculum requirements for the twenty-four (24) hour ADSAC course includes, but is not limited to, appropriate instruction on:
(1) Legal aspects of drinking or using other drugs and driving;
(2) Physiological aspects of using alcohol and other drugs;
(3) Sociological aspects of using alcohol and other drugs;
(4) Effects and possible outcomes of drinking or using other drugs and driving;
(5) Scope of the problem of drinking or using other drugs and driving;
(6) The history/Origins of alcohol and other drug abuse;
(7) Alternatives to using alcohol or other drugs and driving; and
(8) The effects of substance abuse on family and friends.
(c) The curriculum shall be covered within the following time frames:
(1) Not more than two (2) hours of education on a single day;
Paragraphs may include:

1. Not more than four (4) hours of education in a single week;
2. The time frames shall not be inclusive of:
   (A) Meal or break times; or
   (B) ADSAC administrative functions except for enrollment form completion and fee payment.
3. Participants may be admitted up to fifteen (15) minutes after the official time of the class without having to make up the time.
4. The curriculum shall provide for a discussion period following each audiovisual presentation. Audiovisual presentation shall not comprise more than ten (10) percent of the class and must have been submitted and approved at the time of application for certification and at each recertification anniversary thereafter.
5. The curriculum shall provide for a scored pre- and post-test, as prescribed by ODMHSAS. The pre-test shall be given in the first two (2) hour block of classroom facilitation, and the post-test shall be given at the end of the final block of course facilitation. These tests are to determine the participant gain in knowledge of the material based upon the scores of the pre- and post-tests.
6. The ADSAC institution, organization, and facilitator shall provide each participant a list of community referrals and resources approved by ODMHSAS.
7. Class size shall not exceed twenty-four (24) participants.

450:21-1-7.4. Critical incidents
(a) The institution, organization, facilitator, or assessor shall report critical incidents. Documentation of critical incidents shall minimally include:
   (1) The facility name of the institution or organization, and the name and signature of the person(s) reporting the incident;
   (2) The name(s) of the participant(s), staff member(s) or property involved;
   (3) The time, date and physical location of the incident;
   (4) The time and date the incident was reported and the name of the staff person within the facility to whom it was reported;
   (5) A description of the incident;
   (6) Resolution or action taken, date action was taken, and signature of appropriate staff member(s); and
   (7) Severity of each injury, if applicable. Severity shall be indicated as follows:
      (A) No off-site medical care required or first aid care administered on-site;
      (B) Medical care by a physician or nurse or follow-up attention required; or
      (C) Hospitalization or immediate off-site medical attention was required.
(b) Critical incidents shall be reported to ODMHSAS as follows:
   (1) Critical incidents requiring referral to medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax or mail to ODMHSAS within twenty-four (24) hours of the incident being documented;
   (2) Critical incidents involving allegations constituting a sentinel event or abuse shall be reported to ODMHSAS immediately via telephone or fax, but no more than twenty-four (24) hours after the incident. If reported by telephone, the report shall be followed with a written report within twenty-four (24) hours after the incident.
   (c) Critical incidents shall be reported to the Provider Certification Division of ODMHSAS.

450:21-1-7.5. Participant record system
(a) Each institution or organization or assessor shall maintain an organized system for the content, confidentiality, storage retention and disposition of participant records adhering to the following guidelines.
(b) Participant records shall be contained within equipment which shall be maintained under locked and secure measures.
(c) The institution, organization or assessor shall maintain identification and filing systems which enable prompt record location and accessibility by facilitators and staff.
(d) Participant records shall be maintained at the site where the participant is being served. In the case of temporary office space and satellite offices, records may be maintained in the main (permanent) office and transported in secured locked boxes in vehicle trunks and from satellite offices, when necessary. Participant records may be maintained at the administrative offices of the institution or organization; however, in such cases a working copy of the participant record for the purposes of documentation and review of services provided must be maintained at the site in which the participant is receiving services.
(e) Compliance may be determined by a review of records; interviews with facilitators, other staff; and other documentation.
(f) The institution or organization shall store, retain, and dispose of participant records in a manner compatible with the protection of participant's rights against confidential information disclosure at a later date. ODMHSAS-operated facilities shall comply with Records Disposition Schedule 82-17 as approved by the Oklahoma Archives and Records Commission.
(g) Records of ADSAC course attendance shall be retained for six (6) years.

450:21-1-7.6. Participant records, basic requirements
(a) Participant records shall be developed and maintained to ensure that all appropriate individuals have access to relevant course and other information regarding the participant. The record shall communicate information in a manner that is organized, clear, complete, current and legible.
(b) Entries in participant records shall be legible, signed with first name or initial, last name, and dated by the person making the entry.
(c) The participant shall be identified by name on each sheet in the participant record.
(d) A signed consent in a form designated by the Commissioner or designee shall be part of the case record for any
person admitted to an ADSAC course or administered an ADSAC assessment.

450:21-1-7.7. Participant record storage, retention and disposition
(a) Each institution, organization, facilitator or assessor shall:
   (1) Limit access to participant records to persons on a need to know basis;
   (2) Require participant records be stored under lock and key;
   (3) With regard to closed participant records, require:
       (A) Confidential storage under lock and key;
       (B) Record disposal and destruction under confidential conditions; and
       (C) Maintain written documentation to be available for participants for a minimum of six (6) years after completion of all course requirements. Written documentation shall include, but not be limited to:
       (i) completed pre and post tests;
       (ii) notes, if existing;
       (iii) proof of completion of course; and
       (iv) enrollment form.
(b) EXCEPTION: With regard to 450:18-7-4(a) (3) (B), facilities operated by ODMSAS shall comply with the provisions of the Records Disposition Schedule for said facility as approved by the Oklahoma Archives and Records Commission [67 O.S. § 305 and OAC 60:1-1-2].

450:21-1-7.8. Confidentiality of participant information
(a) The confidentiality of all ADSAC information and records (including all ADSAC participant and course records), and drug or alcohol abuse treatment information shall be kept, recorded, released, maintained, and provided to requesting parties in accordance with all applicable state and federal laws.
(b) For the purposes of certification, all institutions, organizations, facilitators, and assessors will abide by 42 CFR, Part 2 as required for covered entities protecting the confidential and privileged nature of information in compliance with state and federal law and which requires at a minimum:
   (1) All ADSAC course and substance abuse treatment information, whether recorded or not, and all communications between institution and organization staff, facilitators, assessors and participant are both privileged and confidential and will not be released without the signed consent of the participant or the participant's legally authorized representative;
   (2) the identity of a participant who has received or is receiving ADSAC services is both confidential and privileged and will not be released without the signed consent of the participant or the participant's legally authorized representative;
   (3) limiting access to ADSAC course substance abuse treatment and participant information to only those persons or agencies actively engaged in the treatment of the participant and to the minimum amount of information necessary to carry out the purpose for the release;
   (4) a participant, or the participant's legally authorized representative, may access the participant's ADSAC course or substance abuse treatment information;
   (5) certain state and federal law exceptions to disclosure of ADSAC course or substance abuse treatment information without the signed consent of the participant or the participant's legally authorized representative exist and the facility will release information as required by those laws; and
   (6) notifying a participant of his or her right to confidentiality in writing.

450:21-1-7.9. Notes
When addressing issues related to the ADSAC course or assessment process that must be reflected by written documentation in the participant's record, the following must be included:
   (1) date;
   (2) start and stop time for each session referenced;
   (3) signature of the staff person providing the service;
   (4) credentials of the staff person providing the service;
   (5) participant response if present;
   (6) any problems identified; and
   (7) any interventions.

450:21-1-8. Administrative responsibilities, institutions or organizations conducting ADSAC [REVOKED]
(a) Each institution or organization certified to conduct ADSAC courses shall provide ODMSAS, in a manner prescribed by the Commissioner of ODMSAS or designee, a monthly schedule of courses to be conducted. The course shall be provided per the submitted course schedule and the course may only be canceled if zero (0) participants show up for the course within fifteen (15) minutes after the scheduled course starting time. Any institution or organization requiring pre-enrollment may cancel a course prior to the scheduled first session and after the expiration of the pre-enrollment time period, if no participants have pre-enrolled. The course schedule shall be submitted no later than thirty (30) days in advance of any course start and shall include:
   (1) the complete address, building name and suite where applicable, city and zip code, where each course will be conducted;
   (2) the name of the course facilitator;
   (3) the beginning and ending times of each session of the course; and
   (4) enrollment in ten (10) or twenty-four (24) hour courses shall be limited to twenty-four (24) participants.
(b) Each institution or organization certified to conduct ADSAC shall advise ODMSAS seven (7) days in advance of:
   (1) a ten (10) hour or twenty-four (24) hour course cancellation; or
   (2) a scheduled facilitator change (unless change is due to illness or other facilitator emergency); or
(3) Any change of the date or hour of the scheduled ten (10) hour or twenty-four (24) hour course.
(c) Failure to offer either a ten (10) hour or twenty-four (24) hour course at an approved site for three (3) consecutive months shall constitute a withdrawal from that site and require another application for certification.
(d) If no participants attend the first session of a ten (10) or twenty-four (24) hour course, a second or subsequent session is not required.
(e) Failure to either provide a scheduled course to one (1) or more attending participants, or staff a scheduled course site for fifteen (15) minutes after the scheduled course starting time may result in administrative reprimand, suspension or revocation. A course may be canceled when zero (0) participants show up for the course within fifteen (15) minutes of the scheduled course starting time.
(f) ODMHSAS personnel shall be admitted to any course without charge, upon request and display of proper credentials for the purpose of audit and review.
(g) Certified institutions, organizations and facilitators must provide, for each telephone number published specific to ADSAC, continuous availability, either in person, by phone, answering machine, electronic voice mail, or engage a professional answering service. Numbers published for the purpose of ADSAC advertisement must be answered by individuals with proper in-service training in all relevant aspects of 42 CFR, Part 2 and HIPAA.
(h) Institutions and organizations certified to conduct ADSAC courses shall be responsible for the conduct of the facilitators; they employ, and shall have written policies outlining the institution's or organization's oversight procedures.

450:21-1-9. Facilities, equipment and instructional material [REVOKED]
(a) Each site where an ADSAC course is held must meet local and state fire, health and safety standards. ODMHSAS may request state or local fire inspectors or other state health or safety officials to conduct an inspection of any facility suspected of being hazardous.
(b) Each institution or organization must provide a safe, confidential, professional and comfortable environment for participants and facilitators, appropriate for conducting an ADSAC course with minimum distractions.
(c) All equipment must be in good working condition.
(d) Instructional material issued to participants, such as handouts, pamphlets, workbooks, etc., must have been submitted to ODMHSAS upon application by the organization or institution for certification or re-certification. Each participant shall be given a new, unused journal of the Level I or Level II ADSAC Journal as his or her property.
(e) Sites shall not be designed or used for the primary purpose of eating or sleeping (hotel/motel sleeping rooms, restaurant dining rooms, etc.).

450:21-1-9.1 Physical facility environment and safety
(a) All institutions and organizations offering ADSAC courses or alcohol and drug assessments shall ensure the safety and protection of all persons within the institution's or organization's physical environment (property and buildings, leased or owned).
(b) Institutions and organizations This shall be accomplished by:
(1) Meeting all fire, health and safety regulations, code and statutory requirements of federal, state, or local government;
(2) All institutions and organizations shall have an annual fire, health and safety inspection, as required from the State Fire Marshal or local authorities, and shall maintain a copy of said inspection and attendant correspondence regarding any deficiency;
(3) If there is no authority available to provide such inspection for the institution or organization, then the institution or organization or assessor shall show evidence to ODMHSAS of:
(A) An emergency preparedness plan to provide effective utilization of resources to best meet the physical needs of participants, visitors, and staff during any disaster (including, but not limited to, fire, flood, tornado, explosion, prolonged loss of heat, light, water, and/or air conditioning). This plan shall be evaluated annually, and revised as needed;
(B) Training and orientation regarding the location and use of all fire extinguishers and first aid supplies and equipment;
(C) Emergency evacuation routes and shelter areas shall be prominently posted in all areas;
(D) Fire alarm systems shall have visual signals suitable for the deaf and hearing-impaired;
(E) An emergency power to supply lighting to pre-selected areas of the institution or organization;
(F) Maintenance of institution and organization grounds to provide a safe environment for participants, facilitators, staff and visitors.
(4) There shall be a written plan for the protection and preservation of participant records in the event of a disaster.

450:21-1-9.2 Hygiene and sanitation
Regarding lavatory facilities, sewage, solid waste disposal, water and pest inspection, institutions and organization shall comply with all local and state rules, regulations, codes and building codes, providing proof to ODMHSAS of such compliance upon audit or request.

450:21-1-10. ADSAC facilitator certification, qualification and disqualification [REVOKED]
(a) Minimum qualifications for certification of ADSAC facilitators are as follows:
(1) Possess a bachelor's degree in behavioral or health care sciences education, psychology, social work or chemical dependency with at least two (2) years verifiable full-
time-equivalent experience in the substance abuse treatment field. This work experience can be in the areas of clinical prevention or direct care. Proof of current licensure as LADC or certification as CADC will fulfill the experience requirement;
(2) A valid driver’s license or state identification card;
(3) Completion of the following in the order listed below:
(A) Observe one (1) complete twenty-four (24) hour ADSAC course in sequential order conducted by a certified facilitator. This observation must be completed and verified to ODMHSAS prior to attending facilitator training;
(B) Attend the new facilitator training and pass the ODMHSAS Certification Examination for ADSAC Facilitator; and
(i) a minimal score to pass the exam shall be eighty (80) percent;
(ii) the exam shall require the participant to correctly identify the major components of the transtheoretical model of change;
(iii) the exam shall require the participant to correctly identify the major components of the interactive journaling process; and
(iv) the exam shall require the participant to correctly identify rules from this chapter.
(C) Conduct one complete twenty-four (24) hour ADSAC under the supervision of a certified ADSAC facilitator or an ODMHSAS representative.
(4) The facilitator candidate shall be allowed nine (9) months to complete training requirements and one (1) year from application to complete all other requirements. Failure to meet all requirements within the specified time frames will result in denial of certification. To be reconsidered, the candidate will be required to re-apply to ODMHSAS.
(5) Renewal of certification as an ADSAC facilitator shall be dependent upon acceptance of a completed renewal application submitted to ODMHSAS, remission of a fifty dollar ($50.00) application fee for renewal of certification, and the accomplishment of minimum standards. These standards are:
(A) Each facilitator shall conduct at least six (6) complete ten (10) or twenty-four (24) hour courses during each certification period beginning with the date of initial certification;
(i) To be eligible for recertification as an ADSAC facilitator capable of conducting both ten (10) and twenty-four (24) hour ADSAC courses, verification of having conducted at least two (2) twenty-four (24) hour ADSAC courses in the last three years prior to the request for recertification; and
(ii) Submission of proof of having conducted less than two (2) twenty-four (24) hour ADSAC courses in the three (3) years prior to the request for recertification, shall result in the facilitator being required to attend a one (1) day training event addressing skills consistent with twenty-four (24) hour course facilitation.
(B) Documentation of receiving twelve (12) continuing education hours each twelve (12) month period beginning with the date of initial certification. These hours shall be from each of the following areas with four (4) hours coming from area (i), four (4) hours coming from area (ii) and four (4) hours coming from area (iii):
(i) adult education,
(ii) facilitation skills,
(iii) general substance abuse training, and
(iv) Hours for any mandatory trainings required by ODMHSAS may come from area (iii) above.
(6) All renewals of certification are due on the third anniversary of certification. After July 1, 2008 all certification renewals may come due on January 1 of the renewal year. If a universal certification date is adopted, then, requirements for certification renewals will be accepted on a prorated basis during the transition period.
(b) An applicant may not be certified nor certification as an ADSAC facilitator renewed under any of the following conditions:
(1) A non-pardoned felony conviction within the last five (5) years;
(2) Conviction of driving under the influence of alcohol or other intoxicating substances or receiving an alcohol or drug related revocation or suspension of driving privileges for five (5) years prior to the application for certification; or,
(3) Having involvement in any business or endeavor which is a conflict of interest. ODMHSAS may, on its own initiative, or upon complaint, investigate potential or alleged conflict of interest, or any other alleged, or suspected violation of these standards.

450:21-1-10.1. Inactive status/closure [REVOKED]
(a) An active ADSAC course, institution or organization certification may be placed on inactive status by written request:
(1) An inactive certification forfeits all rights and privileges granted by the certification;
(2) When certification is placed on inactive status, the certificate shall be returned to ODMHSAS;
(3) When certification is placed on inactive status, it remains inactive for at least one (1) year from the date of inactivation;
(4) Active status may be re-established upon written request;
(5) When an ADSAC institution or organization satellite must cease operation for less than twelve (12) months, all participant records shall be transported to the main site unless they can be secured on site under rules defined in 450:21-1-7.5;
(6) During such a temporary closure due to being placed on inactive status of the main ADSAC site or
location, effort should be made to ensure participant records remain accessible as defined in 450:21-1-7.5;
(7) Participants attending an ADSAC course shall be given written notification of a temporary closure with contact information in the event all course sessions have not been completed;
(8) ODMHSAS shall be notified in writing of the temporary closure of any ADSAC site (DUI school). The written notification shall contain:
(A) The reason for closing;
(B) Contact information for participant course records; and
(C) A projected date for resumption of business.
(9) Upon receipt of written notification of closure, ODMHSAS shall remove the institution or organization(s) telephone number from the monthly State Certified DUI Schools referral list; and
(10) Upon written notification of intent to resume business, ODMHSAS shall add the institution or organization(s) telephone number to the monthly State Certified DUI Schools referral list.
(b) Institutions and organizations operating for the purpose of conducting ADSAC having to close permanently shall comply with the following:
(1) When a satellite closes permanently, all participant records shall be transported to the main location under rules defined in 450:21-1-7.5;
(2) When the main location of an institution or organization closes permanently, all participant records shall be secured as defined in 450:21-1-7.5;
(3) Participant records shall remain accessible as defined in 450:21-1-7.5;
(4) Participants shall be given written notification of the closure with contact information, including ODMHSAS, in the event all coursework is not completed;
(5) ODMHSAS shall be notified in writing of any closure of an institution or organization operating for the purpose of conducting ADSAC courses. The written notification shall contain:
(A) the reason for closing; and
(B) contact information for participant records.
(6) Upon receipt of written notification of closure, ODMHSAS shall remove the site(s) telephone number from the monthly State Certified DUI Schools referral list.
(c) An active ADSAC facilitator certification may be placed on inactive status by written request:
(1) An inactive certification forfeits all rights and privileges granted by the certification;
(2) When certification is placed on inactive status, the certificate shall be returned to ODMHSAS;
(3) When certification is placed on inactive status, the certification remains inactive for at least twelve (12) months from the date of inactivation or until the end of the certification period, whichever is first;
(4) Inactive status shall not be allowed to continue longer than the certification period; and
(5) Active status may be re-established upon written request.

450:21-1-11. Facilitator training [REVOKED]
(a) Minimum qualifications for institutions or organizations conducting ADSAC facilitator training, and the minimum qualifications for individuals conducting facilitator training are as follows:
(1) All ADSAC facilitator training shall only be conducted by non-profit organizations, educational institutions or governmental agencies.
(2) The curricula for the training shall be as follows:
(A) A minimum of twenty-four (24) hours of instruction, and
(B) These hours shall be offered in no less than four (4) days and for no more than eight (8) hours per day.
(3) Instructors for facilitator training must have:
(A) A minimum of two (2) years experience as an ADSAC facilitator; or
(B) A master's degree from an accredited college or university; or
(C) Four (4) years related experience in the subject matter to be taught.
(4) Each facility where facilitator training courses are conducted shall:
(A) Meet all applicable local and state fire, health and safety standards; and
(B) Provide a safe and comfortable environment for facilitators and facilitator candidates conducive to the learning experience.
(5) Instructional equipment must be in good working order.
(6) Institutions or organizations providing facilitator training prior to receiving written approval from ODMHSAS may not be accepted for facilitator certification requirements.
(b) Each institution or organization shall advise ODMHSAS in writing the names of candidates who did not complete training and the names of persons have successfully completed the facilitator training.
(c) All facilitator trainings shall be consistent with the requirements of this Chapter and the training curricula shall consist of recognized evidence based, best practices.

450:21-1-13. Consumers with disabilities
Each institution and organization providing ADSAC or alcohol and drug assessments shall have a written policy addressing its awareness of, and intent to comply with, the (U.S.) Americans with Disabilities Act of 1990.

450:21-1-14. State and federal statutes and regulations
All institutions, organizations, and facilitators and assessors shall comply with all applicable federal and state statutes and regulations.
450:21-1-15. Participant rights and grievance policy
(a) All certified ADSAC institutions, organizations and assessors shall comply with applicable rules in Title 450, Chapter 15, Consumer Rights.
(b) Those programs and individuals which are providing services within a correctional facility shall detail the following due to circumstance:
(1) The provider shall document provisions of 450:15-3-2 (a), (b) and (d);
(2) The provider shall provide written grievance policy and procedure including time frames for the grievance process;
(3) The provider shall describe the procedure used when the grievance is against a staff. This policy may refer to Department of Corrections mandated policy and procedure; and
(4) The provider shall describe the facility's responsibility for evaluation, review, and resolution should the allegation be substantiated. All certified ADSAC institutions, organizations and individuals shall comply with applicable rules in Title 450, Chapter 15, Consumer Rights. Those programs and individuals which are providing services within a correctional facility shall detail the following due to circumstance:
   (A) Provide written grievance policy and procedure including time frames for the grievance process;
   (B) Describe the procedure used when the grievance is against a staff. This policy may refer to Department of Corrections mandated policy and procedure; and
   (C) Describe the facility's responsibility for evaluation, review, and resolution should the allegation be substantiated.

450:21-1-16. ODMHSAS Advocate General
The ODMHSAS Advocate General, in any investigation regarding consumer rights, shall have access to participant, institution, organization and assessor records and staff as set forth in Title 450, Chapter 15.

SUBCHAPTER 3. CERTIFICATION DENIAL OR SANCTIONS AND PARTICIPANT GRIEVANCE [REVOKED]

450:21-3-1. Administrative denial, suspension, or revocation of certification [REVOKED]
(a) ODMHSAS may deny the certification of any institution, organization, or facilitator to conduct ADSAC who fails to qualify for, or comply with, the provisions of this Chapter.
(b) ODMHSAS may reprimand, suspend, revoke or deny renewal of the certification of any institution, organization or facilitator who fails to qualify for or comply with the provisions of this Chapter.
(c) In the event ODMHSAS determines action should be taken against any institution, organization or facilitator certified under this Chapter, the proceeding shall be initiated pursuant to the rules of ODMHSAS as set forth in Oklahoma Administrative Code, Title 450, Chapter 1, Subchapter 5 and the Administrative Procedures Act.
(d) Institutions, organizations or facilitators who have had certification denied or revoked, shall be ineligible for reapplication for a period of five (5) years.
(e) Institutions, organizations or individuals whose certification has expired may apply for initial certification.

450:21-3-1.1 Fitness of applicants [REVOKED]
(a) The purpose of this section is to establish the fitness of the applicant as one of the criteria for approval of certification as a certified ADSAC facilitator and to set forth the criteria by which the Commissioner or designee may determine the fitness of applicants.
(b) The substantiation of the items below related to the applicant may result in the initiation of suspension or revocation of certification, or denial of, or delay of certification of the applicant. These items include, but are not limited to:
   (1) Evidence of the lack of necessary skill and abilities to provide adequate services;
   (2) Misrepresentation on the application or any other materials submitted to the ODMHSAS;
   (3) A violation of the rules of professional conduct set forth in this Chapter.
   (4) Evaluations of supervisors, employers or instructors;
   (5) Allegations from other governmental entities;
   (6) Findings resulting from investigations prompted by allegations of participants, peers or the public;
   (7) Transcripts or other findings from official court, hearing or investigative procedures;
   (8) Any convictions for alcohol and other drug related offenses, violent offenses, or moral turpitude within the last ten (10) years;
   (9) Any unpardoned felony convictions within five (5) years;
   (10) The revocation, suspension, reprimand or any other administrative action ordered by another certifying or licensing body may result in the denial, revocation or suspension of facilitator certification by ODMHSAS.
(c) ODMHSAS may require explanation of negative references prior to issuance of certification.
(d) Those certified to conduct ADSAC courses by ODMHSAS shall not perform such courses when the ability to perform such services are impaired for any reason. Facilitators shall seek assistance for any problems that impair the ability to perform required services, and, if necessary, limit, suspend or terminate the delivery of ADSAC courses.
(e) A field examination submitted through questionnaires answered by persons competent to evaluate a facilitator's professional competence which may include the submission of such documentary evidence relating to a facilitator's experience and competence as required by ODMHSAS may be required.
(f) If in the course of an investigation, ODMHSAS determines that a facilitator has engaged in conduct of a nature that is detrimental to the health, safety, or welfare of the public, and which conduct necessitates immediate action to prevent further harm, the Commissioner, or designee may order a summary suspension of the facilitator's certification to conduct ADSAC courses.

(g) ODMHSAS may require remedial interventions to address any problems or deficiencies identified from this section as a requirement for retaining active certification.

450:21-3-2. Grounds for reprimand, suspension or revocation of certification, organizations and institutions and facilitators  
[REVOKED]

(a) Administrative sanctions may be taken against an institution or organization certified to conduct ADSAC for any of the following reasons:

(1) Refusal to allow a facilitator candidate to observe an ADSAC course;
(2) Allowing more than twenty-four (24) participants in any course;
(3) Tardiness or failure to make reports or to transmit funds required by this Chapter;
(4) Erroneous or falsified information relating to any documents submitted to ODMHSAS including the application for certification;
(5) Conflict of interest by the institution or organization or its personnel;
(6) Allowing a non-certified, non-approved, or inter-facilitator to conduct an ADSAC without a certified ADSAC facilitator (ten (10) hour or twenty-four (24) hour, as required by the ADSAC course being given) present;
(7) Failure to maintain all records required by ODMHSAS;
(8) Using facilities not approved by ODMHSAS;
(9) Allowing a non-certified, non-approved, or inter-facilitator to conduct an ADSAC without a certified ADSAC facilitator (ten (10) hour or twenty-four (24) hour, as required by the ADSAC course being given) present;
(10) Use of unapproved curriculum or instructional material not pre-approved by ODMHSAS;
(11) Use of inappropriate materials/equipment or materials/equipment in poor repair;
(12) Failure to provide at least two (2) complete ADSAC courses within twelve (12) months;
(13) Failure to provide appropriately certified facilitators for courses;
(14) Beginning a course prior to the scheduled time;
(15) Failure to wait at least a full fifteen (15) minutes when zero (0) participants are present at the scheduled beginning time for a course;
(16) Failure to provide the complete course for any participants arriving within fifteen (15) minutes of the scheduled start time;
(17) Failure to provide ADSAC with a course schedule at least thirty (30) days in advance of presentation;
(18) Failure to provide ODMHSAS course schedule changes at least seven (7) days in advance of presentation except when facilitator changes are due to illness or other emergency;
(19) Failure to provide ODMHSAS requirements for adding course sites;
(20) Failure to notify ODMHSAS of any facilitator violations of this Chapter, or of facilitator terminations due to violations of this Chapter;
(21) Establishing the legal business residence of the institution or organization outside the State of Oklahoma;
(22) Issuance of completion certificates to participants who fail to complete the full ten (10) hours of instruction or the full twenty-four (24) hours of instruction or who fail to meet any other course requirement;
(23) Violation of, or failure to meet, any other applicable standard contained in this chapter;
(24) Knowingly allowing an ADSAC facilitator to collect fees, issue receipts, issue completion certificates, conduct an assessment during a course, or solicit participants for assessments at a later date, during the course of an ADSAC; or
(25) Any other just and verifiable cause including, but not limited to, unethical or illegal activities.

(b) Administrative sanctions may be taken against a certified facilitator for any of the following reasons:

(1) Erroneous or false information contained in the individual's application for certification;
(2) A conviction of driving under the influence of alcohol or other intoxicating substances or receiving an alcohol or drug related reconviction or suspension of driving privileges;
(3) Conviction of any alcohol or other drug related misdemeanor or any felony conviction;
(4) Any unlawful act or act in the presence of participants;
(5) Any activity which is a conflict of interest;
(6) Use or abuse of intoxicating beverages or other drugs while facilitating an ADSAC course;
(7) Permitting a participant to attend a course while using or under the influence of any mood-altering substances, including alcohol;
(8) Dismissal by a certified institution or organization for violation of state statutes, or of the standards and criteria in this Chapter;
(9) Use of curriculum or instructional material not approved by ODMHSAS;
(10) Willful failure, or refusal, to cooperate with an investigation by ODMHSAS, or employing ADSAC agency, into a potential or alleged violation of applicable rules in this Chapter;
(11) Refusal to allow a facilitator candidate to observe an ADSAC course;
(12) Issuance of completion certificates to participants who have not completed a full ten (10) hours of instruction, or who fail to complete the full twenty-four (24) hours of instruction, or failure to meet any other ADSAC requirement;
(13) Violation of any applicable rule in this Chapter, or any other applicable chapter.
450:21-3-3. Sanctions and hearings [REVOKED]
All sanctions regarding ADSAC institutions, organizations, and facilitators and all administrative hearings and appeals related to such sanctions shall be made and carried out in accordance with Oklahoma Administrative Code, Title 450, Chapter 1, Subchapter 5 and the Administrative Procedures Act.

450:21-3-4. Participant rights and grievance policy [REVOKED]
(a) All certified ADSAC institutions and organizations shall comply with applicable rules in Title 450, Chapter 15, Consumer Rights.
(b) Those programs which are providing services within a correctional facility should detail the following due to circumstances:

1. The provider shall document provisions of 450:15-3-2 (a), (b) and (d);
2. The provider shall provide written grievance policy and procedure including time frames for the grievance process;
3. The provider shall describe the procedure used when the grievance is against a staff. This policy may refer to Department of Corrections mandated policy and procedure; and
4. The provider shall describe the facility's responsibility for evaluation, review, and resolution should the allegation be substantiated.

450:21-4-1. Compliance with laws, rules
(a) All institutions, organizations and facilitators certified by ODMHSAS to conduct ADSAC courses shall do so in accordance with all applicable laws of the State of Oklahoma and all applicable rules of Title 450 OAC.
(b) That each applicant for ADSAC facilitator shall declare in writing, in a format and manner prescribed by the Commissioner of ODMHSAS, or designee, that he or she has read and understands §§ 3-451 through 3-461 of Title 43A of the Oklahoma Statutes and this Chapter and agrees to abide by the terms thereof, along with future amendments thereto, as a condition for obtaining and retaining such approval or certification.
(c) ODMHSAS shall process all applications for certification and recertification and enforce these standards and criteria (rules) in this Chapter, and related laws.
(d) Approved institutions, organizations and facilitators shall not make reference to ODMHSAS or DPS in any advertisement regarding ADSAC. Advertising shall be truthful in all communication with prospective participants. Implication of exclusive services by any one organization is prohibited.
(e) All institutions, organizations and facilitators certified to conduct ADSAC courses must promptly notify ODMHSAS of a change of email, mailing or physical address within fourteen (14) days of said change.
(f) The fees for those attending a ten (10) hour ADSAC course shall be one hundred and fifty dollars ($150.00) per participant; and for persons attending the twenty-four (24) hour courses the fee shall be three hundred and sixty dollars ($360.00).
(g) The ADSAC institution or organization shall pay ODMHSAS ten percent (10%) of each ADSAC fee collected, which ODMHSAS shall remit to the Oklahoma State Treasurer to be credited to the ODMHSAS Revolving Fund.
(h) The payment from the fee collected for each ADSAC course participant shall be made to ODMHSAS within thirty (30) days of course completion.
(i) A check for the appropriate fee shall accompany the completion roster, unless otherwise stipulated in writing by ODMHSAS.
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(i) Compliance with this Chapter may be determined by a review of all ADSAC-related records; documents and reports; facilitator, staff and participant interviews; and any other relevant documentation of the institution, organization or facilitator.

450:21-4-2. Applications

(a) Applications for certification of institutions, organizations or facilitators to conduct ADSAC courses shall be made to ODMHSAS in writing on a form and in a manner prescribed by the Commissioner of ODMHSAS or designee.

(b) ODMHSAS shall give each institution, organization and facilitator candidate requesting certification to conduct ADSAC courses the following:

(1) A copy of §§ 3-451 through 3-453 of Title 43A of the Oklahoma Statutes;

(2) A copy of these standards and criteria; and

(3) The appropriate application(s).

(c) An institution or organization applying for certification to conduct ADSAC shall provide to ODMHSAS for consideration:

(1) Completed application;

(2) Film approval form(s) for the ten (10) and twenty-four (24) hour ADSAC;

(3) Instructional materials for the ten (10) and twenty-four (24) hour ADSAC;

(4) Written verification the applicant is a nonprofit educational institution of higher learning appropriately accredited pursuant to state law, a governmental entity or a nonprofit corporation. If a non-profit corporation, verification shall be a copy of the U.S. Internal Revenue Service Documents granting the corporation 501(c)(3) status;

(5) Completed certification applications and resumes of proposed facilitators;

(6) The physical address (street, building name and suite [if applicable], city and zip code) and description of all sites at which the ADSAC course(s) will be conducted; and

(7) Letters of support from at least two (2) of the following individuals who serve in the community in which each proposed site, including satellites, is located:

(A) District or Associate District Judge;

(B) County Sheriff;

(C) Municipal Judge;

(D) District or Assistant District Attorney; or

(E) Chief of Police.

(d) If the applicant is a non-profit corporation, the applicant shall submit evidence it was constituted, and is operated, to provide substance abuse, mental health or educational services as its primary services and that the corporation is operated from a professional administrative office, which is open and operated during normal business hours.

(e) Requests from a certified ADSAC provider for additional or replacement course sites shall be submitted to the ODMHSAS and shall meet all requirements for initial applications, except the institution or organization need not submit items previously submitted that are currently applicable to the new site(s) and expressly stated as such in the application for new course site(s).

(f) Renewal of certification of ADSAC institutions or organizations shall be contingent upon submission of renewal application and programmatic history of compliance with Oklahoma Administrative Code, Title 450. The application for renewal shall include all items required for initial certification as well as any unpaid fees required by 450:21-4-1(g). Applications with outstanding unpaid fees will not be processed until a resolution is reached regarding payment of outstanding fees.

(g) In addition to submitting an application and fulfilling the renewal standards for certification per 21-4-2(f), a review of consumer and organization documentation shall be performed. A score of at least 75% on clinical standards must be achieved in order to move forward with certification. The process will follow that of agency certifications found in 450:1-9-7.2. All deficiencies must be resolved in order for certification to be renewed.

(h) An applicant for initial certification as a facilitator to conduct ADSAC courses shall provide to ODMHSAS for consideration:

(1) A letter of recommendation from an administrator of a certified institution or organization;

(2) A current resume, which shall include:

(A) Educational background including an official college transcript from an accredited college or university; and

(B) Employment history covering the previous ten (10) years to include name, complete address and telephone number of employer(s);

(3) A completed application;

(4) A one hundred dollar ($100.00) application fee for initial certification; and

(5) Upon initial application, a completed Oklahoma State Bureau of Investigation background check or a similar background check from any other state(s) of residence for the past five (5) years;

(6) Provide a current, recognizable, color, photographic image, in good condition, no smaller than two (2) inch by two (2) inches of the applicant every six (6) years, upon the anniversary of every second recertification beginning with any qualifying recertifications occurring on or after July 1, 2008; and

(7) A new OSBI background check must be submitted every six (6) years, upon the anniversary of every second recertification beginning with any qualifying recertifications occurring on or after July 1, 2008. The results of the OSBI background check must be submitted with the recertification application and any conviction may result in denial of certification. This will be required of all individuals who have been certified as ADSAC facilitators for six (6) years or more, recertifying after July 1, 2008.

(i) ODMHSAS shall consider each applicant for certification in accordance with these rules. The Commissioner of ODMHSAS or designee shall notify each applicant in writing of an approval or denial of certification. Certification shall be effective for three (3) years commencing with the date of issue.
(i) Fax will not be accepted as permanent copies for an applicant's record.

(k) Applications are good for one (1) year from approval. All requirements must be completed within the initial twelve (12) month period or a new application must be submitted.

(l) Completed applications must be received by ODMHSAS twenty (20) days prior to the new facilitator training event.

(m) A facilitator whose certification has been expired for less than twelve (12) months must make application for an initial certification as set forth in 450:21-4-7. If approved by the Department, such a facilitator will not be required to attend the initial ADSAC facilitator training or successfully complete the training exam.

(n) A facilitator whose certification has been expired for more than twelve (12) months must make application for an initial certification as set forth in 450:21-4-7, including attending the initial ADSAC facilitator training, and successful completion of the training exam.

(o) Each facilitator shall notify ODMHSAS of any change of application information related to his or her email address, phone number, work or home address at least fifteen (15) days in advance of the change. In case of an emergency, the facilitator may notify ODMHSAS of any change up to thirty (30) days after a change has occurred.

450:21-4-3. Minimum curriculum requirements, ten (10) hour courses

(a) The standardized ADSAC curriculum approved by ODMHSAS shall be utilized by all ADSAC institutions, organizations and facilitators for the ten (10) hour ADSAC course. Any additional materials must be consistent with the format of the main curricula, follow the Transtheoretical Model of Change and prior to implementation receive written approval from ODMHSAS.

(b) The ten (10) hour ADSAC Course shall at a minimum include instruction on:

(1) Legal aspects of drinking or using other drugs and driving;
(2) Physiological aspects of using alcohol and other drugs;
(3) Sociological aspects of using alcohol and other drugs;
(4) Effects and possible outcomes of drinking or using other drugs and driving;
(5) Scope of the problem of drinking or using other drugs and driving;
(6) The history/origins of alcohol and other drugs;
(7) The effects of substance abuse on family and friends; and
(8) Alternative plans/strategies to using alcohol or other drugs and driving.

(c) Each curriculum shall provide for a full ten (10) hours of block-teaching classroom instruction, and shall be conducted in no fewer than three (3) sessions with each session no more than three and one half (3.5) hours in duration, and conducted on no fewer than three (3) separate days. These hours shall not be inclusive of:

(1) Meal or break times; or

450:21-4-4. Minimum curriculum requirements, twenty-four (24) hour courses

(a) The standardized ADSAC curriculum approved by ODMHSAS shall be utilized by all ADSAC institutions, organizations and facilitators for the twenty-four (24) hour ADSAC. Any additional materials must be consistent with the format of the main curricula, follow the Transtheoretical Model of Change and prior to implementation receive written approval from ODMHSAS.

(b) The minimum curriculum requirements for the twenty-four (24) hour ADSAC course includes, but is not limited to, appropriate instruction on:

(1) Legal aspects of drinking or using other drugs and driving;
(2) Physiological aspects of using alcohol and other drugs;
(3) Sociological aspects of using alcohol and other drugs;
(4) Effects and possible outcomes of drinking or using other drugs and driving;
(5) Scope of the problem of drinking or using other drugs and driving;
(6) The history/origins of alcohol and other drug abuse;
(7) Alternatives to using alcohol or other drugs and driving; and
(8) The effects of substance abuse on family and friends.

(c) The curriculum shall be covered within the following time-frames:

(1) Not more than two (2) hours of education on a single day;
(2) Not more than four (4) hours of education in a single week;
(3) The time-frames shall not be inclusive of:
(A) Meal or break times; or
(B) ADSAC administrative functions except for enrollment form completion and fee payment.
(4) Participants may be admitted up to fifteen (15) minutes after the official time of the class without having to make up the time.
(d) The curriculum shall provide for a discussion period following each audiovisual presentation. Audiovisual presentation shall not comprise more than ten (10) percent of the class and must have been submitted and approved at the time of application for certification and at each recertification anniversary thereafter.
(e) The curriculum shall provide for a scored pre- and post-test, as prescribed by ODMHSAS. The pre-test shall be given in the first two (2) hour block of classroom facilitation, and the post-test shall be given at the end of the final block of course facilitation. These tests are to determine the participant gain in knowledge of the material based upon the scores of the pre- and post-tests.
(f) The ADSAC institution, organization and facilitator shall provide each participant a list of community referrals and resources approved by ODMHSAS.
(g) Class size shall not exceed twenty-four (24) participants.

450:21-4-5. Administrative responsibilities, institutions or organizations conducting ADSAC

(a) Each institution or organization certified to conduct ADSAC courses shall provide ODMHSAS, in a manner prescribed by the Commissioner of ODMHSAS or designee, a monthly schedule of courses to be conducted. The course shall be provided per the submitted course schedule and the course may only be canceled if zero (0) participants show up for the course within fifteen (15) minutes after the scheduled course starting time. Any institution or organization requiring pre-enrollment may cancel a course prior to the scheduled first session and after the expiration of the pre-enrollment time period, if no participants have pre-enrolled. The course schedule shall be submitted no later than thirty (30) days in advance of any course start and shall include:
(1) The complete address, street, building name and suite where applicable, city and zip code, where each course will be conducted;
(2) The name of the course facilitator;
(3) The beginning and ending times of each session of the course; and
(4) Enrollment in ten (10) or twenty-four (24) hour courses shall be limited to twenty-four (24) participants.
(b) Each institution or organization certified to conduct ADSAC shall advise ODMHSAS seven (7) days in advance of:
(1) A ten (10) hour or twenty-four (24) hour course cancellation; or
(2) A scheduled facilitator change (unless change is due to illness or other facilitator emergency); or
(3) Any change of the date or hour of the scheduled ten (10) hour or twenty-four (24) hour course.
(c) Failure to offer either a ten (10) hour or twenty-four (24) hour course at an approved site for three (3) consecutive months shall constitute a withdrawal from that site and require another application for certification.
(d) If no participants attend the first session of a ten (10) or twenty-four (24) hour course, a second or subsequent session is not required.
(e) Failure to either provide a scheduled course to one (1) or more attending participants, or staff a scheduled course site for fifteen (15) minutes after the scheduled course starting time may result in administrative reprimand, suspension or revocation. A course may be canceled when zero (0) participants show up for the course within fifteen (15) minutes of the scheduled course starting time.
(f) ODMHSAS personnel shall be admitted to any course without charge, upon request and display of proper credentials for the purpose of audit and review.
(g) Certified institutions, organizations and facilitators must provide, for each telephone number published specific to ADSAC, continuous availability, either in person, by phone, answering machine, electronic voice mail, or engage a professional answering service. Numbers published for the purpose of ADSAC advertisement must be answered by individuals with proper inservice training in all relevant aspects of 42 CFR, Part 2 and HIPAA.
(h) Institutions and organizations certified to conduct ADSAC courses shall be responsible for the conduct of the facilitators they employ, and shall have written policies outlining the institution’s or organization’s oversight procedures.

450:21-4-6. Facilities, equipment and instructional material

(a) Each site where an ADSAC course is held must meet local and state fire, health and safety standards. ODMHSAS may request state or local fire inspectors or other state health or safety officials to conduct an inspection of any facility suspected of being hazardous.
(b) Each institution or organization must provide a safe, confidential, professional and comfortable environment for participants and facilitators, appropriate for conducting an ADSAC course with minimum distractions.
(c) All equipment must be in good working condition.
(d) Instructional material issued to participants such as handouts, pamphlets, workbooks, etc., must have been submitted to ODMHSAS upon application by the organization or institution for certification or recertification. Each participant shall be given a new, unused journal of the Level I or Level II ADSAC journal as his or her property.
(e) Sites shall not be designed or used for the primary purpose of eating or sleeping (hotel/motel sleeping rooms, restaurant dining rooms, etc.).

450:21-4-7. ADSAC facilitator certification, qualification and disqualification

(a) Minimum qualifications for certification of ADSAC facilitators are as follows:
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(1) Possess a bachelor's degree in behavioral or health-care sciences education, psychology, social work or chemical dependency with at least two (2) years verifiable full-time equivalent experience in the substance abuse treatment field. This work experience can be in the areas of clinical, prevention or direct care. Proof of current licensure as LADC or certification as CADC will fulfill the experience requirement;

(2) A valid driver's license or state identification card;

(3) Completion of the following in the order listed below:
   (A) Observe one (1) complete twenty-four (24) hour ADSAC course in sequential order, conducted by a certified facilitator. This observation must be completed and verified to ODMHSAS prior to attending facilitator training;
   (B) Attend the new facilitator training and pass the ODMHSAS Certification Examination for ADSAC Facilitator:
      (i) A minimal score to pass the exam shall be eighty (80) percent;
      (ii) The exam shall require the participant to correctly identify the major components of the transtheoretical model of change;
      (iii) The exam shall require the participant to correctly identify the major components of the interactive journaling process; and
      (iv) The exam shall require the participant to correctly identify rules from this Chapter;
   (C) Conduct one complete twenty-four (24) hour ADSAC under the supervision of a certified ADSAC facilitator or an ODMHSAS representative.

(4) The facilitator candidate shall be allowed nine (9) months to complete training requirements and one (1) year from application to complete all other requirements. Failure to meet all requirements within the specified timeframes will result in denial of certification. To be reconsidered, the candidate will be required to re-apply to ODMHSAS.

(5) Renewal of certification as an ADSAC facilitator shall be dependent upon acceptance of a completed renewal application submitted to ODMHSAS, remission of a fifty dollar ($50.00) application fee for renewal of certification, and the accomplishment of minimum standards. These standards are:
   (A) Each facilitator shall conduct at least six (6) complete ten (10) or twenty-four (24) hour courses during each certification period beginning with the date of initial certification:
      (i) To be eligible for recertification as an ADSAC facilitator capable of conducting both ten (10) and twenty-four (24) hour ADSAC courses, verification of having conducted at least two (2) twenty-four hour (24) ADSAC courses in the last three years prior to the request for recertification; and
      (ii) Submission of proof of having conducted less than two (2) twenty-four (24) hour ADSAC courses in the three (3) years prior to the request for recertification, shall result in the facilitator being required to attend a one (1) day training event addressing skills consistent with twenty-four (24) hour course facilitation.
   (B) Documentation of receiving twelve (12) continuing education hours each twelve (12) month period beginning with the date of initial certification. These hours shall be from each of the following areas with four (4) hours coming from area (i), four (4) hours coming from area (ii) and four (4) hours coming from area (iii):
      (i) Adult education;
      (ii) Facilitation skills;
      (iii) General substance abuse training; and
      (iv) Hours for any mandatory trainings required by ODMHSAS may come from area (iii) above.

(6) All renewals of certification are due on the third anniversary of certification. After July 1, 2008 all certification renewals may come due on January 1 of the renewal year. If a universal certification date is adopted, then, requirements for certification renewals will be accepted on a prorated basis during the transition period.

(b) An applicant may not be certified nor certification as an ADSAC facilitator renewed under any of the following conditions:

   (1) A non-pardoned felony conviction within the last five (5) years;
   (2) Conviction of driving under the influence of alcohol or other intoxicating substances or receiving an alcohol or drug related revocation or suspension of driving privileges for five (5) years prior to the application for certification; or,
   (3) Having involvement in any business or endeavor which is a conflict of interest. ODMHSAS may on its own initiative, or upon complaint, investigate potential or alleged conflict of interest, or any other alleged, or suspected violation of these standards.

**450:21-4.8. Inactive status/closure**

(a) An active ADSAC course, institution or organization certification may be placed on inactive status by written request:

   (1) An inactive certification forfeits all rights and privileges granted by the certification;
   (2) When certification is placed on inactive status, the certificate shall be returned to ODMHSAS;
   (3) When certification is placed on inactive status, it remains inactive for at least one (1) year from the date of inactivation;
   (4) Active status may be re-established upon written request;
   (5) When an ADSAC institution or organization satellite must cease operation for less than twelve (12) months, all participant records shall be transported to the main site unless they can be secured on site under rules defined in 450:21-1.7.5;
(6) During such a temporary closure due to being placed on inactive status of the main ADSAC site or location, effort should be made to ensure participant records remain accessible as defined in 450:21-1-7.5;
(7) Participants attending an ADSAC course shall be given written notification of a temporary closure with contact information in the event all course sessions have not been completed;
(8) ODMHSAS shall be notified in writing of the temporary closure of any ADSAC site (DUI school). The written notification shall contain:
   (A) The reason for closing;
   (B) Contact information for participant course records; and
   (C) A projected date for resumption of business.
(9) Upon receipt of written notification of closure, ODMHSAS shall remove the institution or organization(s) telephone number from the monthly State Certified DUI Schools referral list; and
(10) Upon written notification of intent to resume business, ODMHSAS shall add the institution or organization(s) telephone number to the monthly State Certified DUI Schools referral list.

(b) Institutions and organizations operating for the purpose of conducting ADSAC having to close permanently shall comply with the following:
(1) When a satellite closes permanently, all participant records shall be transported to the main location under rules defined in 450:21-1-7.5;
(2) When the main location of an institution or organization closes permanently, all participant records shall be secured as defined in 450:21-1-7.5;
(3) Participant records shall remain accessible as defined in 450:21-1-7.5;
(4) Participants shall be given written notification of the closure with contact information, including ODMHSAS, in the event all coursework is not completed;
(5) ODMHSAS shall be notified in writing of any closure of an institution or organization operating for the purpose of conducting ADSAC courses. The written notification shall contain:
   (A) The reason for closing; and
   (B) Contact information for participant records.
(6) Upon receipt of written notification of closure, ODMHSAS shall remove the site(s) telephone number from the monthly State Certified DUI Schools referral list.
(c) An active ADSAC facilitator certification may be placed on inactive status by written request:
(1) An inactive certification forfeits all rights and privileges granted by the certification;
(2) When certification is placed on inactive status, the certificate shall be returned to ODMHSAS;
(3) When certification is placed on inactive status, the certification remains inactive for at least twelve (12) months from the date of inactivation or until the end of the certification period, whichever is first;
(4) Inactive status shall not be allowed to continue longer than the certification period; and
(5) Active status may be re-established upon written request.

450:21-4-9. Facilitator training
(a) Minimum qualifications for institutions or organizations conducting ADSAC facilitator training, and the minimum qualifications for individuals conducting facilitator training are as follows:
(1) All ADSAC facilitator training shall only be conducted by non-profit organizations, educational institutions or governmental agencies.
(2) The curricula for the training shall be as follows:
   (A) A minimum of twenty-four (24) hours of instruction, and
   (B) These hours shall be offered in no less than four (4) days and for no more than eight (8) hours per day.
(3) Instructors for facilitator training must have:
   (A) A minimum of two (2) years experience as an ADSAC facilitator; or
   (B) A master’s degree from an accredited college or university; or
   (C) Four (4) years related experience in the subject matter to be taught.
(4) Each facility where facilitator training courses are conducted shall:
   (A) Meet all applicable local and state fire, health and safety standards; and
   (B) Provide a safe and comfortable environment for facilitators and facilitator candidates conducive to the learning experience.
(5) Instructional equipment must be in good working order.
(6) Institutions or organizations providing facilitator training prior to receiving written approval from ODMHSAS may not be accepted for facilitator certification requirements.
(b) Each institution or organization shall advise ODMHSAS in writing the names of candidates who did not complete training and the names of persons who successfully completed the facilitator training.
(c) All facilitator trainings shall be consistent with the requirements of this Chapter and the training curricula shall consist of recognized evidence based, best practices.

450:21-4-10. Administrative denial, suspension, or revocation of certification
(a) ODMHSAS may deny the certification of any institution, organization, or facilitator to conduct ADSAC who fails to qualify for, or comply with, the provisions of this Chapter.
(b) ODMHSAS may reprimand, suspend, revoke or deny renewal of the certification of any institution, organization or facilitator who fails to qualify for or comply with the provisions of this Chapter.
(c) In the event ODMHSAS determines action should be taken against any institution, organization or facilitator certified under this Chapter, the proceeding shall be initiated pursuant to the rules of ODMHSAS as set forth in Oklahoma Administrative Code, Title 450, Chapter 1, Subchapter 5 and the Administrative Procedures Act.

(d) Institutions, organizations or facilitators who have had certification denied or revoked, shall be ineligible for reapplication for a period of one (1) year.

(e) Institutions, organizations or individuals whose certification has expired may apply for initial certification.

450:21-4-11. Fitness of applicants

(a) The purpose of this section is to establish the fitness of the applicant as one of the criteria for approval of certification as a certified ADSAC facilitator and to set forth the criteria by which the Commissioner or designee may determine the fitness of applicants.

(b) The substantiation of the items below related to the applicant may result in the initiation of suspension or revocation of certification, or denial of, or delay of certification of the applicant. These items include, but are not limited to:

(1) Evidence of the lack of necessary skill and abilities to provide adequate services;
(2) Misrepresentation on the application or any other materials submitted to ODMHSAS;
(3) A violation of the rules of professional conduct set forth in this Chapter.
(4) Evaluations of supervisors, employers or instructors;
(5) Allegations from other governmental entities;
(6) Findings resulting from investigations prompted by allegations of participants, peers or the public;
(7) Transcripts or other findings from official court hearing or investigative procedures;
(8) Any convictions for alcohol and other drug related offenses, violent offenses, or moral turpitude within the last ten (10) years;
(9) Any unpardoned felony convictions within five (5) years;
(10) The revocation, suspension, reprimand or any other administrative action ordered by another certifying or licensing body may result in the denial, revocation or suspension of facilitator certification by ODMHSAS.

(c) ODMHSAS may require explanation of negative references prior to issuance of certification.

(d) Those certified to conduct ADSAC courses by ODMHSAS shall not perform such courses when the ability to perform such services are impaired for any reason. Facilitators shall seek assistance for any problems that impair the ability to perform required services, and, if necessary, limit, suspend or terminate the delivery of ADSAC courses.

(e) A field examination submitted through questionnaires answered by persons competent to evaluate a facilitator’s professional competence which may include the submission of such documentary evidence relating to a facilitator’s experience and competence as required by ODMHSAS may be required.

(f) If in the course of an investigation, ODMHSAS determines that a facilitator has engaged in conduct of a nature that is detrimental to the health, safety, or welfare of the public, and which conduct necessitates immediate action to prevent further harm, the Commissioner, or designee may order a summary suspension of the facilitator’s certification to conduct ADSAC courses.

(g) ODMHSAS may require remedial interventions to address any problems or deficiencies identified from this section as a requirement for retaining active certification.

450:21-4-12. Grounds for reprimand, suspension or revocation of certification, organizations and institutions and facilitators

(a) Administrative sanctions may be taken against an institution or organization certified to conduct ADSAC for any of the following reasons:

(1) Refusal to allow a facilitator candidate to observe an ADSAC course;
(2) Allowing more than twenty-four (24) participants in any course;
(3) Tardiness or failure to make reports or to transmit funds required by this Chapter;
(4) Erroneous or falsified information relating to any documents submitted to ODMHSAS including the application for certification;
(5) Conflict of interest by the institution or organization or its personnel;
(6) Allowing a non-certified, non-approved, or intern facilitator to conduct an ADSAC without a certified ADSAC facilitator (ten (10) hour or twenty-four (24) hour, as required by the ADSAC course being given) present;
(7) Failure to maintain all records required by ODMHSAS;
(8) Using facilities not approved by ODMHSAS;
(9) Knowingly permitting any facilitator to violate any rule of this Chapter, or any other relevant Chapter of these Administrative Rules;
(10) Use of unapproved curriculum or instructional material not pre-approved by ODMHSAS;
(11) Use of inappropriate materials/equipment or materials/equipment in poor repair;
(12) Failure to provide at least two (2) complete ADSAC courses within twelve (12) months;
(13) Failure to provide appropriately certified facilitators for courses;
(14) Beginning a course prior to the scheduled time;
(15) Failure to wait at least a full fifteen (15) minutes when zero (0) participants are present at the scheduled beginning time for a course;
(16) Failure to provide the complete course for any participants arriving within fifteen (15) minutes of the scheduled start time;
(17) Failure to provide ODMHSAS with a course schedule at least thirty (30) days in advance of presentation;
(18) Failure to provide ODMHSAS course schedule changes at least seven (7) days in advance of presentation.
except when facilitator changes are due to illness or other emergency;

(19) Failure to complete ODMHSAS requirements for adding course sites;

(20) Failure to notify ODMHSAS of any facilitator violations of this Chapter, or of facilitator terminations due to violations of this Chapter;

(21) Establishing the legal business residence of the institution or organization outside of the State of Oklahoma;

(22) Issuance of completion certificates to participants who fail to complete the full ten (10) hours of instruction or the full twenty-four (24) hours of instruction or who fail to meet any other course requirement;

(23) Violation of, or failure to meet, any other applicable standard contained in this chapter;

(24) Knowingly allowing an ADSAC facilitator to collect fees, issue receipts, issue completion certificates, conduct an assessment during a course, or solicit participants for assessments at a later date, during the course of an ADSAC; or

(25) Any other just and verifiable cause including, but not limited to, unethical or illegal activities.

(b) Administrative sanctions may be taken against a certified facilitator for any of the following reasons:

(1) Erroneous or false information contained in the individual’s application for certification;

(2) A conviction of driving under the influence of alcohol or other intoxicating substances or receiving an alcohol or drug related revocation or suspension of driving privileges;

(3) Conviction of any alcohol or other drug related misdemeanor or any felony conviction;

(4) Any unlawful conduct on duty or in the presence of participants;

(5) Any activity which is a conflict of interest;

(6) Use or abuse of intoxicating beverages or other drugs while facilitating an ADSAC course;

(7) Permitting a participant to attend a course while using or under the influence of any mood altering substances, including alcohol;

(8) Dismissal by a certified institution or organization for violation of state statutes, or of the standards and criteria in this Chapter;

(9) Use of curriculum or instructional material not approved by ODMHSAS;

(10) Willful failure, or refusal, to cooperate with an investigation by ODMHSAS, or employing ADSAC agency, into a potential or alleged violation of applicable rules in this Chapter;

(11) Refusal to allow a facilitator candidate to observe an ADSAC course;

(12) Issuance of completion certificate(s) to participants who have not completed a full ten (10) hours of instruction, or who fail to complete the full twenty-four (24) hours of instruction, or failure to meet any other ADSAC requirement;

(13) Violation of any applicable rule in this Chapter, or any other applicable chapter;

(14) Falsification of any report, or document submitted, or prepared for submission, to ODMHSAS;

(15) Collecting fees for; or issuing receipts for; or issuing completion certificates for; or conducting an assessment during; or soliciting participants for assessments at a later date during the process of an ADSAC course;

(16) Any sexual language or actions with or toward a participant, presenting for enrollment or enrolled in an ADSAC course;

(17) Failure to provide at least two (2) complete ADSAC courses within twelve (12) months; or

(18) Any other just and verifiable cause including, but not limited to, unethical or illegal activities.

(c) ADSAC facilitators shall report all violations and suspected violations of this Chapter by any individual to ODMHSAS staff assigned to the ADSAC division.

450:21-4-13. Sanctions and hearings

All sanctions regarding ADSAC institutions, organizations, and facilitators and all administrative hearings and appeals related to such sanctions shall be made and carried out in accordance with Oklahoma Administrative Code, Title 450, Chapter 1, Subchapter 5 and the Administrative Procedures Act.

SUBCHAPTER 5. COURSE ATTENDANCE AND COMPLETION

450:21-5-1. Participant attendance and completion of ADSAC

(a) The ADSAC institution or organization shall require participants to complete all portions of an approved curriculum schedule.

(b) The ADSAC course shall allow a participant unable to attend one (1) or more portions to make up portion or portions missed at another regularly scheduled course at the certified institution or organization at which the course was originally scheduled.

(c) All ten (10) hour course work shall be completed, including payment in full within sixty (60) days of the participant attending the first ADSAC course session. Failure to complete all course work within sixty (60) days shall result in the loss of all course credit and any funds remitted. Re-enrollment in either the same or a different ADSAC course following failure to complete an ADSAC within the stated time limit shall require full course attendance prior to the issuance of a Certificate of Completion. All participants enrolling in a ten (10) hour ADSAC course shall be notified of this fact in writing.

(d) All twenty-four (24) hour course work shall be completed, including payment in full within one hundred eighty (180) days of the first course session. Failure to complete all course work, including payment in full within the one hundred eighty (180) days shall result in the loss of all course credit and any funds remitted. Re-enrollment in either the same, or a different ADSAC following failure to complete an ADSAC
course within the state time limit shall require full course attendance prior to the issuance of a Certificate of Completion. All participants enrolling in a twenty-four (24) hour ADSAC course shall be notified of this fact in writing.

e) All ADSAC institutions, organizations and facilitators shall make required course work available to enrolled participants within the times frames set forth in this standard. ADSAC institutions, organizations and facilitators failing to make required course work available within the stipulated time frames, for any reason, shall refund to participant any fees paid for said course.

(f) Each institution or organization shall issue a receipt on a pre-numbered duplicate receipt set to each participant upon receipt of all or part of the required enrollment fee. Each organization or institution shall have receipts to be used specifically for ADSAC.

(g) Each institution or organization shall maintain the pre-numbered receipts and a record on both course and participant for five (5) years after completion of said course. Such records shall also consist of:

1. Course information:
   (A) Completion roster; and
   (B) Attendance records; and

2. Participant information:
   (A) Enrollment form;
   (B) Written referral documenting an assessment, when appropriate pursuant to OAC 450:22-1-44450:21-7-9;
   (C) Pre- and Post-Test;
   (D) Evaluation Form completed by the participant; and
   (E) Copy of the Completion Certificate.

(h) For participants who have a primary language other than English:

1. The participant shall be referred to an ADSAC course offered in that language if one is available in the area. If no such course is available then an interpreter shall be present for all sessions;

2. If an interpreter is required, the interpreter shall not be younger than eighteen (18) years of age and should not be related to the participant; and

3. An interpreter shall be identified to all ADSAC course participants as an interpreter.

**SUBCHAPTER 7. CERTIFICATION OF ALCOHOL AND DRUG ASSESSORS RELATED TO DRIVER'S LICENSE REVOCATION**

**450:21-7.** **Alcohol and Drug Assessors**

(a) Alcohol and drug assessments shall be provided by individuals or agencies certified by ODMHSAS to provide alcohol and drug assessment and evaluation programs related to driver's license revocation. ODMHSAS certified community mental health centers, ODMHSAS certified alcohol and drug treatment programs, and probation offices shall be considered for such certification.

(b) Certified assessors shall:

1. Recommend and monitor certified assessors for compliance to applicable rules within Title 450; and

2. Provide assessment services only at sites approved by ODMHSAS.

(c) Certified assessors are responsible for:

1. Reporting assessment data to ODMHSAS in the time frames set forth in this Chapter;

2. Make recommendations based upon ODMHSAS-required assessment instruments;

3. Ensure exception findings meet current American Society of Addiction Medicine's (ASAM) over-ride criteria; and

4. Providing liaison with ODMHSAS, the courts and other agencies.

**450:21-7-2. ODMHSAS responsibilities**

ODMHSAS shall have the authority and duty to:

1. Monitor assessors for compliance with applicable State and Federal laws and the rules of this Chapter;

2. Establish, monitor and enforce reporting requirements and report forms;

3. Certify assessors;

4. Approve sites for assessment services;

5. Upon receipt of a valid written consent for release of information, certify to DPS that a person has participated in and successfully completed an ADSAC evaluation and assessment program;

6. Ensure compliance with the rules in this Chapter as determined by a review of ADSAC-related records, documents and reports, staff and participant interviews and any other relevant documentation;

7. Conduct compliance review of all assessors; and

8. Establish training requirements for all assessors.

**450:21-7-3. Assessor applicants**

(a) An applicant for certification as an assessor shall submit proof of the following:

1. Proof of current licensure as an LBHP or certification as an alcohol and drug counselor acting within scope of licensure/certification or proof of current status as a Licensure Candidate under the onsite supervision of a certified ADSAC assessor; and

2. Proof of having at least two (2) years documented full-time clinical experience in drug/alcohol treatment counseling; and

3. Proof of successful completion of a one (1) day ASAM training within two (2) years of the submission of the application; and

4. A recognizable, current, color photographic image of the applicant no smaller than two (2) inch by two (2) inches;

5. A current OSBI background check or a similar background check from another state of residence for the past five (5) years; and

6. A copy of the applicant's resume documenting all education and employment for the previous ten (10) years.
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450:21-7-4. Certification duration

ODMHSAS shall certify assessors for three (3) years.

450:21-7-5. Assessor responsibilities

(a) ADSAC assessments shall be provided by individuals certified by ODMHSAS to provide such assessments.
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(b) All fees due ODMHSAS shall be remitted within thirty (30) days. Any fees identified as being delinquent shall be paid within thirty (30) days of discovery of the omission.

c) Certified assessors shall:

1. Conduct assessments and based on assessment findings, recommend education or treatment or both;

2. Report to the court within seventy-two (72) hours of completing an assessment if the court is anticipating such a report;

3. Provide information in writing regarding state and local area education and treatment resources specific to the area in which the participant resides, to each individual assessed appropriate to the referral recommendations and, in a format prescribed by the Commissioner of ODMHSAS or designee;

4. Manage and distribute all reports according to confidentiality laws under 42 CFR, Part 2, as well as all 45 C.F.R. Parts 160 & 164 (HIPAA) regulations and inform all participants that all contacts, evaluation results and reports are protected through federal confidentiality regulations under 42 CFR, Part 2;

5. Assure there is no conflict of interest by:

A. Referring participants to only those services in which the assessor has no vested interest;

B. Providing three (3) outside referral options in writing for each recommended service, or as many options as available within a 70-mile radius; and

C. Maintaining written assessment documentation pursuant to 450:21-1-7.7(a)(3)(C).

6. Provide liaison with court officials and related other agencies;

7. The fee for those undergoing an assessment and evaluation as a result of their driving privilege being suspended or revoked pursuant to an arrest on or after November 1, 2008 is one hundred sixty dollars ($160.00). The fee for those undergoing an assessment and evaluation as a result of their driving privilege being suspended or revoked pursuant to an arrest prior to November 1, 2008 is one hundred seventy five dollars ($175.00);

A. Remit 10% of each fee collected for any assessment and evaluation completed as a result of a person's driving privilege being suspended or revoked pursuant to an arrest prior to November 1, 2008 to the State Treasurer to be credited to the Department of Mental Health and Substance Abuse Services Revolving Fund within thirty (30) days. No such 10% fee shall be remitted for any assessment and evaluation completed as a result of a person's driving privilege being suspended or revoked pursuant to an arrest on or after November 1, 2008. Completion of assessment includes payment in full by the participant for the assessment service; and

B. No additional charges, extra fees or interest shall be attached to the assessment process;

8. Explain possible liability and ability to pay for ODMHSAS affiliated, private and other education and treatment facilities;

9. For those participants whose license was withdrawn due to an alcohol and drug related offense on or before June 30, 2003, and needing to participate in the ADSAC assessment process for license reinstatement, as verified by DPS, the assessor shall:

A. Verify the participant has completed the assessment to include payment in full;

B. Affix the official red stamp;

C. Provide the participant with a certificate of completion; and

D. Report completion to the Department of Public Safety through ODMHSAS.

10. For those participants whose license was withdrawn due to receiving an alcohol and drug related offense on or after July 1, 2003, and needing to participate in the ADSAC assessment process for license reinstatement, the assessor shall:

A. Verify the participant has completed the ADSAC assessment to include payment in full;

B. Verify the participant has completed all recommendations identified through the assessment and required for license reinstatement prior to affixing the official stamp;

C. Affix the official stamp, with the stamp in red ink;

D. Provide the participant with a certificate of completion; and

E. Report completion to the Department of Public Safety through ODMHSAS.

11. Those participants whose most recent offense was before September 1, 1993 should be referred to DPS to verify an assessment is not required.

12. Provide ODMHSAS notification of those participants successfully completing required education and treatment, including the participant's name, address, date of birth and driver's license number through the online data entry system known as ADSAC online, or in a manner prescribed by the Commissioner or designee. This notification shall be submitted to ODMHSAS within seventy-two (72) hours upon verification of successful completion of all requirements;

13. Certified ADSAC assessors must provide to a caller adequate information regarding the ADSAC assessment process and scheduling requirements. The phone number published specific for each assessor must be continuously available, either answered in person, answering machine, electronic voice mail, or a professional answering service. Numbers published for the purpose of ADSAC assessment and evaluation advertisement must be answered by individuals appropriately trained in all relevant aspects of 42 CFR, Part 2 and HIPAA regulations;

14. All assessors will complete a minimum of six (6) ADSAC assessments during each twelve (12) month period in order for assessor certification to remain active;

15. Each assessor shall maintain an inventory of required and approved instruments sufficient to meet ODMHSAS requirements.
(16) Provide each individual assessed with information regarding all assessor certifications and licenses to include; name, phone number and address of the certifying or licensing body. If certified rather than licensed, the name of the licensed individual serving as supervisor with all licenses including; name, phone number and addresses of the licensing bodies pursuant to Oklahoma state statutes. Contact information for ODMHSAS, ADSAC personnel at ODMHSAS shall be included. All information shall be in a form prescribed by the Commissioner of ODMHSAS or designee;

(17) Each certified assessor shall notify ODMHSAS of any change of application information related to his or her email address, phone number, work or home address at least fifteen (15) days in advance of the change. In case of an emergency, the assessor may notify ODMHSAS of any change up to thirty (30) days after a change has occurred;

(18) For participants who have a language other than English:

(A) The participant shall be referred to an ADSAC assessor fluent in that language, if such as assessor is available. If no assessor fluent in the language is available then an interpreter shall be present for the entire assessment process; and

(B) If an interpreter is required, the interpreter shall not be younger than eighteen (18) years of age and should not be related to the participant.

(19) Provide assessment services only at sites approved by ODMHSAS;

(20) Report all data to ODMHSAS within thirty (30) days or as otherwise directed in this Chapter;

(21) Make recommendations based on ODMHSAS required assessment instruments;

(22) Make all recommendations based on current accepted placement criteria; and

(23) Preference in clinical referrals shall be given to institutions and organizations possessing a substance abuse certification from ODMHSAS, if such service is available.

450:21-7-7. Fitness of applicants

(a) The purpose of this section is to establish the fitness of the applicant as one of the criteria for approval of certification as an assessor for evaluations related to driver's license revocation, and to set forth criteria by which the Commissioner or designee may determine the fitness of applicants.

(b) The substantiation of the items below related to the applicant may result in the initiation of suspension or revocation of certification, or denial of, or delay of certification of the applicant. These items include, but are not limited to:

(1) Evidence of the lack of necessary skill and abilities to provide adequate services;
(2) Misrepresentation on the application or any other materials submitted to the ODMHSAS;
(3) A violation of the rules of professional conduct set forth in this Chapter;
(4) Evaluations of supervisors, employers or instructors;

(5) Allegations form other governmental entities;

(6) Findings resulting from investigations prompted by allegations of participants, peers or the public;

(7) Transcripts or other findings from official court, hearing or investigative procedures;

(8) Any convictions for alcohol and other drug related offenses, violent offenses, or moral turpitude within the last five (5) years; or

(9) Any unpardoned felony convictions within five (5) years; or

(10) The revocation, suspension, reprimand or any other administrative action ordered by another certifying or licensing body may result in the denial, revocation or suspension of assessor certification by ODMHSAS.

(c) ODMHSAS may require explanation of negative references prior to issuance of certification.

(d) Those certified to conduct ADSAC assessments by ODMHSAS shall not perform such assessments when, for any reason, such services are impaired by an inability to perform such services. Assessors shall seek assistance for any problems creating an inability to perform as an assessor, and, if necessary, limit, suspend or terminate the delivery of ADSAC assessment services.

(e) A field examination submitted through questionnaires answered by persons competent to evaluate an assessor's professional competence which may include the submission of such documentary evidence relating to an assessor's experience and competence as required by ODMHSAS may be required.

(f) If in the course of an investigation, ODMHSAS determines that an assessor has engaged in conduct of a nature that is detrimental to the health, safety, or welfare of the public, and which conduct necessitates immediate action to prevent further harm, the Commissioner may order a summary suspension of the assessor's certification to conduct ADSAC assessments.

(g) ODMHSAS may require remedial interventions to address any problems or deficiencies identified from this section as a requirement for retaining active certification.

450:21-7-7. Certified approved sites

Alcohol and other drug assessment and evaluation shall be provided at sites approved by ODMHSAS. Sites shall meet the following standards for consideration of approval:

(1) Sites shall be in professional settings appropriate for the assessment and for safeguarding the confidentiality of the participant;

(2) Hours and days of operation shall be during regularly scheduled periods which make assessment services accessible to participants, including those employed between 8:00 a.m. and 5:00 p.m., and to the general public;

(3) The site's days and hours of operation shall be professionally and conspicuously displayed on the outside of the building along with a business phone number used for scheduling of appointments;

(4) For sites in multi-office buildings, the days and hours of operation shall be posted in the building directory or on the door of the site office;

(5) Sites for the primary purpose of eating or sleeping, i.e., hotel/motel sleeping rooms, restaurant dining areas, etc., will not be considered for approval; and
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(6) Sites shall be handicapped-accessible and meet all other requirements of the Americans with Disabilities Act of 1990.

450:21-7-8. Participant evaluation
(a) The assessment and evaluation of the participant shall be as comprehensive as possible. ADSAC assessors shall not conduct any portion of the assessment process or provide any evaluation services on more than one participant at a time. The assessment shall include, but not be limited to:
(1) A face-to-face biopsychosocial assessment which gathers sufficient information that could assist the participant, and includes the following items:
   (A) Behavioral, including substance use, abuse, and dependence;
   (B) Emotional, including issues related to past or current trauma;
   (C) Physical;
   (D) Social and recreational; and
   (E) Vocational.
(2) The assessor shall obtain and document the participants driving history information from public record(s), when made available. This information shall, at a minimum, include the following:
   (A) Arrest date;
   (B) All charges relating to alcohol and drug offenses; and
   (C) Driving record.
(3) Alcohol and other drug information as supplied by the participant or referring party:
   (A) Blood alcohol concentration at time of arrest;
   (B) Prior alcohol/drug treatment;
   (C) Polydrug use;
   (D) Prior alcohol-related arrest(s); and
   (E) Prior drug related arrest(s).
(4) Pursuant to 450:21-7-9, the use of completed and scored standardized evaluation instruments; and
(5) All information shall be in a format prescribed by the Commissioner of ODMHAS or designee.

(b) Recommendations, known as Intervention Categories, shall be based on scores derived from and verified by a battery of required and appropriate assessment/evaluation instruments, and adhered to by all assessors unless otherwise indicated by ODMHAS:
(1) All those identified as being at low risk to recidivate as indicated by scores derived from the assessment process shall be referred to educational interventions only:
   (A) Intervention Category One shall be identified by alcohol or drug scale scores from the DRI II or DQ of zero (0) to thirty-nine (39) and recommendations shall consist of:
      (i) Ten (10) hour ADSAC course; and
      (ii) Victims Impact Panel.
      (iii) The ten (10) hour ADSAC course and Victims Impact Panel may be attended concurrently.
   (B) Intervention Category Two shall be identified by alcohol or drug scale scores from the DRI II or DQ of zero (0) to thirty-nine (39) and a previous alcohol or drug related offense resulting in license revocation pursuant to Title 47, § 6-212.2. A and recommendations shall consist of:
      (i) Twenty-four (24) hour ADSAC course; and
      (ii) Victims Impact Panel.
      (iii) The twenty-four (24) hour ADSAC course and the Victims Impact Panel may be attended concurrently.
(2) All those identified as being at moderate risk to recidivate shall be referred to a combination of educational and clinical interventions:
   (A) Intervention Category Three, shall be identified by alcohol or drug scale scores from the DRI I or DQ of forty (40) to sixty nine (69) and recommendations shall consist of:
      (i) Twenty-four (24) hour ADSAC course;
      (ii) Victims Impact Panel; and
      (iii) Substance abuse related group involvement for six (6) weeks, meeting one (1) time per week.
      (iv) The twenty-four (24) hour ADSAC should be attended prior to the initiation of the six (6) week substance abuse group.
   (B) Those with scoring appropriate for an Intervention Category Four or Five and placed at this level due to clinical override shall be required to attend:
      (i) Twelve (12) weeks of substance abuse related group meeting a minimum of one (1) time per week and a maximum of two (2) times per week; and
      (ii) Twelve (12) weeks of mutual support group attendance, once per week.
      (iii) It must be possible to complete the combination of interventions within ninety (90) days.
(3) All those identified as being at problem risk to recidivate shall be referred to clinical interventions only: Intervention Category Four shall be identified by alcohol or drug scale scores from the DRI II or DQ of seventy (70) to eighty nine (89) and recommendations shall consist of:
   (A) Intensive outpatient treatment;
   (B) Aftercare; and
   (C) Twelve (12) weeks of mutual support meetings.
   (D) Interventions recommended for this intervention category, with the exception of aftercare, should be completed concurrently.
   (E) The combination of interventions recommended must be able to be completed within ninety (90) days.
(4) All those identified as being at severe risk to recidivate shall be referred to clinical interventions only: Intervention Category Five will be identified by alcohol or drug scale scores from the DRI II/DQ of ninety (90) to one hundred (100) and recommendations shall consist of:
   (A) Residential or inpatient treatment;
   (B) Aftercare; and
   (C) Mutual support meetings.
(D) Interventions recommended for this intervention category, with the exception of aftercare, should be completed concurrently.

(E) The combination of interventions recommended must be able to be completed within ninety (90) days.

(5) If no groups are available or if the participant has a significant, appropriately diagnosed co-occurring disorder, then individual counseling can be substituted for group counseling. This must be addressed with an override and cleared through ODMHSAS.

(6) Interventions completed prior to the assessment may be accepted if:

(A) The intervention is completed after the offense resulting in license revocation;

(B) The intervention meets or exceeds all the requirements listed in the recommendation; and

(C) The provider of the intervention is appropriately accredited.

(7) Assessments will remain valid for six (6) months from the date of completion:

(A) If after six (6) months, action toward completing assessment recommendations has not been initiated, then the assessment shall be considered invalid and a new assessment will be required.

(B) The participant must be notified of this fact in writing upon assessment.

(8) A recommendation can be lowered one intervention category through the appropriate use of one of the available overrides. However, an intervention level for clinical services only or combination of educational and clinical services cannot be lowered to an intervention level for educational services only. ODMHSAS approval must be granted for overrides of more than one intervention category.

(9) Any significant discrepancy between the scores obtained on either the DRI II or the DQ and an appropriately chosen additional supportive instrument should be cause for reevaluation of participant’s answers to the assessment instruments. If the discrepancy cannot be resolved, then an override should be considered.

(10) Any recommendation can be lowered with the appropriate use of one of the following overrides:

(A) "Geographic accessibility";

(B) "On waiting list for appropriate level of care";

(C) "Language barriers";

(D) "Sustained abstinence"; or

(E) "ASAM override".

(11) In each instance, the most appropriate and applicable override category shall be used.

(12) All overrides must be supported in writing and with information or evidence that clearly justifies the decision made. Verifying and/or validating documentation must be included in the record.

(13) "Geographic accessibility" should be used when one or more of the services required for a specific intervention category does not exist within seventy (70) miles from the town the participant identifies as the home town, as no one shall be required to travel more than seventy (70) miles to complete any of the recommendations listed here:

(A) The recommendation should be reduced to the first intervention category with all services available, and

(B) Before using this override, the participant's address shall be verified.

(14) "On waiting list for appropriate level of care" should be used when one or more of the services required for a specific intervention category is not available within seventy (70) miles from the town the participant identifies as a home town as no one shall be required to travel more than seventy (70) miles to complete any of the recommendations listed here:

(A) The service recommended must also not be available within thirty (30) days of the initial date of assessment.

(B) The recommendation should be reduced to the first intervention category with all services available, and

(C) Before using this override, the participant's address shall be verified.

(15) "Language barriers" should be used when one or more of the services required for a specific intervention category is not offered in the language of a non-English speaking participant within seventy (70) miles from the town the participant identifies as the home town:

(A) The recommendation should be altered to include the most appropriate combination of interventions available in the participant's language.

(B) Due to problems with service availability caused by language barriers, this is the only override in which interventions from multiple categories can be commingled, and

(C) Before using this override, the participant's address shall be verified.

(16) "Sustained abstinence" should be used when an override may be appropriate when recognizing that a significant period of verifiable abstinence or recovery exists between the time of the offense and the assessment:

(A) The abstinence/recovery must be at least six (6) months' duration.

(B) The abstinence/recovery must be continuous.

(C) The abstinence/recovery must be verifiable.

(D) Three notarized statements from individuals who know, but are not related to, the participant, and

(E) The notarized statement verifying abstinence/recovery will be in a form prescribed by the commissioner of ODMHSAS or designee.

(17) "ASAM override" should be used when the participant has been assessed by a receiving provider as not meeting the ASAM level of care recommended by the ADSAC assessment. This override must be substantiated by including the receiving provider's ASAM in the participant's ADSAC file.
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450:21-7.9. Standardized evaluation instruments
(a) Standardized evaluation instruments shall be administered in the manner intended and findings shall be a component of the overall assessment and recommendations.
(b) The approved standardized evaluation instruments shall be limited to:
   (1) For all alcohol and drug related driving offenses resulting in license revocation, a completed and scored, current computerized version of the Driver Risk Inventory-II (DRI-II) in a face-to-face structured interview. For all non-driving alcohol and drug related convictions resulting in license revocation, a completed and scored, current computerized version of the Defendant Questionnaire (DQ) shall be used and;
   (2) A completed biopsychosocial;
   (3) A completed and scored additional, supportive clinical instrument to support initial findings shall be chosen by the assessor from the menu of approved supportive instruments listed below:
      (A) Needs Assessment (NEEDS); or
      (B) Triage Assessment for Addictive Disorders (TAAD); and
   (4) A thorough face-to-face interview.
   (5) All additional, supportive clinical assessment instruments shall be used only in a manner consistent with the instrument design, intended purpose and to support the identified level of severity of the participant;
   (6) All assessment instruments approved for use in the ADSAC process shall be used according to directions from the manual of each instrument; and
   (7) Assessment instruments appropriate for use with those with a primary language other than English shall be identified as the instruments are approved for use by ODMHSAS.

450:21-7.10. Denial or revocation of assessment certification
(a) ODMHSAS may reprimand, suspend, revoke or deny certification or renewal of the certification of any assessor failing to qualify for, or comply with the provisions of this Chapter.
(b) In the event that ODMHSAS determines action should be taken against any person certified under this Chapter, the proceeding shall be initiated pursuant to the rules of ODMHSAS as set forth in Oklahoma Administrative Code, Title 450, Chapter 1, Subchapter 5 and the Administrative Procedures Act.
(c) Assessors that have had certification renewal denied or certification revoked shall not be eligible for re-application for a period of one (1) year.
(d) Assessors whose certification has expired may apply for certification in accordance with 450:21-7.3.
(e) All those certified by ODMHSAS shall report all violations and suspected violations of this chapter to ODMHSAS staff assigned to the ADSAC division immediately.
(f) ODMHSAS may also impose the following administrative sanctions against any certified assessor for any of the following reasons, including, but not limited to:
   (1) Erroneous or false information contained in the individual’s application for certification;
   (2) A conviction of driving under the influence of alcohol or other intoxicating substances or receiving an alcohol or drug related revocation or suspension of driving privileges while certified as an assessor;
   (3) Any alcohol or drug related misdemeanor or felony conviction while certified as an assessor;
   (4) Unlawful conduct in the presence of a participant;
   (5) Conducting an assessment on more than one (1) participant at a time;
   (6) Tardiness or failure to make reports, or to transmit funds as required by this Chapter;
   (7) Erroneous or falsified information relating to any documents submitted to ODMHSAS;
   (8) Allowing a non-certified individual to conduct an assessment without a certified ADSAC assessor present at all times unless otherwise permitted by this Chapter;
   (9) Failure to maintain all records required by ODMHSAS;
   (10) Use of facilities not approved by ODMHSAS;
   (11) Any activity which is a conflict of interest;
   (12) Use of any intoxicating substance or illegal drugs while conducting an assessment;
   (13) Conducting an assessment while the participant is using or under the influence of any intoxicating substance causing impairment, including alcohol;
   (14) Dismissal by an ODMHSAS certified organization or institution for violation of state statutes, or of the standards and criteria in this Chapter;
   (15) Knowingly permitting any assessor to violate any rule of this Chapter, or any other relevant Chapter of these Administrative Rules;
   (16) Use of assessment instruments not pre-approved by ODMHSAS for use in ADSAC assessments as one of the standardized instruments;
   (17) Willful failure, or refusal, to cooperate with an investigation by ODMHSAS, or employing agency, into a potential or alleged violation of applicable rules in this Chapter;
   (18) Refusal to allow an ADSAC assessor candidate to observe an ADSAC assessment as required for training;
   (19) Issuance of completion certificate(s) to participant(s) who have not completed, or who fail to complete any ADSAC assessment recommendation requirement;
   (20) Violation of any applicable rule in this Chapter, or any other applicable Chapter;
   (21) Falsification of any report, or document submitted, or prepared for submission, to ODMHSAS and DPS;
   (22) Collecting fees for; or issuing receipts for; or issuing completion certificates for; or conducting an assessment during; or soliciting students for assessments at a later date during any ADSAC course;
   (23) Any sexual language or actions with or toward a participant;
   (24) Any other just and verifiable cause including, but not limited to, moral turpitude, unethical or illegal activities.
(25) Failure to wait at least a full fifteen (15) minutes when a participant is late for an assessment prior to canceling the session;
(26) Failure to provide ODMHSAS with the physical address for conducting assessments;
(27) Failure to complete ODMHSAS requirements for adding assessment sites;
(28) Failure to notify ODMHSAS of knowledge of any ADSAC assessor violations of this chapter, or of assessor terminations due to violations of this chapter;
(29) Establishing the legal business residence for the purpose of conducting assessments outside the state of Oklahoma;
(30) Violation of or failure to meet any applicable rule contained in this chapter;
(31) Knowingly allowing an assessor to conduct an assessment or solicit students for an assessment during an ADSAC; or
(32) Any other just and verifiable cause including but not limited to verbal or physical abuse of participants.

450:21-7-11. Inactive status and closure
An active ADSAC assessor certification may be placed on inactive status by written request:
1. An inactive certification forfeits all rights and privileges granted by the certification;
2. When certification is placed on inactive status, the certificate shall be returned to ODMHSAS along with the official stamp;
3. When certification is placed on inactive status, it shall remain inactive for at least twelve (12) months from the date of inactivation, or until the end of the certification period, whichever is first;
4. Active status may be re-established upon written request;
5. When an ADSAC assessor must cease operation for less than twelve (12) months all ADSAC assessment records must be secured as defined in 450:21-1-7.5;
6. During such a temporary closure ADSAC assessment records shall remain accessible as defined in 450:21-1-10;
7. Participants having received assessments shall be given written notification of the temporary closure with contact information for completing the ADSAC assessment process, in the event all recommendations are completed during the temporary closure; and
8. ODMHSAS shall be notified in writing within thirty (30) days of any temporary closure of any office providing ADSAC assessments. The written notification shall contain:
   (A) The reason for closing;
   (B) Contact information for participant assessment records; and
   (C) A projected date for resumption of business.

[OAR Docket #21-433; filed 6-14-21]
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to increase consistency and reduce regulatory language in accordance with Executive Order 2020-03.

CONTACT PERSON:
Melissa Miller, Policy Director and Administrative Rules Liaison, Melissa.Miller@odmhas.org or (405) 248-9345

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 15, 2021:

450:22-1-1. Purpose and applicability [REVOKED]
This chapter implements 43 A.O.S. § 3-160 through 3-461 and sets forth the standards and criteria for persons applying for certification and certified by ODMHSAS to conduct alcohol and drug assessment and evaluation related to driver's license revocation.

450:22-1-1.1. Certification duration [REVOKED]
ODMHSAS shall certify assessors for three (3) years.

450:22-1-3. Definitions [REVOKED]
The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Abuse" means the causing or permitting of harm or threatened harm to the health, safety, or welfare of a participant by a staff member responsible for the participant's health, safety, or welfare including, but not limited to:
(A) non-accidental physical injury or mental anguish;
(B) sexual abuse;
(C) sexual exploitation;
(D) use of mechanical restraints without proper authority;
(E) the intentional use of excessive or unauthorized force aimed at hurting or injuring the participant; or
(F) deprivation of food, clothing, shelter, or healthcare by staff responsible for providing these services to a participant.

"ADSAC" means Alcohol and Drug Substance Abuse Counselor.

"American Society of Addiction Medicine Patient Placement Criteria" or "ASAM-PPC" means the most recent clinical guide published by the American Society of Addiction Medicine to be used in matching patients to appropriate levels of care.

"Assessor" means an individual certified to conduct alcohol and other drug assessments related to driver's license revocation.

"Assessment" means a face-to-face clinical interview evaluating an individual's need and receptivity to substance abuse treatment and his or her prognosis.

"Assessment agency" means an agency certified by ODMHSAS to provide substance abuse treatment services authorized through Title 43A, 3-415, A 1, with an additional certification to provide ADSAC assessments using certified assessors.

"Audit" means a systematic inspection of accounting records, involving analyses, tests, and confirmations or the hearing or investigation by an auditor.

"Biopsychosocial Assessment" means a face-to-face clinical interview conducted by an ADSAC assessor designed to elicit historical and current information regarding the behavior and experiences of a participant and is designed to provide sufficient information for problem formulation, intervention planning, and formulation of appropriate substance abuse related clinical and/or educational interventions to reduce or eliminate recidivism.

"Certification" means ODMHAS approval for an individual or agency to conduct alcohol and other drug assessments related to driver’s license revocation.

"Certified Alcohol and Drug Counselor" or "CADC" means any person who is certified through the State of Oklahoma pursuant to the provisions of the Licensed Alcohol and Drug Counselors Act.

"Conflict of Interest" means a conflict between the private interests and public obligations of a certified institution, organization or assessor.

"Consumer" means an individual, adult or child, who has applied for, is receiving, or has received services, evaluation or treatment, from an entity operated or certified by ODMHAS, or with which ODMHAS contracts and includes all persons referred to in OAC Title 450 Chapters 16, 17, 18, 19 and 23 as client(s) or patient(s) or resident(s) or a combination thereof.

"Critical incident" means an occurrence or set of events inconsistent with the routine operation of an approved ADSAC assessor or assessment agency, or the routine work with a participant during the course of an ADSAC assessment. Critical incidents specifically include, but are not limited to, the following: adverse drug events; self-destructive behavior; deaths and injuries to the participant, participant's family, staff and visitors; medication errors; neglect or abuse of a participant; fire; unauthorized disclosure of information; damage to or theft of property belonging to a participant or an approved assessment agency; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or results.

"Defendant Questionnaire" or "DQ" is an automated assessment or screening instrument used in assessing an offender with alcohol or other drug involvement. This instrument contains scales to measure truthfulness, stress coping ability, and severity of alcohol or other drug abuse and classifies an individual as being either a substance abuser or substance dependent using the American Society of Addiction Medicine, patient placement criteria.

"DOC" means the Oklahoma Department of Corrections.

"DPS" means the Oklahoma Department of Public Safety.

"Driver Risk Inventory II" or "DRI-II" is an assessment or screening instrument, which contains six scales measuring truthfulness, driver risk, stress coping ability, and severity of alcohol or other drug abuse and classifies a participant as...
being either a substance abuser or substance dependent in compliance with current Diagnostic and Statistical Manual criteria.

"Evidenced-based practice" means programs or practices that are proven to be successful through research methodology and have produced consistently positive patterns of results.

"Group counseling" means a method of using various commonly accepted treatment approaches provided face-to-face by a treatment professional with two (2) or more participants that does not consist of solely related individuals, to promote positive emotional or behavioral change. Services rendered in this setting should be guided by the participant's treatment goals and objectives, and do not include social or daily living skill development as described in educational group counseling.

"Independent practitioner" means any professional, appropriately licensed or certified as an alcohol and drug counselor through the State of Oklahoma, pursuant to state law, and certified by ODMHSAS to conduct ADSAC assessments who does so through the format of a private practice.

"Individual counseling" means a method of using various commonly accepted treatment approaches provided face-to-face by a treatment professional with one participant to promote positive emotional or behavioral change.

"Intensive outpatient services" or "IOP" means an organized, non-residential outpatient treatment service with scheduled sessions that provide a range of nine (9) to fifteen (15) treatment hours per week. Intensive outpatient services may offer evening outpatient services several nights per week or be incorporated into an inpatient or residential treatment program in which the individual participates in daytime treatment services but goes home at night. Intensive Outpatient shall correspond to ASAM Patient Placement Criteria Treatment Level: Level III, Intensive outpatient.

"Licensed Alcohol and Drug Counselor" or "LADC" means any person who is licensed through the State of Oklahoma pursuant to the provisions of the Licensed Alcohol and Drug Counselors Act.

"Licensed Behavioral Health Professional" or "LBHP" means:

(A) Psychologist;
(B) Social Work (clinical specialty only);
(C) Professional Counselor;
(D) Marriage and Family Therapist;
(E) Behavioral Practitioner;
(F) Alcohol and Drug Counselor.

"Mutual support group" means a non-professional, widely available, peer-directed, system of support meetings, available at little or no charge to the participant, in a group format, dedicated to the support and teaching of the skills related to an alcohol and other drug-free lifestyle.

"Needs assessment" or "NEEDS" is a one-hundred and thirty (130) item comprehensive adult assessment instrument addressing attitude, emotional stability, employment, health, education, substance abuse, relationships, support systems, criminal history and supervision needs.

"Note" means a complete chronological written description of any intervention(s) provided to a participant requiring documentation. Notes may include the participant's response and are written by the ADSAC staff delivering the service.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"OSBI" means Oklahoma State Bureau of Investigation.

"Participant" means a person convicted of driving under the influence of alcohol or other intoxicating substances or who has received an alcohol or drug-related revocation or suspension of driving privileges in Oklahoma and is involved in the ADSAC process.

"Professional setting" means a building or site that is adequate and suitable for the purpose of providing adult education or assessment services, meeting all confidentiality requirements of 42 C.F.R. Part 2 and 45 C.F.R. Parts 160 & 164 (HIPAA), and without distraction or interruption from adjacent business or activities.

"Program" means a structured set of treatment activities designed to achieve specific objectives relative to the needs of individuals served by the facility and certified or recognized by ODMHSAS.

"Residential treatment" means treatment for a participant in a live-in setting which provides a twenty-four (24) hour therapeutic regimen. Corresponding ASAM Patient Placement Criteria Treatment Level: Level III. 5. Clinically managed High-Intensity Residential Services.

"Sentinel event" is a type of critical incident that is an unexpected occurrence involving the death or serious physical or psychological injury to a participant, or risk thereof. Serious injury specifically includes loss of limb or limb function. The phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a participant. These events signal the need for immediate investigation and response. Sentinel events include, but are not limited to: suicide, homicide, criminal activity, assault and other forms of violence, including domestic violence or sexual assault, and adverse drug events resulting in serious injury or death.
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"TAAD" or "Triage Assessment for Addictive Disorders" is a very brief, structured interview covering current alcohol and drug problems related to DSM-IV criteria for substance abuse and dependency. The TAAD is intended to be presented as an interview and not as a paper and pencil instrument.

"Victims Impact Panel!" or "VIP" means the two (2) hour presentation identified statutorily, intended to enhance awareness of the participant regarding possible impact on others by the individual while impaired.

450:22-1.4. Meaning of verbs in rules [REVOKED]
The attention of the assessment agency and practitioner is drawn to the distinction between the use of the words "shall," "should," and "may" in this chapter:
(1) "Shall" is the term used to indicate a mandatory statement, the only acceptable method under the present standards.
(2) "Should" is the term used to reflect the most preferable procedure, yet allowing for the use of effective alternatives.
(3) "May" is the term used to reflect an acceptable method that is recognized but not necessarily preferred.

450:22-1.5. General statement [REVOKED]
The following standards and criteria govern:
(1) Certification of individuals and agencies approved to provide assessment services;
(2) Assessment standards;
(3) Assessment responsibilities and activities of certified assessors and assessment agencies; and
(4) Requirements for reporting completed assessments to ODMHAS.

450:22-1.6. ADSAC assessors and assessment agencies [REVOKED]
(a) Alcohol and other drug assessments shall be provided by individuals or agencies certified by ODMHAS to provide alcohol and drug assessment and evaluation programs related to driver’s license revocation. ODMHAS certified community mental health centers, ODMHAS certified alcohol and drug treatment programs, and probation offices shall be considered for such certification.
(b) Certified assessors and assessment agencies shall:
(1) Recommend and monitor certified assessors for compliance to applicable rules within Title 450; and
(2) Provide assessment services only at sites approved by ODMHAS.
(c) Certified assessors and assessment agencies are responsible for:
(1) Reporting assessment data to ODMHAS in the time frames set forth in this Chapter;
(2) Make recommendations based upon ODMHAS-required assessment instruments;
(3) Ensure exception findings meet current American Society of Addiction Medicine’s (ASAM) over ride criteria; and
(4) Providing liaison with ODMHAS, the courts and other agencies.
(d) Each agency certified to conduct assessments for the evaluation related to driver's license revocation shall be responsible for the conduct of assessors they employ, and shall have written policies outlining the agency's oversight procedures to include, but not limited to, financial arrangements with the participant.

450:22-1.6.1. Institutional and organizational description, assessment agencies [REVOKED]
(a) The certified assessment agency shall have a written organizational description. The written organizational description at a minimum shall include:
(1) defining the overall target population for whom services will be provided;
(2) stating in writing the overall mission statement; and
(3) stating in writing the agency goals and objectives.
(b) There shall be documentation that these statements have been approved by the certified agencies governing authority.
(c) The certified assessment agency shall have documentation demonstrating these documents are available and communicated to ADSAC staff.
(d) The certified assessment agency shall have documentation demonstrating these documents are available to the general public upon request.
(e) Each certified assessment agency shall have in writing, the following:
(1) Identification of the ADSAC assessors to provide these services; and
(2) Admission and exclusionary criteria to identify the type of participants for whom the ADSAC services are primarily intended.
(f) The certified agency shall have a written statement of the procedures and plans for attaining goals and objectives. These procedures and plans should define specific tasks, set target dates and designate staff responsible for carrying out the procedures and plans.

450:22-1.7. ODMHAS responsibilities [REVOKED]
ODMHAS shall have the authority and duty to:
(1) Monitor assessors and assessment agencies for compliance with applicable State and Federal laws and the rules of this Chapter;
(2) Establish, monitor and enforce reporting requirements and report forms;
(3) Certify assessors and assessment agencies;
(4) Approve sites for assessment services;
(5) Upon receipt of a valid written request for release of information, certify to DPS that a person has participated in and successfully completed an ADSAC evaluation and assessment program;
(6) Ensure compliance with the rules in this Chapter as determined by a review of ADSAC-related records, documents and reports, staff and participant interviews and any other relevant documentation;
(7) Conduct compliance review of all assessors and assessment agencies; and
(8) Establish training requirements for all assessors.

450:22-1-8. Consumers with disabilities [REVOKED]  
Each site shall have a written policy addressing its awareness of, and intent to comply with, the U.S. Americans with Disabilities Act of 1990.

450:22-1-9. Certified approved sites [REVOKED]  
Alcohol and other drug assessment and evaluation shall be provided at sites approved by ODMHSAS. Sites shall meet the following standards for consideration of approval:
(1) Sites shall be in professional settings appropriate for the assessment and for safeguarding the confidentiality of the participant;
(2) Hours and days of operation shall be during regularly scheduled periods which make assessment services accessible to participants, including those employed between 8:00 a.m. and 5:00 p.m., and to the general public;
(3) The site's days and hours of operation shall be professionally and conspicuously displayed on the outside of the building along with a business phone number used for scheduling of appointments;
(4) For sites in multi-office buildings, the days and hours of operation shall be posted in the building directory or on the door of the site office;
(5) Sites for the primary purpose of eating or sleeping, i.e., hotel/motel or sleeping rooms, restaurant dining areas, etc., will not be considered for approval; and
(6) Sites shall be handicapped-accessible and meet all other requirements of the Americans with Disabilities Act of 1990.

450:22-1-10. Participant evaluation [REVOKED]  
(a) The assessment and evaluation of the participant shall be as comprehensive as possible. ADSAC assessors shall not conduct any portion of the assessment process or provide any evaluation services on more than one participant at a time. The assessment shall include, but not be limited to:
(1) A formal face-to-face biopsychosocial assessment (see OAC 450:22-1-11.7 for requirements).
(2) The assessor shall obtain and document the participants driving history information from public record(s) when made available. This information shall, at a minimum, include the following:
(A) Arrest date;
(B) All charges relating to alcohol and drug offenses, and
(C) Driving record.
(2) Alcohol and other drug information as supplied by the participant or referring party.

(A) Blood alcohol concentration at time of arrest;
(B) Prior alcohol/drug treatment;
(C) Polydrug use;
(D) Prior alcohol-related arrest(s); and
(E) Prior drug-related arrest(s).
(4) Pursuant to 450:22-1-11, the use of completed and scored standardized evaluation instruments; and
(5) All information shall be in a format prescribed by the Commissioner of ODMHSAS or designee.
(b) Recommendations, known as Intervention Categories, shall be based on scores derived from and verified by a battery of required and appropriate assessment/evaluation instruments, and adhered to by all assessors unless otherwise indicated by ODMHSAS.
(1) All those identified as being at low risk to recidivate as indicated by scores derived from the assessment process shall be referred to educational interventions only:
(A) Intervention Category One shall be identified by alcohol or drug scale scores from the DRI I or DQ of zero (0) to thirty-nine (39) and recommendations shall consist of:
(i) ten (10) hour ADSAC course, and
(ii) Victim-Impact Panel;
(iii) the ten (10) hour ADSAC course and Victim-Impact Panel may be attended concurrently.
(B) Intervention Category Two shall be identified by alcohol or drug scale scores from the DRI I or DQ of zero (0) to thirty-nine (39) and a previous alcohol or drug-related offense resulting in license revocation pursuant to Title 47, § 6-212-2. A and recommendations shall consist of:
(i) twenty-four (24) hour ADSAC course, and
(ii) Victim-Impact Panel;
(iii) the twenty-four (24) hour ADSAC course and the Victim-Impact Panel may be attended concurrently.
(2) All those identified as being at moderate risk to recidivate shall be referred to a combination of educational and clinical interventions:
(A) Intervention Category Three, shall be identified by alcohol or drug scale scores from the DRI I or DQ of forty (40) to sixty-nine (69) and recommendations shall consist of:
(i) twenty-four (24) hour ADSAC course, and
(ii) Victim-Impact Panel;
(iii) substance abuse related group involvement for six (6) weeks, meeting one (1) time per week.
(iv) The twenty-four (24) hour ADSAC should be attended prior to the initiation of the six (6) week substance abuse group;
(B) Those with scoring appropriate for an Intervention Category Four or Five and placed at this level due to clinical override shall be required to attend:
(i) twelve (12) weeks of substance abuse related group meeting a minimum of one (1) time per week and a maximum of two (2) times per week, and
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(ii) twelve (12) weeks of mutual support-group attendance, once per week, and
(iii) It must be possible to complete the combination of interventions within ninety (90) days.
(3) All those identified as being at problem risk to recommit shall be referred to clinical interventions only:
(A) Intervntion Category Four shall be identified by alcohol or drug scale scores from the DRI II or DQ of seventy (70) to eighty nine (89) and recommendations shall consist of:
(i) intensive outpatient treatment, and
(ii) aftercare, and
(iii) twelve (12) weeks of mutual support meetings.
(iv) Interventions recommended for this intervention category, with the exception of aftercare, should be completed concurrently.
(v) The combination of interventions recommended must be able to be completed within ninety (90) days.
(4) All those identified as being at severe risk to recommit shall be referred to clinical interventions only:
(A) Intervention Category Five will be identified by alcohol or drug scale scores from the DRI II/DQ of ninety (90) to one hundred (100) and recommendations shall consist of:
(i) residential or inpatient treatment, and
(ii) aftercare, and
(iii) mutual support meetings.
(iv) Interventions recommended for this intervention category, with the exception of aftercare, should be completed concurrently.
(v) The combination of interventions recommended must be able to be completed within ninety (90) days.
(5) If no groups are available or if the participant has a significant, appropriately diagnosed co-occurring disorder, then individual counseling can be substituted for group counseling. This must be addressed with an override and cleared through ODMHSAS.
(6) Interventions completed prior to the assessment may be accepted if:
(A) the intervention is completed after the offense resulting in license revocation, and
(B) the intervention meets or exceeds all the requirements listed in the recommendation, and
(C) the provider of the intervention is appropriately accredited.
(7) Assessments will remain valid for six (6) months from the date of completion:
(A) If after six (6) months, action toward completing assessment recommendations has not been initiated, then the assessment shall be considered invalid and a new assessment will be required, and
(B) The participant must be notified of this fact in writing upon assessment.
(8) A recommendation can be lowered one intervention category through the appropriate use of one of the available overrides. However, an intervention level for clinical services only, or combination of educational and clinical services cannot be lowered to an intervention level for educational services only. ODMHSAS approval must be granted for overrides of more than one intervention category.
(9) Any significant discrepancy between the scores obtained on either the DRI II or the DQ and an appropriately chosen additional supportive instrument should be cause for reevaluation of participant’s answers to the assessment instrument. If the discrepancy cannot be resolved, then an override should be considered.
(10) Any recommendation can be lowered with the appropriate use of one of the following overrides:
(A) “geographic accessibility”,
(B) “on waiting list for appropriate level of care”,
(C) “language barriers”,
(D) “sustained abstinence” or
(E) “ASAM override”.
(11) In each instance, the most appropriate and applicable override category shall be used.
(12) All overrides must be supported in writing and with information or evidence that clearly justifies the decision made. Verifying and/or validating documentation must be included in the record.
(13) “Geographic accessibility” should be used when one or more of the services required for a specific intervention category does not exist within seventy (70) miles from the town the participant identifies as the home town, as no one shall be required to travel more than seventy (70) miles to complete any of the recommendations listed here:
(A) The recommendation should be reduced to the first intervention category with all services available, and
(B) Before using this override, the participant’s address shall be verified.
(14) “On waiting list for appropriate level of care” should be used when one or more of the services required for a specific intervention category is not available within seventy (70) miles from the town the participant identifies as a home town as no one shall be required to travel more than seventy (70) miles to complete any of the recommendations listed here:
(A) The service recommended must also not be available within thirty (30) days of the initial date of assessment,
(B) The recommendation should be reduced to the first intervention category with all services available, and
(C) Before using this override, the participant’s address shall be verified.
(15) “Language barriers” should be used when one or more of the services required for a specific intervention category is not offered in the language of a non-English
speaking participant within seventy (70) miles from the
town the participant identifies as the home town.
(A) The recommendation should be altered to in-
clude the most appropriate combination of inter-
ventions available in the participant’s language.
(B) Due to problems with service availability
caused by language barriers, this is the only override
in which interventions from multiple categories can
be commingled, and
(C) Before using this override, the participant’s ad-
dress shall be verified.
(16) “Sustained abstinence” should be used when an
override may be appropriate when recognizing that a
significant period of verifiable abstinence or recovery
exists between the time of the offense and the assessment.
(A) The abstinence/recovery must be at least six (6)
months’ duration,
(B) The abstinence/recovery must be continuous,
(C) The abstinence/recovery must be verifiable,
(D) Three notarized statements from individuals
who know, but are not related to, the participant, and
(E) The notarized statement verifying abstinence/recovery will be in a form prescribed by the
commissioner of ODMHSAS or designee.
(17) “ASAM override” should be used when the partici-
pants has been assessed by a receiving provider as not meet-
ing the ASAM level of care recommended by the ADSAC
assessment. This override must be substantiated by in-
cluding the receiving provider’s ASAM in the participant’s
ADSAC file.

450:22-1-11. Standardized evaluation instruments
[REVOKED]
(a) Standardized evaluation instruments shall be adminis-
tered in the manner intended and findings shall be a component
of the overall assessment and recommendations.
(b) The approved standardized evaluation instruments shall be
limited to:
(1) For all alcohol and drug-related driving offenses
resulting in license revocation, a completed and scored,
current computerized version of the Driver Risk Inven-
tory II (DRI-II) in a face to face structured interview. For
all non-driving alcohol and drug-related convictions re-
sulting in license revocation, a completed and scored, cur-
cent computerized version of the Defendant Questionnaire
(DQ) shall be used and;
(2) A completed biopsychosocial;
(3) A completed and scored additional, supportive clinical
instrument to support initial findings shall be chosen by the
assessor from the menu of approved supportive instru-
ments listed below:
(A) Needs Assessment (NEEDS); or
(B) Triage Assessment for Addictive Disorders
(TAAD); and
(4) A thorough face to face interview.
(5) All additional, supportive clinical assessment instru-
ments shall be used only in a manner consistent with
the instrument design, intended purpose and to support the
identified level of severity of the participant;
(6) All assessment instruments approved for use in the
ADSAC process shall be used according to directions
from the manual of each instrument; and
(7) Assessment instruments appropriate for use with
those with a primary language other than English shall
be identified as the instruments are approved for use by
ODMHSAS.

450:22-1-11.1. Critical incidents, assessors and
assessment agencies [REVOKED]
(a) The ADSAC assessor or assessment agency shall report
every critical incident. Documentation of critical incidents
shall minimally include:
(1) The facility, name and signature of the person(s)
reporting the incident;
(2) The name(s) of the participant(s), staff member(s)
or property involved;
(3) The time, date and physical location of the incident;
(4) The time and date the incident was reported and the
name of the staff person within the facility to whom it was
reported;
(5) A description of the incident;
(6) Resolution or action taken, description of the action
taken, date action was taken, and signature of appropriate
staff member(s); and
(7) Severity of each injury, if applicable. Severity shall
be indicated as follows:
(A) No off-site medical care required or first aid
care administered on-site;
(B) Medical care by a physician or nurse or follow-
up attention required; or
(C) Hospitalization or immediate off site medical
attention was required.
(b) Critical incidents shall be reported to ODMHSAS as fol-
lows:
(1) Critical incidents requiring medical care by a physi-
cian or nurse or follow-up attention and incidents requiring
hospitalization or immediate off site medical attention
shall be delivered via fax or mail to ODMHSAS Provider
Certification within twenty-four (24) hours of the incident
being documented;
(2) Critical incidents involving allegations constituting
a sentinel event or patient abuse shall be reported to
ODMHSAS immediately via telephone or fax, but not
more than twenty four (24) hours of the incident. If
reported by telephone, the report shall be followed with
a written report within twenty-four (24) hours.
(c) Critical incidents involving those involved in the AD-
SAC process shall be reported to Provider Certification.

450:22-1-11.2. Participant record system [REVOKED]
(a) Each ADSAC assessor and assessment agency shall
maintain an organized system for the content, confidentiality,
storage retention and disposition of participant records.
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(h) The assessor or assessment agency shall have required documentation within the record.
(c) Participant records shall be contained within equipment which shall be maintained under locked and secure measures.
(d) The assessor and assessment agency shall maintain identification and filing systems which enable prompt record location and accessibility by appropriate ADSAC assessors and other treatment professionals.
(e) Participant records shall be maintained in the facility or office where the individual is being served. In the case of temporary office space and satellite offices, records may be maintained in the main (permanent) office and transported in secured locked boxes in vehicle trunks to and from satellite offices, when necessary. Participant records may be permanently maintained at the administrative offices, however, a working copy of the participant record for the purposes of documentation and review of services provided must be maintained at the site in which the participant is receiving services.
(f) The assessor and assessment agency shall store, retain and dispose of participant records in the manner set forth in this Chapter. These procedures shall be compatible with protection of participant rights against confidential information disclosure at a later date. ODMH SAS operated facilities shall comply with Records Disposition Schedule 82-17 as approved by the Oklahoma Archives and Records Commission.

450:22-1-11.3. Participant records, basic requirement assessors, assessment agencies [REVOKED]

All participant records shall be developed and maintained to ensure that all appropriate individuals have access to relevant clinical and other information regarding the participant. The participant record shall communicate information in a manner that is organized, clear, complete, current, and legible. All participant records shall contain the following:

1. Entries in participant records shall be legible, signed with first name or initial, last name, and date by the person making the entry;
2. The participant shall be identified by name on each sheet in the participant record, on both sides of each page if both sides are used; and
3. A signed consent for assessment shall be obtained before any person can receive an ADSAC assessment and, placed in the participants record.

450:22-1-11.4. Participant record storage, retention and disposition [REVOKED]

(a) Each assessment agency and ADSAC assessor shall:

1. Limit access to participant records to persons on a need to know basis;
2. Require participant records be stored under lock and key; and
3. With respect to closed participant records, require:
   (A) Confidential storage under lock and key;
   (B) Record disposition and destruction under confidential conditions; and

(c) Maintain written assessment documentation to be available for participants for a minimum of six (6) years after completion of all assessment requirements. Written documentation shall include, but not be limited to:

1. completed assessment instrument(s) and associated raw data;
2. notes; and
3. referrals and recommendations made as a result of the assessment; and
4. verification of each requirement of the recommended intervention level prior to affixing the red stamp.

(b) EXCEPTION: With regard to 450:18-7-1(a) (3)(B), facilities operated by ODMH SAS shall comply with the provisions of the Records Disposition Schedule for said facility as approved by the Oklahoma Archives and Records Commission [67 O.S. § 305 and OAC 60:1-1-2].

450:22-1-11.5. Confidentiality of drug or alcohol abuse treatment information [REVOKED]

(a) The confidentiality of all drug or alcohol abuse treatment information and records shall be kept, recorded, released, maintained, and provided to requesting parties in accordance with state and federal laws.

(b) All assessors and assessment agencies shall protect the confidential and privileged nature of substance abuse treatment information in compliance with state and federal law by ensuring at a minimum:

1. all substance abuse treatment information, whether recorded or not, and all communications between an ADSAC assessor, staff and a participant are both privileged and confidential and will not be released without the written consent of the participant or the participant’s legally authorized representative;
2. the identity of a participant who has received or is receiving substance abuse treatment services is both confidential and privileged and will not be released without the written consent of the participant or the participant’s legally authorized representative;
3. to limit access to substance abuse treatment information to only those persons or agencies actively engaged in the treatment of the participant and to the minimum amount of information necessary to carry out the purpose for the release;
4. a participant, or the participant’s legally authorized representative, may access the participant’s substance abuse treatment information;
5. certain state and federal law exceptions to disclosure of drug or alcohol abuse treatment information without the written consent of the participant or the participant’s legally authorized representative exist and the agency will release information as required by those laws; and
6. to notify a participant of his or her right to confidentiality.
450:22-1-11.6. Note [REVOKED]
When addressing any issues related to the ADSAC assessment process that must be reflected in written documentation in the participant’s ADSAC assessment record, the following shall be included:

1. Date;
2. Start and stop time for each assessment or session referenced;
3. Signature of the staff person providing the service;
4. Credentials of the staff person providing the service;
5. Participant response, if present;
6. Any problems identified; and
7. Any interventions.

450:22-1-11.7. Biopsychosocial assessment [REVOKED]
All assessors shall complete a biopsychosocial assessment which gathers sufficient information that could assist the participant, and includes the following items:

1. Behavioral, including substance use, abuse, and dependence;
2. Emotional, including issues related to past or current trauma;
3. Physical;
4. Social and recreational; and
5. Vocational.

450:22-1-12. Assessor applicants [REVOKED]
(a) An applicant for certification as an assessor shall submit proof of the following:

1. Proof of current licensure as an LBHP or certification as an alcohol and drug counselor acting within scope of licensure/certification or proof of current status as a Licensure Candidate under the onsite supervision of a certified ADSAC assessor; and
2. Proof of having at least two (2) years documented full-time clinical experience in drug-alcohol treatment counseling; and
3. Proof of successful completion of a one (1) day ASAM training within two (2) years of the submission of the application; and
4. A recognizable, current, color photographic image of the applicant no smaller than two (2) inch by two (2) inch;
5. A current OSBI background check or a similar background check from another state of residence for the past five (5) years; and
6. A copy of the applicant’s resume documenting all education and employment for the previous ten (10) years to include names, addresses and phone numbers for all employers; and
7. Fees.

(b) Applications for certification as an assessor shall be made in writing to ODMHSAS on a form in a manner prescribed by the Commissioner or designee.

c) Completed applications must be received by ODMHSAS twenty (20) days prior to the training event. Before being certified, the applicant shall:

1. Observe one (1) assessment with written permission of the participant prior to completing new assessor training;
2. Complete the ODMHSAS new assessor training; and
3. Complete and pass the ODMHSAS assessment skills competency examination. A minimum score to pass the exam shall be eighty (80) percent:
   1. the exam shall require the applicant to correctly identify the major aspects of the Driver Risk Inventory-revised (DRI-II), and the Defendant Questionnaire (DQ);
   2. the exam shall require the applicant to correctly identify the major components of motivational interviewing; and
   3. the exam shall require the applicant to correctly identify rules from this chapter.
4. Conduct two (2) assessments, after completing the new assessor training under the supervision of a certified ADSAC assessor, with written permission of the participant; and
   1. Submit a copy of one written court report completed by the applicant on each assessment;
   2. The observing assessor shall submit an evaluation of the applicant’s skill level on a form and in a manner prescribed by the ODMHSAS Commissioner or designee.

(d) ODMHSAS may require explanation of negative references prior to issuance of certification.
(e) Faxes will not be accepted as part of a permanent record.
(f) Applications are good for one (1) year from approval. All requirements must be completed within the initial twelve (12) month period or a new application must be submitted.
(g) Any prior sanctions by ODMHSAS of an individual may be cause for denial of an assessor application.
(h) An assessor applying for renewal shall submit the following for ODMHSAS review:

1. Complete ODMHSAS renewal application form;
2. Submit documentation of receiving ten (10) continuing education hours in each twelve (12) month period beginning with the date of original certification. Acceptable continuing education hours shall include the following subject areas with four (4) hours coming from area (A), four (4) hours coming from area (B) and two (2) hours coming from area (C):
   1. the application and use of the following:
      i. ASAM;
      ii. DRI;
      iii. DQ;
      iv. NEEDS; and
      v. TAAD;
   2. Evidence-based interview techniques;
   3. General Substance Abuse;
   4. If a mandatory training is required by ODMHSAS the hours may come from area (C) above.
   5. Training hours shall not include ADSAC course facilitation; and
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(3) A new recognizable, current, photographic image of the applicant every six years no smaller than two (2) inch by two (2) inch, with any qualifying recertifications occurring on or after July 1, 2008;

(4) Provide ODMHSAS a new OSBI background check for the applicant every six years, with any qualifying recertifications occurring on or after July 1, 2008;

(5) The fifty dollar ($50) application renewal fee for certification and

(6) Any unpaid fees required by 450:22-1-15(7)(A).
Renewal applications with outstanding unpaid fees will not be processed until a resolution is reached regarding payment of outstanding fees.

(1) In addition to submitting an application and fulfilling the renewal standards for certification per 221-1-12(h) and 221-1-15(e)(14), a review of consumer and agency documentation shall be performed. A score of at least 75% on clinical standards must be achieved in order to move forward with certification. The process will follow that of agency certifications found in Title 450:1-9.72. All deficiencies must be resolved in order for certification to be renewed.

(1) Certification shall be valid for thirty-six (36) months.

(6) Failure to timely renew the certification shall result in expiration of certification and forfeiture of the rights and privileges granted by the certification.

(1) A person whose certification has expired for less than twelve (12) months must make application for an initial certification as set forth in 450:22-1-12 with the exception of attending the initial ADSAC assessor training or having to pass the training exam.

(2) A person whose certification has expired for twelve (12) months or more must make application for an initial certification as set forth in 450:22-1-12.

(1) Each assessor shall notify ODMHSAS of any change of application information related to his or her licensure status, email address, phone number, work or home address at least fifteen (15) days in advance of the change. In case of an emergency, the assessor may notify ODMHSAS of any change up to thirty (30) days after a change has occurred.

(1) All renewals of certification are due on the third anniversary of certification.

450:22-1-15. Assessor responsibilities [REVOKED]

(a) ADSAC assessments shall be provided by individuals certified by ODMHSAS to provide such assessments.

(b) All fees due ODMHSAS shall be remitted within thirty (30) days. Any fees identified as being delinquent shall be paid within thirty (30) days of discovery of the omission.

(c) Certified assessors shall:

(1) Conduct assessments and based on assessment findings, recommend education or treatment; or both;

(2) Report to the court within seventy-two (72) hours of completing an assessment if the court is anticipating such a report;

(3) Provide information in writing regarding state and local area education and treatment resources specific to the area in which the participant resides, to such individual assessed appropriate to the referral recommendations and, in a format prescribed by the Commissioner of ODMHSAS or designee;

(4) Manage and distribute all reports according to confidentiality laws under 42 CFR, Part 2, as well as all 45 C.F.R. Parts 160 & 164 (HIPAA) regulations and inform all participants that all contacts, evaluation results and reports are protected through federal confidentiality regulations under 42 CFR, Part 2;

(5) Assure there is no conflict of interest by:

(A) referring participants to only those services in which the assessor has no vested interest;

(B) providing three (3) outside referral options in writing for each recommended service, or as many options as available within a 70 mile radius; and

(C) maintaining written assessment documentation pursuant to 221-1-11.4(a)(3)(C).

(d) Provide liaison with court officials and related other agencies;

(e) The fee for those undergoing an assessment and evaluation as a result of their driving privilege being suspended or revoked pursuant to an arrest on or after November 1, 2008 is one hundred sixty dollars ($160.00). The fee for those undergoing an assessment and evaluation as a result of their driving privilege being suspended or revoked pursuant to an arrest prior to November 1, 2008 is one hundred seventy-five dollars ($175.00);

(A) Remit 10% of each fee collected for any assessment and evaluation completed as a result of a person's driving privilege being suspended or revoked pursuant to an arrest prior to November 1, 2008 to the State Treasurer to be credited to the Department of Mental Health and Substance Abuse Services Revolving Fund within thirty (30) days. No such 10% fee shall be remitted for any assessment and evaluation completed as a result of a person's driving privilege being suspended or revoked pursuant to an arrest on or after November 1, 2008. Completion of assessment includes payment in full by the participant for the assessment service; and

(B) No additional charges, extra fees or interest shall be attached to the assessment process.

(f) Explain possible liability and ability to pay for ODMHSAS affiliated, private and other education and treatment facilities;

(g) For those participants whose license was withdrawn due to an alcohol and drug related offense on or before June 30, 2003, and needing to participate in the ADSAC assessment process for license reinstatement, as verified by DPS, the assessor shall:

(A) verify the participant has completed the assessment to include payment in full;

(B) affix the official red stamp;

(C) provide the participant with a certificate of completion; and

(D) report completion to the Department of Public Safety through ODMHSAS.

(h) For those participants whose license was withdrawn due to receiving an alcohol and drug related offense
on or after July 1, 2003, and needing to participate in the ADSAC assessment process for license reinstatement, the assessor shall:

(A) verify the participant has completed the ADSAC assessment to include payment in full;

(B) verify the participant has completed all recommendations identified through the assessment and required for license reinstatement prior to affixing the official stamp;

(C) affix the official stamp, with the stamp in red ink;

(D) provide the participant with a certificate of completion; and

(E) report completion to the Department of Public Safety through ODMHSAS;

(14) Those participants whose most recent offense was before September 1, 1993 should be referred to DPS to verify an assessment is not required.

(12) Provide ODMHSAS notification of those participants successfully completing required education and treatment, including the participant's name, address, date of birth and driver's license number through the online data entry system known as ADSAC online, or in a manner prescribed by the Commissioner or designee. This notification shall be submitted to ODMHSAS within seventy-two (72) hours upon verification of successful completion of all requirements;

(13) Certified ADSAC assessors and agencies must provide a caller adequate information regarding the ADSAC assessment process and scheduling requirements. The phone number published specific for each assessor must be continuously available, either answered in person, answering machine, electronic voice mail, or a professional answering service. Numbers published for the purpose of ADSAC assessment and evaluation advertisement must be answered by individuals appropriately trained in all relevant aspects of 42 CFR, Part 2 and HIPAA regulations;

(14) All assessors will complete a minimum of six (6) ADSAC assessments during each twelve (12) month period in order for assessor certification to remain active;

(15) Each assessor and program shall maintain an inventory of required and approved instruments sufficient to meet ODMHSAS requirements;

(16) Provide each individual assessed with information regarding all assessor certifications and licensures to include: name, phone number and address of the certifying or licensing body. If certified rather than licensed, the name of the licensed individual serving as supervisor with all licensures including; name, phone number and addresses of the licensing bodies pursuant to Oklahoma state statutes. Contact information for ODMHSAS, ADSAC personnel at ODMHSAS shall be included. All information shall be in a form prescribed by the Commissioner of ODMHSAS or designee;

(17) Each certified assessor shall notify ODMHSAS of any change of application information related to his or her email address, phone number, work or home address at least 15 days in advance of the change. In case of an emergency, the assessor may notify ODMHSAS of any change up to 30 days after a change has occurred;

(18) For participants who have a language other than English:

(A) The participant shall be referred to an ADSAC assessor fluent in that language, if such an assessor is available. If no assessor fluent in the language is available then an interpreter shall be present for the entire assessment process; and

(B) If an interpreter is required, the interpreter shall not be younger than eighteen (18) years of age and should not be related to the participant.

(19) Provide assessment services only at sites approved by ODMHSAS;

(20) Report all data to ODMHSAS within thirty (30) days or as otherwise directed in this Chapter;

(21) Make recommendations based on ODMHSAS required assessment instruments;

(22) Make all recommendations based on current accepted placement criteria; and

(23) Preference in clinical referrals shall be given to institutions and organizations possessing a substance abuse certification from ODMHSAS, if such service is available.

450:22-1-15.1. Fitness of applicants [REVOKED]

(a) The purpose of this section is to establish the fitness of the applicant as one of the criteria for approval of certification as an assessor for evaluations related to driver's license revocation, and to set forth criteria by which the Commissioner or designee may determine the fitness of applicants.

(b) The substantiation of the items below related to the applicant may result in the initiation of suspension or revocation of certification, or denial of, or delay of certification of the applicant. These items include, but are not limited to:

(1) Evidence of the lack of necessary skill and abilities to provide adequate services;

(2) Misrepresentation on the application or any other materials submitted to the ODMHSAS;

(3) A violation of the rules of professional conduct set forth in this Chapter;

(4) Evaluations of supervisors, employers or instructors;

(5) Allegations from other governmental entities;

(6) Findings resulting from investigations prompted by allegations of participants, peers or the public;

(7) Transcripts or other findings from official court, hearing or investigative procedures;

(8) Any convictions for alcohol and other drug related offenses, violent offenses, or moral turpitude within the last five (5) years;

(9) Any unpardoned felony convictions within five (5) years;

(10) The revocation, suspension, reprimand or any other administrative action ordered by another certifying or licensing body may result in the denial, revocation or suspension of assessor certification by ODMHSAS;
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(c) ODMHSAS may require explanation of negative references prior to issuance of certification.
(d) Those certified to conduct ADSAC assessments by ODMHSAS shall not perform such assessments when, for any reason, such services are impaired by an inability to perform such services—Assessors shall seek assistance for any problems creating an inability to perform as an assessor, and, if necessary, limit, suspend or terminate the delivery of ADSAC assessment services.
(e) A field examination submitted through questionnaires answered by persons competent to evaluate an assessor’s professional competence which may include the submission of such documentary evidence relating to an assessor’s experience and competence as required by ODMHSAS may be required.
(f) If in the course of an investigation, ODMHSAS determines that an assessor has engaged in conduct of a nature that is detrimental to the health, safety, or welfare of the public, and which conduct necessitates immediate action to prevent further harm, the Commissioner may order a summary suspension of the assessor’s certification to conduct ADSAC assessments.
(g) ODMHSAS may require remedial interventions to address any problems or deficiencies identified from this section as a requirement for retaining active certification.

450:22-1-16. Denial or revocation of assessment certification [REVOKED]
(a) ODMHSAS may reprimand, suspend, revoke or deny certification or renewal of the certification of any assessor or assessment agency failing to qualify for, or comply with the provisions of this Chapter.
(b) In the event that ODMHSAS determines action should be taken against any person certified under this Chapter, the proceeding shall be initiated pursuant to the rules of ODMHSAS as set forth in Oklahoma Administrative Code, Title 450, Chapter 1, Subchapter 5 and the Administrative Procedures Act.
(c) Assessors and assessment agencies that have had certification renewal denied or certification revoked shall not be eligible for re-application for a period of five (5) years.
(d) Assessors and assessment agencies whose certification has expired may apply for certification in accordance with 450:27-1-12.
(e) All those certified by ODMHSAS shall report all violations and suspected violations of this chapter to ODMHSAS staff assigned to the ADSAC division immediately.
(f) ODMHSAS may also impose the following administrative sanctions against any certified assessor or assessment agency for any of the following reasons, including, but not limited to:
   (1) Erroneous or false information contained in the individual’s application for certification;
   (2) A conviction of driving under the influence of alcohol or other intoxicating substances or receiving an alcohol or drug related revocation or suspension of driving privileges while certified as an assessor;
   (3) Any alcohol or other drug related misdemeanor or felony conviction while certified as an assessor;
   (4) Unlawful conduct in the presence of a participant;
   (5) Conducting an assessment on more than one (1) participant at a time;
   (6) Tardiness or failure to make reports, or to transmit funds as required by this Chapter;
   (7) Erroneous or falsified information relating to any documents submitted to ODMHSAS;
   (8) Allowing a non-certified individual to conduct an assessment without a certified ADSAC assessor present at all times unless otherwise permitted by this Chapter;
   (9) Failure to maintain all records required by ODMHSAS;
   (10) Use of facilities not approved by ODMHSAS;
   (11) Any activity which is a conflict of interest;
   (12) Use of any intoxicating substance or illegal drugs while conducting an assessment;
   (13) Conducting an assessment while the participant is using or under the influence of any intoxicating substance causing impairment, including alcohol;
   (14) Dismissal by an ODMHSAS certified organization or institution for violation of state statutes, or of the standards and criteria in this Chapter;
   (15) Knowingly permitting any assessor to violate any rule of this Chapter, or any other relevant Chapter of these Administrative Rules;
   (16) Use of assessment instruments not pre-approved by ODMHSAS for use in ADSAC assessments as one of the standardized instruments;
   (17) Willful failure, or refusal, to cooperate with an investigation by ODMHSAS, or employing agency, into a potential or alleged violation of applicable rules in this Chapter;
   (18) Refusal to allow an ADSAC assessor candidate to observe an ADSAC assessment as required for training;
   (19) Issuance of completion certificate(s) to participant(s) who have not completed, or who fail to complete any ADSAC assessment recommendation requirement;
   (20) Violation of any applicable rule in this Chapter, or any other applicable Chapter;
   (21) Falsification of any report, or document submitted, or prepared for submission, to ODMHSAS and DPS;
   (22) Collecting fees for, or issuing receipts for, or issuing completion certificates for, or conducting an assessment during, or soliciting students for assessments at a later date during any ADSAC course;
   (23) Any sexual language or actions with or toward a participant;
   (24) Any other just and verifiable cause including, but not limited to, moral turpitude, unethical or illegal activities;
   (25) Failure to wait at least a full fifteen (15) minutes when a participant is late for an assessment prior to canceling the session;
   (26) Failure to provide ODMHSAS with the physical address for conducting assessments;
   (27) Failure to complete ODMHSAS requirements for adding assessment sites;
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450:22-1-18. Hygiene and sanitation, assessors and assessment agencies [REVOKED]

Regarding lavatory facilities, sewage, solid waste disposal, water and pest inspection, assessors and assessment agencies offering ADSAC assessments shall comply with all local and state rules, regulations, codes and building codes, providing proof to ODMHSAS of such compliance upon audit or request.

450:22-1-19. State and federal statutes and regulations [REVOKED]

All assessors and assessment agencies shall comply with all applicable federal, state and local statutes and regulations.

450:22-1-20. Inactive status and closure [REVOKED]

(a) An active ADSAC-assessor certification may be placed on inactive status by written request:

(1) An inactive certification forfeits all rights and privileges granted by the certification;

(2) When certification is placed on inactive status, the certificate shall be returned to ODMHSAS along with the official stamp;

(3) When certification is placed on inactive status, it shall remain inactive for at least twelve (12) months from the date of inactivation, or until the end of the certification period, whichever is first;

(4) Active status may be re-established upon written request;

(5) When an ADSAC-assessor must cease operation for less than twelve (12) months all ADSAC assessment records must be secured as defined in 450:22-1-8;

(6) During such a temporary closure ADSAC assessment records shall remain accessible as defined in 450:22-1-22;

(7) Participants having received assessments shall be given written notification of the temporary closure with contact information for completing the ADSAC assessment process, in the event all recommendations are completed during the temporary closure; and

(b) An active ADSAC-assessment agency certification may be placed on inactive status by written request:

(1) An inactive certification forfeits all rights and privileges granted by the certification;

(2) When certification is placed on inactive status, the certificate shall be returned to ODMHSAS;

(3) When certification is placed on inactive status, it must remain inactive for a minimum of one (1) year and no more than (3) years from the date of inactivation, or until the end of the certification period, whichever is first;
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(4) Active status may be re-established upon request;
(5) When an assessment agency must cease operation for less than twelve (12) months, all participant records must be secured as defined in 450:22-1-22 and 450:22-1-25;
(6) During such a temporary closure, participant records shall remain accessible as defined in 450:22-1-22;
(7) Participants having received assessments shall be given written notification of the temporary closure with contact information for completing the ADSAC assessment process, in the event all recommendations are completed during the temporary closure; and
(8) ODMHSAS shall be notified in writing of any permanent closure of any assessment agency providing ADSAC assessments. The written notification shall contain:
   (A) The reason for closing; and
   (B) Contact information for participant assessment records.

450:22-1-21. Participant rights and grievance policy

[REVOKED]

All certified assessment agencies and ADSAC assessors conducting ADSAC assessments shall comply with applicable rules in Title 450, Chapter 15, Consumer Rights. Those programs which are providing services within a correctional facility shall detail the following due to circumstance:
(1) The provider shall document provisions of 450:15-3-2 (a), (b) and (d);
(2) The provider must provide written grievance policy and procedure including time frames for the grievance process;
(3) The provider must describe the procedure used when the grievance is against a staff. This policy may refer to DOC mandated policy and procedure; and
(4) The provider must describe the facility’s responsibility for evaluation, review, and resolution should the allegation be substantiated. All certified ADSAC assessors and assessment agencies shall comply with applicable rules in Title 450, Chapter 15, Consumer Rights. Those programs which are providing services within a correctional facility shall detail the following due to circumstance:
   (A) provide written grievance policy and procedure including time frames for the grievance process;
   (B) describe the procedure used when the grievance is against a staff. This policy may refer to Department of Corrections mandated policy and procedure; and
   (C) describe the facility’s responsibility for evaluation, review, and resolution should the allegation be substantiated.

450:22-1-22. ODMHSAS advocate general

[REVOKED]

The ODMHSAS Advocate General, in any investigation regarding consumer rights, shall have access to participant, assessment agencies and ADSAC assessors, ADSAC assessment records and facility staff as set forth in Title 450, Chapter 15.

[OAR Docket #21-434; filed 6-14-21]

TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

CHAPTER 23. STANDARDS AND CRITERIA FOR COMMUNITY-BASED STRUCTURED CRISIS CENTERS

[OAR Docket #21-435]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:

450:23-1-1 [AMENDED]
450:23-1-2 [AMENDED]
Subchapter 3. CBSCC Services
Part 2. Urgent Recovery Clinic Services
450:23-3-21 [AMENDED]
450:23-3-23 [AMENDED]
Subchapter 7. Confidentiality [REVOKED]
450:23-7-1.1 [REVOKED]
Subchapter 11. Organizational Management [REVOKED]
450:23-11-1 [REVOKED]
450:23-11-2 [REVOKED]
Subchapter 13. Performance Improvement and Quality Management [REVOKED]
450:23-13-1 [REVOKED]
450:23-13-5 [REVOKED]
Subchapter 17. Personnel [REVOKED]
450:23-17-1 [REVOKED]
450:23-17-2 [REVOKED]
Subchapter 19. Staff Development and Training [REVOKED]
450:23-19-1 [REVOKED]
450:23-19-2 [REVOKED]
450:23-19-3 [REVOKED]
Subchapter 21. Facility Environment
450:23-21-1 [AMENDED]
450:23-21-4 [REVOKED]
Subchapter 23. Governing Authority [REVOKED]
450:23-23-1 [REVOKED]
Subchapter 25. Special Populations [REVOKED]
450:23-25-1 [REVOKED]
450:23-25-2 [REVOKED]

AUTHORITY:
Oklahoma Board of Mental Health and Substance Abuse Services; 43A O.S. § 3-317

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n/a

**INCORPORATIONS BY REFERENCE:**
n/a

**GIST/ANALYSIS:**
The proposed rule revisions to Chapter 23 amend language to remove duplicative language that is addressed under new proposed language in Chapter 1. The intent is to consolidate duplicative language to increase consistency and reduce regulatory language in accordance with Executive Order 2020-03. Revisions also remove time restrictions on Urgent Recovery Clinic services.

**CONTACT PERSON:**
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**PURSUANT TO THE ACTIONS DESCRIBED HEREIN,**
THE FOLLOWING RULES ARE CONSIDERED
FINALLY ADOPTED AS SET FORTH IN 75 O.S.,
SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE
DATE OF SEPTEMBER 15, 2021:

**SUBCHAPTER 1. GENERAL PROVISIONS**

450:23-1-1. **Purpose**
This chapter sets forth the Standards and Criteria used in the certification of CBSCC's (43A O.S. § 3-317). The rules regarding the certification processes including, but not necessarily limited to, applications, fees, requirements for, levels of, and administrative sanctions are found at OAC 450:1, Subchapters 5 and 9. Rules outlining general certification qualifications applicable to facilities and organizations certified under this Chapter are found in OAC 450:1-9-5 through OAC 450:1-9-5.3.

450:23-1-2. **Definitions**
The following words or terms, when used in this Chapter, shall have the defined meaning, unless the context clearly indicates otherwise:

"Abuse" means the causing or permitting of harm or threatened harm to the health, safety, or welfare of a resident by a staff responsible for the resident's health, safety, or welfare, including but not limited to: non-accidental physical injury or mental anguish; sexual abuse; sexual exploitation; use of mechanical restraints without proper authority; the intentional use of excessive or unauthorized force aimed at hurting or injuring the resident; or deprivation of food, clothing, shelter, or healthcare by a staff responsible for providing these services to a resident.

"Clinical privileging" means an organized method for treatment facilities to authorize an individual permission to provide specific care and treatment services to consumers within well-defined limits, based on the evaluation of the individual's license, education, training, experience, competence, judgment, and other credentials.

"Community-based Structured Crisis Center" or "CBSCC" means a program of non-hospital emergency services for mental health and substance use disorder crisis stabilization as authorized by O.S. 43A 3-317, including, but not limited to, observation, evaluation, emergency treatment and referral, when necessary, for inpatient psychiatric or substance use disorder treatment services. This service is limited to CMHC's and Comprehensive Community Addiction Recovery Centers (CCARCs) who are certified by the Department of Mental Health and Substance Abuse Services or facilities operated by the Department of Mental Health and Substance Abuse Services.

"Consumer" means an individual, who has applied for, is receiving or has received evaluation or treatment services from a facility operated or certified by ODMHSAS or with which ODMHSAS contracts and includes all persons.

"Co-occurring disorder" means any combination of mental health and substance use disorder symptoms or diagnoses in a client.

"Co-occurring disorder capability" means the organized capacity within any type of program to routinely screen, identify, assess, and provide properly matched interventions to individuals with co-occurring disorders.

"Crisis intervention" means an immediately available service to meet the psychological, physiological and environmental needs of individuals who are experiencing a mental health and/or substance abuse crisis.

"Crisis stabilization" means emergency psychiatric and substance abuse services for the resolution of crisis situations and may include placement of an individual in a protective environment, basic supportive care, and medical assessment and referral.

"Critical incident" means an occurrence or set of events inconsistent with the routine operation of the facility, or the routine care of a consumer. Critical incidents specifically include but are not necessarily limited to the following: adverse drug events; self-destructive behavior; deaths and injuries to consumers, staff and visitors; medication errors; consumers that are absent without leave (AWOL); neglect or abuse of a consumer; fire; unauthorized disclosure of information; damage to or theft of property belonging to a consumers or the facility; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or results.

"Emergency detention" as defined by 43A § 5-206 means the detention of a person who appears to be a person requiring treatment in a facility approved by the Commissioner of Mental Health and Substance Abuse Services as appropriate for such detention after the completion of an emergency examination, either in person or via telemedicine, and a determination that emergency detention is warranted for a period not to exceed one hundred twenty (120) hours or five (5) days, excluding weekends and holidays, except upon a court order authorizing detention beyond a one hundred twenty (120) hour period or pending the hearing on a petition requesting involuntary commitment or treatments provided by 43A of the Oklahoma Statutes.

"Emergency examination" For adults: means the examination of a person who appears to be a mentally ill person, an alcohol-dependent person, or drug-dependent person and a person requiring treatment, and whose condition is such that
it appears that emergency detention may be warranted, by a licensed mental health professional to determine if emergency detention of the person is warranted. The examination must occur within twelve (12) hours of being taken into protective custody.

"Homeless" a homeless person is a person who; a) lacks a fixed, regular and adequate night time residence AND b) has a primary nighttime residence that is a supervised publicly or privately operated shelter designated to provide temporary living accommodations including welfare hotels, congregate shelters, half way houses, and transitional housing for the mentally ill; or an institution that provides a temporary residence for individuals intended to be institutionalized; or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, not limited to people living on the streets. Individuals are considered homeless if they have lost their permanent residence, and are temporarily living in a shelter to avoid being on the street.

"Initial Assessment" means examination of current and recent behaviors and symptoms of a person or minor who appears to be mentally ill or substance dependent.

"Intervention plan" means a description of services to be provided in response to the presenting crisis situation that incorporates the identified problem(s), strengths, abilities, needs and preferences of the individual served.

"Licensed mental health professional" or "LMHP" as defined in Title 43A § 1-103(11).

"Linkage services" means the communication and coordination with other service providers that assure timely appropriate referrals between the CBSCC and other providers.

"Minor" means any person under eighteen (18) years of age.

"Oklahoma Administrative Code" or "OAC" means the publication authorized by 75 O.S. § 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"Performance Improvement" or "PI" means an approach to the continuous study and improvement of the processes of providing health care services to meet the needs of consumers and others. Synonyms, and near synonyms include continuous performance improvement, continuous improvement, organization-wide performance improvement and total quality management.

"Persons with special needs" means any persons with a condition which is considered a disability or impairment under the "American with Disabilities Act of 1990" including, but not limited to the deaf/hearing impaired, visually impaired, physically disabled, developmentally disabled, persons with disabling illness, persons with mental illness and/or substance abuse disorders. See "Americans with Disabilities Handbook," published by U.S. Equal Employment Opportunity Commission and U.S. Department of Justice.

"PICIS" means a comprehensive management information system based on national standards for mental health and substance abuse databases. It is a repository of diverse data elements that provide information about organizational concepts, staffing patterns, consumer profiles, program or treatment focus, and many other topics of interest to clinicians, administrators and consumers. It includes unique identifiers for agencies, staff and consumers that provide the ability to monitor the course of consumer services throughout the statewide DMHSAS network. PICIS collects data from hospitals, community mental health centers, substance abuse agencies, domestic violence service providers, residential care facilities, prevention programs, and centers for the homeless which are operated or funded in part by DMHSAS.

"Progress notes" mean a chronological description of services provided to a consumer, the consumer's progress, or lack of, and documentation of the consumer's response related to the intervention plan.

"Psychosocial evaluations" are in-person interviews conducted by professionally trained personnel designed to elicit historical and current information regarding the behavior and experiences of an individual, and are designed to provide sufficient information for problem formulation and intervention.

"Restraint" refers to manual, mechanical, and chemical methods that are intended to restrict the movement or normal functioning of a portion of the individual's body. For minors: mechanical restraints shall not be used.

"Sentinel event" is a type of critical incident that is an unexpected occurrence involving the death or serious physical or psychological injury to a consumer, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a consumer. These events signal the need for immediate investigation and response. Sentinel events include, but are not limited to: suicide, homicide, criminal activity, assault and other forms of violence, including domestic violence or sexual assault, and adverse drug events resulting in serious injury or death.

"Triage" means a dynamic process of evaluating and prioritizing the urgency of crisis intervention needed based on the nature and severity of consumers' presenting situations.

"Trauma Informed" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of all consumers.

**SUBCHAPTER 3. CBSCC SERVICES**

**PART 2. URGENT RECOVERY CLINIC SERVICES**

450:23-3-21. Urgent Recovery Clinic services

(a) Urgent Recovery Clinics (URC) offer services aimed at the assessment and immediate stabilization of acute symptoms of mental illness, alcohol and other drug abuse, and emotional distress. Each facility must be specifically accessible to individuals who present with co-occurring disorders. URCs shall
not provide more than twenty-three (23) hours and fifty-nine (59) minutes of services to a consumer during one episode of care.

(b) URC services shall include, but not be limited to, the following service components and each shall be co-occurring disorder capable and trauma informed, with policies and procedures that support this capability:
   (1) Triage crisis response;
   (2) Crisis intervention;
   (3) Crisis assessment;
   (4) Crisis intervention plan development; and
   (5) Linkage and referral to other services as applicable.

450:23-3-23. URC Crisis intervention services
(a) URCs shall provide up to twenty-three (23) hours fifty-nine (59) minutes of evaluation, crisis stabilization, and social services intervention per consumer per episode of care and must be available seven (7) days per week for consumers experiencing substance abuse related crisis; consumers in need of assistance for emotional or mental distress; or those with co-occurring disorders.

(b) Licensed behavioral health professionals and other support staff shall be adequate in number to provide care needed by consumers twenty-four (24) hours a day seven (7) days per week.

(c) The URC shall provide or otherwise ensure the capacity for a practitioner with prescriptive authority at all times for consumers in need of emergency medication services.

(d) Crisis intervention services shall be provided by a co-occurring disorder capable team of social services, clinical, administrative, and other staff adequate to meet the clinical needs of the individuals served and make appropriate clinical decisions to:
   (1) Determine an appropriate course of action;
   (2) Stabilize the situation as quickly as possible; and
   (3) Guide access to inpatient services or less restrictive alternatives, as necessary.

e) Compliance with this Section shall be determined by a review of the following: personnel files and clinical privileges records; clinical records; PICIS information; policy and procedures; critical incident reports; staffing; census; and by on-site observation.

SUBCHAPTER 7. CONFIDENTIALITY [REVOKED]

450:23-7-1. Confidentiality of mental health and drug or alcohol abuse treatment information [REVOKED]

Confidentiality policy, procedures and practices must comply with federal and state law, guidelines, and standards, and with department rules as outlined in 450:13-2-20.1.
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(4) Stakeholders;
(5) Outcomes management processes; and
(6) Quality record review.

(b) The CBSCC shall have a defined system to collect data and information on a quarterly basis to manage the organization.

(c) Information collected shall be analyzed to improve consumer services and organizational performance.

(d) The CBSCC shall prepare an end of year management report, which shall include but not be limited to:

(1) An analysis of the needs assessment process; and
(2) Performance improvement program findings.

(e) The management report shall be communicated and made available to among others:

(1) The governing authority;
(2) CBSCC staff; and
(3) ODMHSAS if and when requested.

(f) Compliance with 450:23-11-2 shall be determined by a review of the following: written program evaluation plan(s); written annual program evaluation(s); special or interim program evaluations; program goals and objectives; and other supporting documentation provided.

SUBCHAPTER 13. PERFORMANCE IMPROVEMENT AND QUALITY MANAGEMENT
[REVOKED]

450:23-13-1. Performance improvement program
[REVOKED]

(a) The CBSCC shall have an ongoing performance improvement program designed to objectively and systematically monitor, evaluate and improve the quality of consumer care.

(b) The Performance improvement program shall also address the fiscal management of the organization.

(c) There shall be an annual written plan for performance improvement activities. The plan shall include, but not be limited to:

(1) Outcomes management processes specific to each program component minimally measuring:

(A) efficiency;
(B) effectiveness; and
(C) consumer satisfaction.

(2) A quarterly record review to minimally assess:

(A) quality of services delivered;
(B) appropriateness of services;
(C) patterns of service utilization;
(D) consumers relevant to:
(i) their orientation to the CBSCC and services being provided; and
(ii) their active involvement in making informed choices regarding the services they receive;
(E) the consumer assessment information thoroughness, timelines and completeness;
(F) treatment goals and objectives are based on:
(i) assessment findings; and
(ii) consumer input;
(G) services provided were related to the goals and objectives;
(H) services are documented as prescribed by policy;
(I) the treatment plan is reviewed and updated as prescribed by policy;
(3) Clinical privileging;
(4) Fiscal management and planning, which shall include:

(A) an annual budget that is approved by the governing authority and reviewed at least annually;
(B) the organization’s capacity to generate needed revenue to produce desired consumer and other outcomes;
(C) monitoring consumer records to ensure documented dates of services provided coincide with billed service encounters; and,

(5) Review of critical incident reports and consumer grievances or complaints.

(d) The CBSCC shall monitor the implementation of the performance improvement plan on an ongoing basis and makes adjustments as needed.

(e) Performance improvement findings shall be communicated and made available to among others:

(1) the governing authority;
(2) CBSCC staff; and
(3) ODMHSAS if and when requested.

(f) Compliance with 450:23-13-1 shall be determined by a review of the following: written program evaluation plan; written program evaluations; annual, special or interim; program goals and objectives; and other supporting documentation provided.

450:23-13-5. Incident reporting
[REVOKED]

(a) The CBSCC shall have written policies and procedures requiring documentation and reporting of critical incidents.

(b) The documentation for critical incidents shall contain, minimally:

(1) the facility name and name and signature of person(s) reporting the incident;
(2) the name of consumer(s), staff person(s), or others involved in the incident;
(3) the time, place and date the incident occurred;
(4) the time and date the incident was reported and name of the person within the facility to whom it was reported;
(5) description of the incident; and
(6) the severity of each injury, if applicable. Severity shall be indicated as follows:

(A) No off-site medical care required or first aid care administered on-site;
(B) Medical care by a physician or nurse or follow-up attention required; or
(C) Hospitalization or immediate off-site medical attention was required;

(7) Resolution or action taken, date action taken, and signature of CBSCC director.
(e) The CBSCC shall report those critical incidents to ODMHSAS that include:
   (1) Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off site medical attention shall be delivered via fax or mail to ODMHSAS Provider Certification within twenty-four (24) hours of the incident being documented.
   (2) Critical incidents involving allegations constituting a sentinel event or resident abuse shall be reported to ODMHSAS immediately via telephone or fax, but not less than twenty-four (24) hours of the incident. If reported by telephone, the report shall be followed with a written report within twenty-four (24) hours.
   (d) Compliance with 450:23-13.5 shall be determined by a review of policy and procedures and critical incident reports at the CBSCC and those submitted to ODMHSAS.

SUBCHAPTER 17. PERSONNEL [REVOKED]

450:23-17-1. Personnel policies and procedures [REVOKED]

(a) The CBSCC shall have written personnel policies and procedures approved by the governing authority.
(b) All employees shall have access to personnel policies and procedures, as well as other Rules and Regulations governing the conditions of their employment.
(c) The CBSCC shall develop, adopt and maintain policies and procedures to promote the objectives of the program and provide for qualified personnel during all hours of operation to support the functions of the center and provide quality care.
(d) Compliance with 450:23-17-1 shall be determined by a review of written personnel policies and procedures, and other supporting documentation provided.

450:23-17-2. Job descriptions [REVOKED]

(a) The CBSCC shall have written job descriptions for all positions setting forth minimum qualifications and duties of each position.
(b) All job descriptions shall include an expectation of core competencies in relation to individuals with co-occurring disorders.
(c) Compliance with 450:23-17-2 shall be determined by a review of written job descriptions for all center positions, and other supporting documentation provided.

SUBCHAPTER 19. STAFF DEVELOPMENT AND TRAINING [REVOKED]

450:23-19-1. Staff qualifications [REVOKED]

(a) The CBSCC shall document the qualifications and training of staff providing crisis stabilization services which shall be in compliance with the CBSCC’s clinical privileging process.

(b) Compliance with 450:23-19-1 shall be determined by a review of personnel files, clinical privileging records and other supporting documentation provided.
(c) Failure to comply with 450:23-19-1 will result in the initiation of procedures to deny, suspend and/or revoke certification.

450:23-19-2. Staff development [REVOKED]

(a) The CBSCC shall have a written plan for the professional growth and development of all administrative, professional clinical and support staff.
(b) This plan shall include but not be limited to:
   (1) orientation procedures;
   (2) in-service training and education programs;
   (3) availability of professional reference materials; and
   (4) mechanisms for insuring outside continuing educational opportunities for staff members.
(c) The results of performance improvement activities and accrediting and audit findings and recommendations shall be addressed by and documented in the staff development and clinical privileging processes.
(d) Staff competency development shall be aligned with the organization’s goals related to co-occurring capability, and incorporate a training plan, training activities, and supervision designed to improve co-occurring core competencies of all staff.
(e) Staff education and in-service training programs shall be evaluated by the CBSCC at least annually.
(f) Compliance with 450:23-19-2 shall be determined by a review of the staff development plan, clinical privileging processes, documentation of in-service training programs, and other supporting documentation provided.

450:23-19-3. In-service [REVOKED]

(a) In-service trainings are required annually for all employees who provide clinical services within the CBSCC program on the following topics:
   (1) Fire and safety;
   (2) Infection Control and universal precautions;
   (3) Consumer’s rights and the constraints of the Mental Health Consumer’s Bill of Rights;
   (4) Confidentiality;
   (5) Oklahoma Child Abuse Reporting and Prevention Act, 10 O.S. §§ 7101 et seq., and Protective Services for the Elderly and for Incapacitated Adults Act, 43A O.S. §§ 10-101 et seq.;
   (6) Facility policy and procedures;
   (7) Cultural competence;
   (8) Co-occurring disorder competency and treatment principles; and
   (9) Trauma informed and age and developmental specific trainings.
(b) All staff providing clinical services shall have a current certification in basic first aid and in Cardiopulmonary Resuscitation (CPR).
(c) All clinical staff shall have training in non-physical intervention techniques and philosophies addressing appropriate
non-violent interventions for potentially-physical interpersonal conflicts, staff attitudes which promote dignity and enhanced self-esteem, keys to effective communication skills, verbal and non-verbal interaction and non-violent intervention within 30 days of being hired with annual updates thereafter.

(d) The local facility Executive Director shall designate which positions and employees, including temporary employees, will be required to successfully complete physical intervention training. The employee shall successfully complete this training within 30 days of being hired, with annual updated thereafter.

(e) The training curriculum for 450:23-19-3 (c) and (d) must be approved by the ODMHSAS commissioner or designee in writing prior to conducting of any training pursuant to this provision.

(f) Compliance with 450:23-19-3 shall be determined by a review of the following: in-service training records; personnel records; and other supporting written information provided.

SUBCHAPTER 21. FACILITY ENVIRONMENT

450:23-21-1. Facility environment
(a) The CBSCC shall obtain an annual fire and safety inspection from the State Fire Marshall or local authorities which documents approval for continued occupancy. Compliance with 450:23-21-1 shall be determined by a review of the CBSCC’s annual fire and safety inspection report.
(b) CBSCC staff shall know the exact location, contents, and use of first aid supply kits and fire fighting equipment and fire detection systems. All fire fighting equipment shall be annually maintained in appropriately designated areas within the facility.
(c) The CBSCC shall post written plans and diagrams noting emergency evacuation routes in case of fire, and shelter locations in case of severe weather.
(d) Facility grounds shall be maintained in a manner which provides a safe environment for consumers, personnel, and visitors.
(e) The CBSCC Facility Director or designee shall appoint a safety officer.
(f) The CBSCC shall have an emergency preparedness program designed to provide for the effective utilization of available resources in consumer care can be continued during a disaster. The CBSCC shall evaluate the emergency preparedness program annually and update as needed.
(g) Policies for the use and control of personal electrical equipment shall be developed and implemented.
(h) The CBSCC shall have an emergency power system to provide lighting throughout the facility.
(i) The CBSCC Facility Director shall ensure there is a written plan to respond to internal and external disasters. External disasters include, but are not limited to, tornadoes, explosions, and chemical spills.
(j) All CBSCCs shall be inspected annually by designated fire and safety officials of the municipality who exercise fire safety jurisdiction in the facility’s location which results in the facility being allowed to continue to operate.

(k) The CBSCC shall have a written Infection Control Program and staff shall be knowledgeable of Center for Disease Control (CDC) Guidelines for Tuberculosis and of the Blood Borne Pathogens Standard, location of spill kits, masks, and other personal protective equipment.

(l) The CBSCC shall have a written Hazardous Communication Program and staff shall be knowledgeable of chemicals in the workplace, location of Material Safety Data Sheets, personal protective equipment; and toxic or flammable substances shall be stored in approved locked storage cabinets.

(m) Compliance with 450:23-21-1 shall be determined by visual observation, posted evacuation plans and a review of policy procedures, regulatory or internal inspection reports, training documentation and other supporting documentation provided.

In addition to the requirements set forth in OAC 450:9-1-5.2(a), the CBSCC shall:

1. Have a written Infection Control Program and staff shall be knowledgeable of Center for Disease Control (CDC) Guidelines for Tuberculosis and of the Blood Borne Pathogens Standard, location of spill kits, masks, and other personal protective equipment; and

2. Have a written Hazardous Communication Program and staff shall be knowledgeable of chemicals in the workplace, location of Material Safety Data Sheets, personal protective equipment; and toxic or flammable substances shall be stored in approved locked storage cabinets.

450:23-21-4. Technology [REVOKED]

(a) The facility shall have a written plan regarding the use of technology and systems to support and advance effective and efficient service and business practices. The plan shall include, but not be limited to:

1. Hardware and software.
3. Confidentiality.
4. Backup policies.
5. Assistive technology.
6. Disaster recovery preparedness.
7. Virus protection.

(b) Compliance with 450:23-21-1 shall be determined by a review of the facility policies, performance improvement plans and technology and system plan.

SUBCHAPTER 23. GOVERNING AUTHORITY [REVOKED]

450:23-23-1. Documents of authority [REVOKED]

(a) There shall be a duly constituted authority and governance structure for ensuring legal responsibility and for requiring accountability for performance and operation of the CBSCC.

(b) The governing authority shall have written documents of its source of authority, which shall be available to the public upon request.
(e) The governing body's bylaws, rules or regulations shall identify the chief executive officer who is responsible for the overall day-to-day operation of the CBSCC, including the control, utilization and conservation of its physical and financial assets and the recruitment and direction of the staff.

(1) The source of authority document shall state:

(A) The eligibility criteria for governing body membership;
(B) The number and types of membership;
(C) The method of selecting members;
(D) The number of members necessary for a quorum;
(E) Attendance requirements for governing body membership;
(F) The duration of appointment or election for governing body members and officers;
(G) The powers and duties of the governing body and its officers and committees or the authority and responsibilities of any person legally designated to function as the governing body.

(2) There shall be an organizational chart setting forth the structure of the organization.

(d) Compliance with 450:23-23-1 shall be determined by a review of the following: bylaws, articles of incorporation, written document of source of authority, minutes of governing board meetings, job description of the CEO, and the written organizational chart.

SUBCHAPTER 25. SPECIAL POPULATIONS


(a) The CBSCC shall have written policy and procedure for the provision of, or arrangements for, serving persons who fall under the protection of the Americans With Disabilities Act of 1990. [A recommended reference is the "Americans with Disabilities Handbook" published by the U.S. Equal Employment Opportunities Commission and the U.S. Department of Justice.]

(b) Compliance with 450:23-25-1 shall be determined through a review of CBSCC written policy and procedure, and any other supporting documentation.

450:23-25-2. Human Immunodeficiency Virus (HIV), and Acquired Immunodeficiency Syndrome (AIDS) [REVOKED]

(a) A policy of non-discrimination against persons with HIV infection or AIDS shall be adopted and in force in the policy and procedure of the CBSCC.

(b) All CBSCCs shall observe the Universal Precautions For Transmission of Infectious Diseases as set forth in "Occupational Exposure to Blood-Borne Pathogens" published by the United States Occupations Safety Health Administration (OSHA); and

450:23-25-3. There shall be written documentation the aforesaid Universal Precautions are the policy of the CBSCC.

(2) Inservice training regarding the Universal Precautions shall be a part of employee orientation and at least once per year, is included in employee inservice training.

(e) Compliance with 450:23-25-2 is determined by review of CBSCC policy and procedure and inservice training records, on-site observation, schedules and other documentation.

[OAR Docket #21-435; filed 6-14-21]
PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 15, 2021:

**SUBCHAPTER 1. GENERAL PROVISIONS**

450:24-1-1. Purpose

(a) This chapter sets forth the Standards and Criteria used in the certification of Comprehensive Community Addiction Recovery Centers (CCARC) and implements 43A O.S. § 3-415. A.1., which authorizes the Board of Mental Health and Substance Abuse Services to certify private facilities and organizations which provide treatment, counseling and rehabilitation services directed toward alcohol and drug dependent persons. A CCARC is considered distinct and separate from facilities that may be certified under OAC 450:18 in that 450:24 requires the provision of all services stipulated in Subchapter 450: 24-3 et seq.

(b) The rules regarding the certification process including but not necessarily limited to application, fees and administrative sanctions are found in the Oklahoma Administrative Code, Title 450 Chapter 1, Subchapters 5 and 9.

(c) Rules outlining general certification qualifications applicable to facilities and organizations certified under this Chapter are found in OAC 450:1-9-5 through OAC 450:1-9-5.3.

450:24-1-2. Definitions

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

"Ambulatory Withdrawal Management without extended on-site monitoring" means withdrawal management within an outpatient setting, directed by a physician and has attendant medical personnel including nurses for intoxicated consumers, and consumers withdrawing from alcohol and other drugs, presenting with no apparent medical or neurological symptoms as a result of their use of substances require ambulatory withdrawal management as determined by an examining physician. This corresponds to ASAM Service Level: Level 1-WM Ambulatory withdrawal management without extended on-site monitoring.

"ASAM" means the American Society of Addiction Medicine.

"ASAM criteria" or "ASAM" means the most current edition of the American Society of Addiction Medicine’s published criteria for admission to treatment, continued services, and discharge.

"ASAM level 1" means Outpatient Services for adolescents and adults. This level of care typically consists of less withdrawal management providers and other clean-up language to address programmatic changes.
than nine (9) hours of services per week for adults or less than six (6) hours of services per week for adolescents. Services may be delivered in a wide variety of settings.

"ASAM level 2.1" means Intensive Outpatient Services for adolescents and adults. This level of care typically consists of nine (9) or more hours of service a week for adults or six (6) or more hours of service a week for adolescents. Services are delivered as organized outpatient services during the day, before or after work or school, in the evening, and/or on weekends.

"ASAM level 3" means residential and inpatient services and encompasses ASAM levels 3.1, 3.3, 3.5 and 3.7.

"ASAM level 3.1" means Clinically Managed Low-Intensity Residential Services for adolescents and adults. This level of care typically provides at least five (5) hours of clinical services a week and provides twenty-four (24) hour living support and structure with trained personnel. The corresponding service description for this level of care is Halfway House Services.

"ASAM level 3.3" means Clinically Managed Population-Specific High-Intensity Residential Services. This level of care is for adults only and typically offers twenty-four (24) hour care with trained personnel and is designed to accommodate individuals with cognitive or other impairments. The corresponding service description for this level of care is Residential Treatment for Adults with Co-Occurring Disorders.

"ASAM level 3.5" means Clinically Managed Medium-Intensity Residential Services for adolescents and Clinically Managed High-Intensity Residential Services for adults. This level of care provides twenty-four (24) hour care and offers a wide range of therapeutic services. The corresponding service descriptions for this level of care are Residential Treatment and Intensive Residential Treatment.

"ASAM level 3.7" means Medically Monitored High-Intensity Inpatient Services for adolescents and Medically Monitored Intensive Inpatient Withdrawal Management for adults. This level of care provides twenty-four (24) hour nursing care with physician supervision and medication availability. This level of care is appropriate for individuals withdrawing from alcohol or other drugs with subacute biomedical and emotional, behavioral, or cognitive problems severe enough to require inpatient treatment but for whom hospitalization is not necessary. The corresponding service description for this level of care is Medically Supervised Withdrawal Management.

"Case management services" means planned referral, linkage, monitoring and support, and advocacy provided in partnership with a consumer to assist that consumer with self sufficiency and community tenure and take place in the individual's home, in the community, or in the facility, in accordance with a service plan developed with and approved by the consumer and qualified staff.

"Clinical privileging" means an organized method for treatment facilities to authorize an individual permission to provide specific care and treatment services to consumers within well-defined limits, based on the evaluation of the individual's license, education, training, experience, competence, judgment, and other credentials.

"Comprehensive Community Addiction Recovery Center" or "CCARC" means a facility offering a comprehensive array of community-based substance use disorder treatment services, including but not limited to, outpatient services, Intensive outpatient services, ambulatory withdrawal management services, emergency care, consultation and education; and, certain services at the option of the center, including but not limited to, prescreening, rehabilitative services, aftercare, training programs, research and evaluation.

"Community-based Structured Crisis Center" or "CBSCC" means a program of non-hospital emergency services for mental health and substance use disorder crisis stabilization as authorized by 43A O.S. §3-317, including, but not limited to, observation, evaluation, emergency treatment and referral, when necessary, for inpatient psychiatric or substance use disorder treatment services. This service is limited to CCARC's who are certified by the Department of Mental Health and Substance Abuse Services or facilities operated by the Department of Mental Health and Substance Abuse Services.

"Consumer" means an individual, adult, adolescent, or child, who has applied for, is receiving or has received evaluation or treatment services from a facility operated or certified by ODMHSAS or with which ODMHSAS contracts and includes all persons referred to in OAC Title 450 as client(s) or patient(s) or resident(s) or a combination thereof.

"Consumer advocacy" includes all activities on behalf of the consumer to assist with or facilitate resolution of problems in the acquisition of resources or services needed by the consumer.

"Co-occurring disorder" (COD) means any combination of mental health symptoms and substance use disorder symptoms or diagnoses that affect a consumer and are typically determined by the current Diagnostic and Statistical Manual of Mental Disorders.

"Co-occurring disorder capability" means the organized capacity within any type of program to routinely screen, identify, assess, and provide properly matched interventions to consumers with co-occurring disorders.

"Co-occurring disorder enhanced" means that the program (or subunit of the program) provides a specialized service designed for individuals with co-occurring disorders, usually with a higher level of available service capacity or intensity for the co-occurring substance use disorder than would be the case in a comparable co-occurring disorder capable program.

"Crisis Diversion" means an 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.

"Crisis Intervention" means actions taken, and services provided to address emergency psychological, physiological, and safety aspects of alcohol, drug-related, and mental health crises.

"Crisis stabilization" means emergency, psychiatric, and substance use disorder treatment services for the resolution of crisis situations and may include placement of an individual in a protective environment, basic supportive care, and medical
"Critical incident" means an occurrence or set of events inconsistent with the routine operation of a facility, service setting, or otherwise routine care of a consumer. Critical incidents specifically include but are not necessarily limited to the following: adverse drug events; self-destructive behavior; deaths and injuries to consumers, staff and visitors; medication errors; residential consumers that are absent without leave (AWOL); neglect or abuse of a consumer; fire; unauthorized disclosure of information; damage to or theft of property belonging to consumers or the facility; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or result.

"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual’s racial, ethnic, religious, sexual orientation, and/or social group.

"Emergency examination" means the examination of a person who appears to be a mentally ill person, an alcohol-dependent person, or drug-dependent person and a person requiring treatment, and whose condition is such that it appears that emergency detention may be warranted by a licensed mental health professional to determine if emergency detention of the person is warranted.

"Face-To-Face" for the purposes of the delivery of behavioral health care, means a face-to-face physical contact and in-person encounter between the health care provider and the consumer, including the initial visit. The use of telemedicine shall be considered a face-to-face encounter.

"Gambling disorder treatment services" means treatment activities for consumers by a gambling treatment professional that include, but are not limited to, the following:

(A) Assessment and diagnostic impression, ongoing;
(B) Treatment planning and revision, as necessary;
(C) Individual, group and family therapy;
(D) Case management;
(E) Psychosocial rehabilitation; and
(F) Discharge planning.

"Gambling-related disorders/problems" means persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as defined by the most recent edition of the DSM.

"Independent living skills, assistance in development of" means all activities directed at assisting individuals in the development of skills necessary to live and function within the community, e.g., cooking, budgeting, meal planning, housecleaning, problem-solving, communication and vocational skills.

"Intensive outpatient services" means an organized, non-residential outpatient treatment services with scheduled sessions that provide a range of nine (9) to fifteen (15) treatment hours per week for adults or six (6) to twelve (12) treatment hours per week for children. Intensive outpatient services may offer evening outpatient services several nights per week or be incorporated into an inpatient or residential treatment program in which the consumer participates in daytime treatment services but goes home at night. This corresponds to ASAM patient Placement Criteria Treatment Level: Level II.1 Intensive outpatient.

"Levels of care" means the different options for treatment as described in the current edition of the ASAM criteria that vary according to the services offered. Each treatment option is a level of care.

"Licensed Behavioral Health Professional" or "LBHP" means:

(A) An allopathicAllopathic or osteopathicOsteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry;
(B) An Advanced Practice Registered Nurse 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 certified in a psychiatric mental health specialty;
(C) A Clinical Psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists;
(D) A Physician Assistant who is licensed in good standing in Oklahoma and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions;
(E) A practitioner/practitioner with a license to practice in the state in which services are provided by one of the following licensing boards:
   (i) Psychology;
   (ii) Social Work (clinical specialty only);
   (iii) Professional Counselor;
   (iv) Marriage and Family Therapist;
   (v) Behavioral Practitioner; or
   (vi) Alcohol and Drug Counselor(s);
(C) 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
(D) a physician assistant who is licensed in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or therapy functions.

"Licensed mental health professional" or "LMHP" as defined in Title 43A §1-103(11).
"Licensure Candidate" means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board’s supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:
(A) Psychology;
(B) Social Work (clinical specialty only);
(C) Professional Counselor;
(D) Marriage and Family Therapist;
(E) Behavioral Practitioner; or
(F) Alcohol and Drug Counselor.

"Linkage" refers to the communication and coordination with other service providers to assure timely appropriate referrals between the CCARC and other providers.

"Medication error" means an error in prescribing, dispensing or administration of medication, regardless if the error reached the consumer, e.g., omission of prescribed drugs, giving drugs not prescribed, prescribing inappropriate drugs, prescribing or administering incorrect dosages, incorrectly filling or labeling prescriptions, incorrectly transcribing medication orders.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"Oklahoma Administrative Code" or "OAC" means the publication authorized by 75 O.S. § 256 known as The Oklahoma Administrative Code or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A) (1) (a) and maintained in the Office of Administrative Rules.

"On-premise meal service" means meals that are prepared and cooked in a commercial kitchen located on the facility premises.

"Outpatient services" means an organized, non-residential treatment service in regularly scheduled session intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimens. This corresponds to ASAM criteria Treatment Level I, Outpatient Treatment. Services can address early intervention needs and increase in frequency and intensity up to 9 treatment hours per week.

"Peer Recovery Support Specialist" or "PRSS" means an individual who meets the qualifications and is certified as a PRSS pursuant to OAC 450:53.

"Performance Improvement" or "PI" means an approach to the continuous study and improvement of the processes of providing health care services to meet the needs of consumers and others. Synonyms, and near synonyms include continuous quality improvement, continuous improvement, organization-wide quality improvement and total quality management.

"Progress notes" means a chronological written description of services provided to a consumer, resident, client, or patient that documents, utilizing acceptable documentation practices, the consumer's response related to the intervention plan or services provided.

"Psychological-Social evaluations" are in person interviews conducted by a LBHP or Licensure Candidate trained to elicit historical and current information regarding the behavior and experiences of an individual, and are designed to provide sufficient information for problem formulation and intervention.

"Psychotherapy" or "Therapy" means a goal directed process using generally accepted clinical approaches provided face-to-face by a LBHP or Licensure Candidate with consumers in individual, group or family settings to promote positive emotional or behavioral change.

"Rehabilitation Services" means face-to-face individual or group services provided by qualified staff to develop skill necessary to perform activities of daily living and successful integration into community life.

"Screening" means the process to determine whether the person seeking assistance needs further comprehensive assessment.

"Sentinel event" is a type of critical incident that is an unexpected occurrence involving the death or serious physical or psychological injury to a consumer, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a consumer. These events signal the need for immediate investigation and response. Sentinel events include, but are not limited to: suicide, homicide, criminal activity, assault and other forms of violence, including domestic violence or sexual assault, and adverse drug events resulting in serious injury or death.

"Service area" means a geographic area established by the Department of Mental Health and Substance Abuse Services for support of mental health and substance use disorder treatment services [43A O.S.§3-302(1)].

"Service plan" or "Treatment plan" means the document used during the process by which a LBHP or Licensure Candidate and the consumer together and jointly identify and rank problems, establish agreed-upon immediate short-term and long-term goals, and decide on the treatment process and resources to be utilized.

"Substance withdrawal" means a state of being in which a group of symptoms of variable clustering and degree of severity occur on cessation or reduction of use of a psychoactive substance that has been taken repeatedly, usually for a prolonged period and/or in high doses. The syndrome may be accompanied by signs of physiological disturbance. Onset and course of the withdrawal state are time-limited and are related to the type of substance and the dose being used immediately before abstinence.

"Supportive services" refers to assistance with the development of problem-solving and decision-making skills to maintain or achieve optimal functioning within the community and can include consumer education.

"Tobacco" means any nicotine delivery product or device that is not approved by the U.S. Food and Drug Administration (FDA) for the purpose of nicotine dependence treatment, including, but not limited to cigarettes, cigars, snuff, chewing tobacco, electronic cigarettes and vaping devices.

"Trauma informed capability" means the capacity for a facility and all its programs to recognize and respond accordingly to the presence of the effects of past and current traumatic experiences in the lives of its consumers.
"Urgent Recovery Clinic" means a program of non-hospital emergency services for mental health and substance use crisis response including, but not limited to, observation, evaluation, emergency treatment, and referral, when necessary to a higher level of care. This service is time limited and cannot exceed 23 hours and 50 minutes. This service is limited to CMHCs and Comprehensive Community Addiction Recovery Centers (CCARCs) certified by ODMHAS or facilities operated by ODMHAS.

"Vocational assessment services" means a process utilized to determine the individual's functional work-related abilities and vocational preferences for the purpose of the identification of the skills and environmental supports needed by the individual in order to function more independently in an employment setting, and to determine the nature and intensity of services which may be necessary to obtain and retain employment.

"Vocational placement services" means a process of developing or creating an appropriate employment situation matched to the functional abilities and choices of the individual for the purpose of vocational placement. Services may include, but are not limited to, the identification of employment positions, conducting job analysis, matching individuals to specific jobs, and the provision of advocacy with potential employers based on the choice of the individual served.

"Vocational preparation services" means services that focus on development of general work behavior for the purpose of vocational preparation such as the utilization of individual or group work-related activities to assist individuals in understanding the meaning, value and demands of work; to modify or develop positive work attitudes, personal characteristics and work behaviors; to develop functional capacities; and to obtain optimum levels of vocational development.

"Volunteer" means any person who is not on the program's payroll, but provides services and fulfills a defined role within the program and includes interns and practicum students.

"Walk through" means an exercise in which staff members of a facility walk through the program's treatment processes as a consumer. The goal is to view the agency processes from the consumer's perspective for the purpose of removing barriers and enhancing treatment.

"Wellness" means the condition of good physical, mental and emotional health, especially when maintained by an appropriate diet, exercise, and other lifestyle habits.

SUBCHAPTER 3. REQUIRED SERVICES

PART 3. SCREENING, ASSESSMENT AND REFERRAL

450:24-3-21. Integrated screening and assessment services
(a) CCARC policy and procedure shall require that a screening of each consumer's service needs is completed in a timely manner. An integrated screening should be welcoming, trauma-informed, and culturally appropriate, include screening of whether the consumer is a risk to self or others, including suicide risk factors, as well as maximize recognition of the prevalence of co-occurring disorders among those who present for services at a Community Comprehensive Addiction Recovery Center.
(b) Upon determination of appropriate admission, a biopsychosocial assessment must be completed using the Addiction Severity Index (ASI) for adults or the Teen Addiction Severity Index (T-ASI) for adolescents, which gathers sufficient information to assist the consumer in developing an individualized service plan. The assessment must also list the client's past and current psychiatric medications. The assessment must be completed by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing.
(c) The consumer and family as appropriate shall be an active participant(s) in the screening and assessment process.
(d) The CCARC shall have policy and procedures specific to each program service which dictate timeframes by when assessments must be completed and documented. If halfway house, residential, or medically supervised withdrawal management services are provided, assessments shall be completed in accordance with 450:18-7-24 through 450:18-7-26 and 450:18-13-61(b)(5)(B). In the event the consumer is not admitted and as a result the assessment is not included in the clinical record, the policy shall specify how screening and assessment information is maintained and stored.
(e) Compliance with 450:24-3-21 shall be determined by a review of clinical records, and policy and procedures.

PART 9. OUTPATIENT TREATMENT SERVICES ASAM LEVEL 1

PART 11. INTENSIVE OUTPATIENT SERVICES ASAM LEVEL 2.1

SUBCHAPTER 5. OPTIONAL SERVICES

PART 2. MEDICALLY-SUPERVISED AND NON-MEDICAL WITHDRAWAL MANAGEMENT, ASAM LEVEL 3.7

450:24-5-11. Medically-supervised withdrawal management
If provided, Medically-supervised withdrawal management shall be provided pursuant to OAC 450:18-5-5.1 and 450:18-13-61 through 18-13-63.

If provided, non-medical withdrawal management shall be provided pursuant to OAC 450:18-13-81 through 18-13-83.
PART 3. RESIDENTIAL TREATMENT, ASAM LEVEL 3.5

450:24-5-21. Residential treatment for adults
Facilities providing substance use disorder treatment services for adults in the residential setting must meet the requirements found in Sections 450:18-5-5.1, 450:18-5-14 and 450:18-13-101 through 18-13-103.

PART 5. RESIDENTIAL TREATMENT FOR PERSONS WITH DEPENDENT CHILDREN AND PREGNANT WOMEN, ASAM LEVEL 3.5

450:24-5-41. Residential treatment for persons with dependent children and pregnant women
Facilities providing substance use disorder treatment services for persons with dependent children or pregnant women in the residential setting must meet the requirements found in Sections 450:18-5-5.1, 450:18-5-14 and 450:18-13-121 through 18-13-124.

PART 7. RESIDENTIAL TREATMENT FOR ADULTS WITH CO-OCCURRING DISORDERS, ASAM LEVEL 3.3

450:24-5-61. Adult residential treatment for consumers with co-occurring disorders
Facilities providing treatment services for adults with co-occurring disorders in the residential setting must meet the requirements found in Sections 450:18-5-5.1, 450:18-5-14 and 450:18-13-141 through 18-13-143.

PART 9. RESIDENTIAL TREATMENT FOR ADOLESCENTS, ASAM LEVEL 3.5

450:24-5-81. Residential treatment for adolescents
Facilities providing substance use disorder treatment services for adolescents in the residential setting must meet the requirements found in Sections 450:18-5-5.1, 450:18-5-14 and 450:18-13-161 through 18-13-163.

PART 11. HALFWAY HOUSE SERVICES, ASAM LEVEL 3.1

450:24-5-101. Halfway house services
Facilities providing halfway house services must meet the requirements found in Sections 450:18-5-5.1 and 450:18-13-181 through 18-13-183.

PART 13. ADOLESCENT HALFWAY HOUSE SERVICES, ASAM LEVEL 3.1

450:24-5-121. Adolescent halfway house services
Facilities providing adolescent halfway house services must meet the requirements found in Sections 450:18-5-5.1 and 450:18-13-190 through 18-13-192.

PART 15. HALFWAY HOUSE SERVICES FOR PERSONS WITH DEPENDENT CHILDREN AND PREGNANT WOMEN, ASAM LEVEL 3.1

450:24-5-141. Halfway house services for persons with dependent children and pregnant women
Facilities providing halfway house services for persons with dependent children and pregnant women must meet the requirements found in Sections 450:18-5-5.1 and 450:18-13-201 through 18-13-203.

SUBCHAPTER 7. FACILITY CLINICAL RECORDS

450:24-7-3. Basic requirements [REVOKED]
(a) The CCARC's policies and procedures shall:
(1) Define the content of the consumer record in accordance with 450:24-7-4 through 24-7-9.
(2) Define storage, retention and destruction requirements for consumer records. ODMHAS-operated CCARCs shall comply with the Department's Records Disposition Schedule as approved by the Oklahoma Archives and Records Commission.
(3) Require consumer records be maintained in locked equipment which is kept within a locked room, vehicle, or premise.
(4) Require legible entries in consumer records, signed with first name or initial, last name, and dated by the person making the entry.
(5) Require the consumer's name be typed or written on each page in the consumer record.
(6) Require a signed consent for treatment before a consumer is admitted on a voluntary basis.
(7) Require a signed consent for follow-up before any contact after discharge is made.
(b) Compliance with 450:24-7-3 shall be determined by a review of the following: facility policy, procedures or operational methods; clinical records; other facility provided documentation; and PI information and reports. A CCARC may propose administrative and clinical efficiencies through a streamlining of the requirements noted in this subchapter if client outcomes are maintained or improved and face-to-face clinical time is able to be increased by proposed reduction in recordkeeping requirements. Such proposal shall be submitted for consideration and approval by the Department.

450:24-7-5. Clinical record content, screening and assessment
(a) All facilities shall complete a face-to-face screening with each individual to determine appropriateness of admission.
(b) The CCARC shall document the face-to-face screening between the potential consumer and the CCARC including how the consumer was welcomed and engaged, how the consumer was assisted to identify goals and experience hope, how the consumer received integrated screening to identify both immediate and ongoing needs and how the consumer was assisted to determine appropriateness of admission, and/or to access other appropriate services.

(c) All facilities shall assess each consumer for appropriateness of admission to the treatment program. Each presenting consumer for substance use disorder treatment shall be assessed, according to ASAM criteria, which includes a list of symptoms for all six dimensions and each level of care to determine a clinically appropriate placement in the least restrictive level of care. The Oklahoma Determination of ODMHSAS designated ASAM Service Level (ODASL) instrument must be completed when determining to determine clinically appropriate residential/inpatient level of care (ASAM Level 3) treatment placement prior to admission into the treatment facility. For facilities offering gambling disorder treatment services, each presenting consumer for gambling disorder treatment shall be assessed using the Southern Oaks Gambling Screen (SOGS). Facilities must ensure that a consumer's refusal of a particular service does not preclude the consumer from accessing other needed mental health or substance-related or addictive disorder treatment services. Should the service provider determine the consumer's needs cannot be met within the facility, clinical assessments and referrals for the consumer shall be documented.

(d) Any consumer seeking admission to inpatient or residential services, including medically-supervised withdrawal management and non-medical withdrawal management while under the influence or undergoing withdrawal of alcohol or drugs, shall be assessed prior to admission for medical needs. The written criteria to be used for medical needs assessment of persons under the influence or undergoing withdrawal of alcohol or drugs, and the protocols for determining when physician review of the assessment is needed, shall be approved by the facility's consulting physician.

(e) Upon determination of appropriate admission, consumer assessment demographic information shall contain, but not be limited to, the following:

- Date of initial contact requesting services;
- Date of the screening and/or assessment;
- Consumer's name;
- Gender;
- Birthdate;
- Home address;
- Telephone number;
- Referral source;
- Reason for referral;
- Significant other to be notified in case of emergency; and
- PICIS data core content, if the facility reports on PICIS.

(f) Compliance with 450:18-7-21 may be determined by a review of the following:

- Policies and procedures;
- Intake protocols;
- Assessment instruments;
- Treatment records;
- Interviews with staff and consumers; and
- Other facility documentation.

450:24-7-7. Behavioral Health Service Plan

(a) The service plan is performed by a LBHP or Licensure Candidate with the active participation of the consumer and a support person or advocate if requested by the consumer. In the case of children under the age of sixteen (16), it is performed with the participation of the parent or guardian, if allowed by law, and the child as age and developmentally appropriate. The service plan shall provide the formation of measurable service objectives and reflect ongoing changes in goals and objectives based upon consumer's progress or preference or the identification of new needs, challenges and problems.

(b) The service plan is operated after and based on information obtained in the mental health assessment and includes the evaluation of the assessment information by the clinician and the consumer.

(c) For adults, the service plan must be focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. For children, the service plan must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care.

(d) Comprehensive service plans must be completed within six (6) treatment sessions and adhere to the format and content requirements described in the facility policy and procedures.

(e) Service plan updates should occur at a minimum of every six (6) months while services are provided and adhere to the format and content requirements described in the facility policy and procedures. Service plan updates shall occur at a minimum of once every thirty (30) days while services are provided for levels of care with ASAM Level 3 (residential and inpatient services).

(f) Service plans, both comprehensive and update, must include dated signatures for the consumer customer (if age 14), the parent/guardian (if under age sixteen (16) or otherwise applicable), and the primary service practitioner LBHP or Licensure Candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. Signatures must be obtained after the service plan is completed.

(g) Service plans for residential and halfway house services shall be completed in accordance with the time frames specified in 450:18-7-82.

(h) Service plans for medically supervised withdrawal management services shall be completed in accordance with 450:18-7-84.

(i) Compliance with 450:24-7-7 shall be determined by a review of the clinical records, policies and procedures, and interviews with staff and consumers, and other agency documentation.
450:24-7-12. Continuing care\textit{Transition/discharge plan}

(a) The facility shall assist the consumer to obtain services that are needed, but not available within the facility, and/or in transitioning from one level of care to another, and/or discharging from a facility. A written plan of recommendations and specific referrals for implementation of continuing care services, including medications, shall be prepared for each consumer who meets the ASAM PPC dimensional continued service criteria, in each level of care. \textit{Continuing care\textit{transition/discharge plans} shall be developed with the knowledge and cooperation of the consumer. The continuing care plan may be included in the discharge summary. The consumer's response to the continuing care plan shall be noted in the plan or a note shall be made that the consumer was not available and why. In the event of the death of a consumer, a summary statement including this information shall be documented in the record.

(b) Appointments for outpatient therapy and other services, as applicable, should be scheduled prior to discharge from residential/inpatient level of care (ASAM level 3) service settings. Development of the transition/discharge plan shall begin no later than two (2) weeks after admission into residential service settings.

(c) The consumer's response to the continuing care plan shall be noted in the plan or a note shall be made that the consumer was not available and why. In the event of the death of a consumer, a summary statement including this information shall be documented in the record.

(d) The transition/discharge plan shall be included in the discharge summary.

(e) Compliance with 450:24-7-12 may be determined by a review of closed clinical records.

450:24-7-13. Discharge Summary [REVOKED]

(a) The discharge summary shall document the consumer's progress made in treatment and response to services rendered.

(b) A completed discharge summary shall be entered in each consumer's record within fifteen (15) days of the consumer completing, transferring, or discontinuing services. Consumers who have received no services for one hundred eighty (180) days shall be discharged if it is determined that services are no longer needed or desired.

(c) In the event of death of a consumer: A summary statement including this information shall be documented in the record.

(d) Compliance with 450:247 13 may be determined by a review of closed consumer records.

450:24-9-1. Confidentiality of mental health and drug or alcohol abuse treatment information [REVOKED]

Confidentiality policy, procedures and practices must comply with federal and state law, guidelines, and standards, and with OAC 450:15-3-20.1, OAC 450:15-3-20.2 and OAC 450:15-30.60.

\textbf{SUBCHAPTER 13. ORGANIZATIONAL AND FACILITY MANAGEMENT [REVOKED]}

450:24-13-1. Organizational and facility description [REVOKED]

(a) The CCARC shall have a written organizational description which is reviewed annually and minimally includes:

\begin{enumerate}
\item The overall target population to be served;
\item The overall mission statement; and
\item The annual facility goals and objectives, including the goal of continued progress for the agency in providing recovery oriented, culturally competent, trauma informed and co-occurring capable services.
\end{enumerate}

(b) The CCARC's governing authority shall review and approve the mission statement and annual goals and objectives and document their approval.

(c) The CCARC shall make the organizational description, mission statement and annual goals available to staff.

(d) The CCARC shall make the organizational description, mission statement and annual goals available to the general public upon request.

(e) Each CCARC shall have in writing, by program component or service, the following:

\begin{enumerate}
\item Philosophy and description of services, including the philosophy of recovery oriented and welcoming service delivery;
\item Identity of the professional staff that provides these services;
\item Admission and exclusionary criteria that identify the type of consumers for whom the services is primarily intended, with no exclusion criteria based on active substance use disorders;
\item Goals and objectives, including making progress toward co-occurring capable, trauma informed, and culturally competent service delivery; and
\item Delineation of processes to assure welcoming accessible, integrated, and co-occurring capable services and a plan for how each program component will address the needs of individuals with co-occurring disorders.
\end{enumerate}

(f) The CCARC shall have written statement of the quality improvement processes, procedures and plans for attaining the organization's goals and objectives. These procedures and plans shall define specific tasks, including actions regarding the organization's co-occurring capability, set target dates and designate staff responsible for carrying out the procedures and plans.

(g) Compliance with OAC 450:24-13-1 shall be determined by a review of the facility's target population definition; facility policy and procedures; mission statement; written plan

\textbf{SUBCHAPTER 9. CONSUMER RECORDS AND CONFIDENTIALITY [REVOKED]}

8 August 16, 2021

1351 Oklahoma Register (Volume 38, Number 23)
450:24-13-2. Information analysis and planning [REVOKED]

(a) The CCARC shall have a defined and written plan for conducting an organizational needs assessment which specifies the methods and data to be collected, to include, but not limited to information from:

(1) Consumers;
(2) Governing Authority;
(3) Staff;
(4) Stakeholders;
(5) Outcomes management processes;
(6) Quality record review and
(7) Self-assessment tools to determine progress toward co-occurring, recovery-oriented, trauma-informed and consumer-driven capability.

(b) The CCARC shall have a defined ongoing system to collect data and information on a quarterly basis to manage the organization.

(c) Information collected shall be analyzed to improve consumer services and organizational performance.

(d) The CCARC shall prepare an end of year management report, which shall include but not be limited to:

(1) an analysis of the needs assessment process, and
(2) performance improvement program findings, and
(3) claims and accomplishments by facilities, including but not limited to consumer count and success rates, which may be verified by the ODMHSAS Board.

(e) The management report shall be communicated and made available to, among others:

(1) the governing authority;
(2) facility staff, and
(3) ODMHSAS if and when requested.

(f) Compliance with OAC 450:17-13-2 shall be determined by a review of the written program evaluation plan(s), written annual program evaluation(s), special or interim program evaluations; program goals and objectives; and other supporting documentation provided.

SUBCHAPTER 15. PERFORMANCE IMPROVEMENT AND QUALITY MANAGEMENT [REVOKED]

450:24-15-1. Performance improvement program [REVOKED]

(a) The CCARC shall have an ongoing performance improvement program designed to objectively and systematically monitor, evaluate and improve the quality of consumer care.

(b) The Performance improvement program shall also address the fiscal management of the organization.

(c) The facility shall have an annual written plan for performance improvement activities. The plan shall include but not be limited to:

(1) Outcomes management specific to each program component which minimally measures:

(A) efficiency;
(B) effectiveness; and
(C) consumer satisfaction.

(2) A quarterly quality consumer record review to evaluate and ensure, among others:

(A) the quality of services delivered;
(B) the appropriateness of services;
(C) patterns of service utilization;
(D) consumers are provided an orientation to services, and actively involved in making informed choices regarding the services they receive;
(E) assessments are thorough, timely and complete;
(F) treatment goals and objectives are based on, at a minimum,

(i) assessment findings, and
(ii) consumer input;
(G) services provided are related to the treatment plan goals and objectives;
(H) services are documented as prescribed by policy; and
(I) the service plan is reviewed and updated as prescribed by policy.

(3) Clinical privileging;
(4) Review of critical and unusual incidents and consumer grievances and complaints; and
(5) Improvement in the following:

(A) co-occurring capability, including the utilization of self-assessment tools as determined or recommended by ODMHSAS;
(B) provision of trauma informed services;
(C) provision of culturally competent services; and
(D) provision of consumer driven services; and
(6) Activities to improve access and retention within the treatment program, including an annual "walk through" of the intake and admission process.

(d) The CCARC will identify a performance improvement officer.

(e) The CCARC shall monitor the implementation of the performance improvement plan on an ongoing basis and make adjustments as needed.

(f) Performance improvement findings shall be communicated and made available to, among others:

(1) the governing authority;
(2) facility staff;
(3) consumers;
(4) stakeholders; and
(5) ODMHSAS, as requested.

(g) Compliance with 450:24-15-1 shall be determined by a review of the written program evaluation plan; written program evaluations (annual and or special or interim; program goals and objectives; and other supporting documentation provided).

450:24-15-2. Critical incident reporting [REVOKED]

(a) The facility shall have written policies and procedures requiring documentation and reporting of critical incidents and
analysis of the contributors to the incident, with attention to issues that may reflect opportunities for system-level or program level improvement.

(b) The documentation for critical incidents shall minimally include:

1. the facility, name and signature of the person(s) reporting the incident;
2. the name(s) of the consumer(s), staff member(s) or property involved;
3. the time, date and physical location of the critical incident;
4. the time and date the incident was reported and name of the staff person within the facility to whom it was reported;
5. a description of the incident;
6. resolution or action taken, date action taken, and signature of appropriate staff; and
7. severity of each injury, if applicable. Severity shall be indicated as follows:
   (A) No off-site medical care required or first-aid care administered on-site;
   (B) Medical care by a physician or nurse or follow-up attention required; or
   (C) Hospitalization or immediate off-site medical attention was required;

(e) Critical incidents shall be reported to ODMHSAS with specific timeframe, as follows:

1. Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off site medical attention shall be delivered via fax or mail to ODMHSAS Provider Certification within twenty-four (24) hours of the incident being documented.
2. Critical incidents involving allegations constituting a sentinel event or consumer abuse shall be reported to ODMHSAS immediately via telephone or fax, but not more than twenty-four (24) hours of the incident. If reported by telephone, the report shall be followed with a written report within twenty-four (24) hours.

(d) Compliance with 450:24-15-2 shall be determined by a review of facility policy and procedures; critical incident reports at the facility and those submitted to ODMHSAS; performance improvement program documents and reports; and staff interviews.

SUBCHAPTER 17. HUMAN RESOURCES [REVOKED]

450:24-17. Personnel policies and procedures [REVOKED]

(a) The facility shall have written personnel policies and procedures approved by the governing authority.

(b) All employees shall have access to personnel policies and procedures, as well as other Rules and Regulations governing the conditions of their employment.

(c) The facility shall develop, adopt, and maintain policies and procedures at each provider location to promote the objectives of the center and provide for qualified personnel during all hours of operation to support the functions of the facility and the provision of quality care.

(d) Compliance with 450:24-17-1 shall be determined by a review of written personnel policies and procedures, and other supporting documentation provided.

450:24-17-2. Job descriptions [REVOKED]

(a) There shall be job descriptions for all positions setting forth minimum qualifications and duties of each position.

(b) All job descriptions shall include an expectation of core competencies in relation to individuals with co-occurring disorders.

(c) Compliance with 450:24-17-2 shall be determined by a review of written job descriptions for all facility positions, and other supporting documentation provided.

450:24-17-3. Utilization of volunteers [REVOKED]

(a) In facilities where volunteers are utilized, specific policies and procedures shall be in place to define the purpose, scope, and training, supervision and operations related to the use of volunteers.

(b) A qualified staff member shall be assigned the role of, or responsibility as, the volunteer coordinator.

(c) Volunteer policies and procedures shall be reviewed by the governing authority upon revision.

(d) There shall be documentation to verify orientation of each volunteer which shall enable him or her to have knowledge of program goals and familiarity with routine procedures.

(e) Volunteers are required to receive in-service training pursuant to 450:24-19-3.

(f) Compliance with 450:24-17-3 shall be determined by a review of volunteer policies and procedures; designation of a volunteer coordinator; written orientation plan; orientation program; written goals and objectives; volunteer personnel files; and volunteer records.

SUBCHAPTER 19. STAFF DEVELOPMENT [REVOKED]

450:24-19-1. Staff qualifications [REVOKED]

(a) All staff who provide clinical services shall have documented qualifications or training specific to the clinical services they provide within the CCARC.

(b) Staff qualifications for contracted entities shall be in compliance with 450:1-1-1.1 and 450:1-3.5.

(c) Compliance with 450:24-19-1 shall be determined by a review of staff personnel files and other supporting documentation provided.
Permanent Final Adoptions

450:24-19-2. Staff development [REVOKED]
(a) The CCARC shall have a written plan for the professional growth and development of all administrative, professional and support staff.
(b) This plan shall include, but not be limited to:
   (1) orientation procedures;
   (2) in-service training and education programs;
   (3) availability of professional reference materials; and
   (4) mechanisms for insuring outside continuing educational opportunities for staff members.
(c) The results of performance improvement activities, accrediting and audit findings and recommendations shall be addressed by and documented in the staff development and clinical privileging processes.
(d) Staff competency development shall be aligned with the organization’s goals related to co-occurring capability, and incorporate a training plan, training activities, and supervision designed to improve co-occurring core competencies of all staff.
(e) Staff education and in-service training programs shall be evaluated by the CCARC at least annually.
(f) Compliance with 450:24-19-2 shall be determined by a review of the staff development plan, clinical privileging processes; documentation of in-service training programs; and other supporting documentation provided.

450:24-19-3. Annually required in-service training for all employees and volunteers [REVOKED]
(a) In-service presentations shall be conducted each calendar year and are required for all employees and volunteers upon hire and annually thereafter on the following topics:
   (1) Fire and safety;
   (2) AIDS and HIV precautions and infection control;
   (3) Consumer’s rights and the constraints of the Mental Health and Drug or Alcohol Abuse Services Consumer Bill of Rights;
   (4) Confidentiality;
   (5) Oklahoma Child Abuse Reporting and Prevention Act, 10 O.S. §§ 7101-7115; and
   (6) Facility policy and procedures;
   (7) Cultural Competence;
   (8) Co-occurring disorder competency and treatment principles;
   (9) Trauma-informed; and
   (10) Age and developmentally-appropriate trainings, where applicable.
(b) All clinical staff shall have non-physical intervention training in techniques and philosophies addressing appropriate non-violent interventions for potentially-physical interpersonal conflicts, staff attitudes which promote dignity and enhanced self-esteem, keys to effective communication skills, verbal and non-verbal interaction and non-violent intervention within three (3) months of being hired with annual updates thereafter.
(c) The local facility Executive Director shall designate which positions and employees, including temporary employees and volunteers, will be required to successfully complete physical intervention training. An employee or volunteer, so designated by the Executive Director, shall not provide direct care services to consumers until completing this training.
(d) The training curriculum for 450:24-19-3(b) and (c) must be approved by the ODMHAS commissioner or designee in writing prior to conducting of any training pursuant to this provision.
(e) Compliance with 450:24-19-3 shall be determined by a review of in-service training records; personnel records; and other supporting written information provided.

450:24-19-4. First Aid and CPR training [REVOKED]
(a) The CCARC shall have staff during all hours of operation at each program site who maintains current certification in Basic first aid and Cardiopulmonary Resuscitation (CPR).
(b) Compliance with 450:24-19-4 shall be determined by a review of staff training records and other supporting written information, including, but not limited to staff schedules to assure all program sites are continuously staff with staff trained in item (a) above.

SUBCHAPTER 21. FACILITY ENVIRONMENT

450:24-21-1. Facility environment [REVOKED]
(a) The CCARC shall obtain an annual fire and safety inspection from the State Fire Marshall or local authorities which documents approval for continued occupancy.
(b) CCARC staff shall know the exact location, contents and use of first aid supply kits and firefighting equipment. First aid supplies and firefighting equipment shall be maintained in appropriately designated areas within the facility.
(c) There shall be posted written plans and diagrams noting emergency evacuation routes in case of fire, and shelter locations in case of severe weather.
(d) Facility grounds shall be maintained in a manner to provide a safe environment for consumers, personnel, and visitors.
(e) The director of the CCARC or designee shall appoint a safety officer.
(f) The facility shall have an emergency preparedness program designed to provide for the effective utilization of available resources so that consumer care can be continued during a disaster. The emergency preparedness program is evaluated annually and is updated as needed.
(g) Policies for the use and control of personal electrical equipment shall be developed and implemented.
(h) There shall be an emergency power system to provide lighting throughout the facility.
(i) The CCARC director shall ensure there is a written plan to cope with internal and external disasters. External disasters include, but are not limited to, tornadoes, explosions, and chemical spills.
(j) Compliance with 450:24-21-1 shall be determined by visual observation; posted evacuation plans; a review of the CCARC’s annual fire and safety inspection report; and a review of policy, procedures and other supporting documentation provided.
450:24-21-1. Tobacco-free campus [REVOKED]
(a) The facility shall provide a tobacco-free campus for its employees, consumers and visitors. Possession and use of any tobacco product is prohibited on the grounds of the facility by employees, consumers, volunteers and visitors.
(b) Facility will visibly post signs on the property notifying consumers, employees and visitors that the visible possession and use of tobacco products is prohibited.
(c) Facility employees shall not share tobacco or tobacco replacement products with consumers.
(d) The facility shall offer assistance to employees who are tobacco users while he or she is employed by the facility. The assistance shall include, but is not limited to, the provision of information on the health impact of continued tobacco use; the integrated assessment of consumer's tobacco use into standard practice; referrals to tobacco cessation programs such as the Oklahoma Tobacco Helpline; the provision of or access to FDA-approved prescription and/or non-prescription medications for the treatment of nicotine dependence when available; the delivery of evidence based behavioral interventions for tobacco use cessation by counselors and other clinicians; and provision of appropriate follow-up to facilitate cessation intervention and prevent relapse.
(e) The facility shall always inquire of the consumers' tobacco-use status and be prepared to offer treatment upon request of the consumer.
(f) Compliance with this Section shall be determined by visual observation, posted signs, consumer and staff interviews; and a review of the facility's policy, procedures and other supporting documentation provided.

450:24-21-1.2. Hygiene and sanitation [REVOKED]
(a) Residential facilities shall provide the following services and applicable supporting documentation:
(1) Lavatories in a minimum ratio of one per each eight resident beds.
(2) Toilet facilities in a minimum ratio of one per eight resident beds. Each toilet room shall include a lavatory in the same room or immediately adjacent thereto.
(3) Bathing facilities in a minimum ratio of one tub or shower per each eight resident beds.
(4) Sewage discharge into a municipal sewerage system or collected, treated, and disposed of in an independent sewerage system.
(5) The facility shall have proof of regular inspections and treatment by a licensed pest control operator.
(6) Solid waste disposal through public systems or in a manner approved by the local agency having jurisdiction and the OSDH or Department of Environmental Quality (DEQ), as necessary.
(7) Water obtained from an approved public water supply or tested at least quarterly and treated as necessary, thereby maintaining a determination as an approved water supply by the authority having jurisdiction and the OSDH or DEQ, as necessary.
(8) Linen in quantities adequate to provide at least two changes of bedding each week.
(9) Housekeeping services so that a hygienic environment is maintained in the facility.
(b) Outpatient treatment facilities shall provide:
(1) Lavatories and toilet facilities in a minimum ratio of one (1) per twenty (20) persons.
(2) Water and sewerage in the same manner as prescribed for residential facilities.
(3) Housekeeping services so that a hygienic environment is maintained in the facility.

450:24-21-2. Technology [REVOKED]
(a) The facility shall have a written plan regarding the use of technology and systems to support and advance effective and efficient service and business practices. The plan shall include, but not be limited to:
(1) Hardware and software.
(2) Security.
(3) Confidentiality.
(4) Backup policies.
(5) Assistive technology.
(6) Disaster recovery preparedness.
(7) Virus protection.
(b) Compliance with 450:24-21-2 shall be determined by a review of the facility policies, performance improvement plans and technology and system plan.

SUBCHAPTER 23. GOVERNING AUTHORITY

450:24-23-1. Documents of authority [REVOKED]
(a) There shall be a duly constituted authority to govern the facility for assuring legal responsibility and for requiring accountability for performance and operation of the facility (including all components and satellites).
(b) The governing authority shall have written documents of its source of authority, which shall be available to the public upon request.
(c) In accordance with governing body bylaws, rules and regulations, the chief executive officer is responsible to the governing body for the overall day-to-day operation of the facility, including the control, utilization, and conservation of its physical and financial assets and the recruitment and direction of the staff.

(1) The source of authority document shall state:
A. The eligibility criteria for governing body membership;
B. The number and types of membership;
C. The method of selecting members;
D. The number of members necessary for a quorum;
E. Attendance requirements for governing body membership;
F. The duration of appointment or election for governing body members and officers; and
G. The powers and duties of the governing body and its officers and committees or the authority and
permanent final adoptions

responsibilities of any person legally designated to function as the governing body.

(2) There shall be an organizational chart setting forth the operational components of the facility and their relationship to one another.

(d) Compliance with 450:24-23-1 shall be determined by a review of the following: bylaws, articles of incorporation, written document of source of authority, minutes of governing board meetings, job description of the CEO, and the written organizational chart.

SUBCHAPTER 25. SPECIAL POPULATIONS [REVOKED]

450:24-25-1. Americans with Disabilities Act of 1990 [REVOKED]
(a) Under Titles 11 and 111 of the ADA, the CCARC's shall comply with the "Accessibility Guidelines for Buildings and Facilities (ADAAG) for alterations and new construction." United States government facilities are exempt from the ADA as they shall comply with the "Uniform Federal Accessibility Standards (UFAS)", effective August 7, 1984. Also available for use in assuring quality design and accessibility is the American National Standards Institute (ANSI) A117.1 "American National Standard for Accessible and Usable Buildings and Facilities."
(b) State and local standards for accessibility and usability may be more stringent than ADA, UFAS, or ANSI A117.1. The CCARC shall assume responsibility for verification of all applicable requirements and comply with the most stringent standards.
(c) The CCARC shall have written policy and procedures providing or arranging for services for persons who fall under the protection of the Americans With Disabilities Act of 1990 and provide documentation of compliance with applicable Federal, state, and local requirements. A recommended reference is the "Americans With Disabilities Handbook" published in U.S. Equal Employment Opportunities Commission and the U.S. Department of Justice.
(d) Compliance with 450:24-25-1 shall be determined through a review of facility written policy and procedure, and any other supporting documentation.

450:24-25-2. Human Immunodeficiency Virus (HIV), and Acquired Immunodeficiency Syndrome (AIDS) [REVOKED]
(a) The facility shall have a policy of non-discrimination against persons with HIV infection or AIDS.
(b) All facilities shall observe the Universal Precautions For Transmission of Infectious Diseases as set forth in, "Occupational Exposure to Bloodborne Pathogens" published by the (U.S.) Occupations Safety Health Administration [OSHA]; and
(1) There shall be written documentation the aforesaid Universal Precautions are the policy of the facility.
(2) In-service training regarding the Universal Precautions shall be a part of employee orientation and, at least once per year, is included in employee in-service training.
(e) Compliance with 450:24-25-2 is determined by reviews of facility policy and procedure and in-service training records, schedules, or other documentation.

SUBCHAPTER 27. CERTIFICATE OF NEED

450:24-27-1. Purpose
The purpose of this Subchapter is to set forth rules regulating Certificate of Need requirements for applicable facilities.

450:24-27-2. Applicability
The rules set forth in this Subchapter are applicable only to facilities that seek to obtain initial certification under this Chapter for residential substance use disorder services, medically supervised withdrawal management services, or halfway house services and that intend to enroll with the Oklahoma Health Care Authority as a Medicaid provider. Such facilities will be required to provide a Certificate of Need from the Department to the Oklahoma Health Care Authority upon enrollment as a Medicaid provider, in accordance with OAC 317:30-5-95.44(a)(3).

450:24-27-3. Certificate of Need requirements
(a) Applicable providers must provide required documentation and meet criteria as specified in 450:18-17-3 to obtain a Certificate of Need.
(b) Failure of a facility to obtain a Certificate of Need shall not prohibit the facility from obtaining certification from the Department.

[TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES]

CHAPTER 27. STANDARDS AND CRITERIA FOR MENTAL ILLNESS SERVICE PROGRAMS

[OAR Docket #21-437]

RULEMAKING ACTION: PERMANENT final adoption

RULES:
450:27-1-1 [AMENDED]
450:27-1-2 [AMENDED]
Subchapter 3. Organization Structure and Administrative Operations
Part 1. Services and Facility Organization
450:27-3-3 [REVOKED]
450:27-3-3.1 [REVOKED]
450:27-3-4 [REVOKED]
450:27-3-5 [REVOKED]
Part 3. Human Resources Organization [REVOKED]
450:27-3-21 [REVOKED]
INCORPORATIONS BY REFERENCE:

n/a

GIST/ANALYSIS:

The proposed rule revisions to Chapter 27 amend language to remove duplicative language that is addressed under new proposed language in Chapter 1. The intent is to consolidate duplicative language to increase

consistency and reduce regulatory language in accordance with Executive Order 2020-03. Revisions also include the removal of language regarding

Behavioral Health Homes that is unnecessary due to programmatic changes.

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., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE

DATE OF SEPTEMBER 15, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS

450:27-1-1. Purpose

(a) This chapter sets forth the Standards and Criteria used in the certification of certain facilities or organizations providing mental health treatment services and implements 43A O.S. § 3-323A which authorizes the Board of Mental Health and Sub-

stance Abuse Services, or the Commissioner upon delegation by the Board, to certify facilities as a Mental Illness Service Program.

(b) The rules regarding the certification process including but not necessarily limited to application, fees and administrative sanctions are found in the Oklahoma Administrative Code, Title 450 Chapter 1, Subchapters 5 and 9.

(c) Rules outlining general certification qualifications applicable to facilities and organizations certified under this Chapter are found in OAC 450:1-9-5 through OAC 450:1-9-5.3.

450:27-1-2. Definitions

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

"Abuse" means the causing or permitting of harm or threatened harm to the health, safety, or welfare of a consumer by a staff responsible for the consumer's health, safety, or welfare, including but not limited to: non-accidental physical injury or mental anguish; sexual abuse; sexual exploitation; use of mechanical restraints without proper authority; the intentional use of excessive or unauthorized force aimed at hurting or injuring the resident; or deprivation of food, clothing, shelter, or healthcare by a staff responsible for providing these services to a consumer.

"Advanced Practice Registered Nurse or (APRN)" means a registered nurse in good standing with the Oklahoma Board of Nursing, and has acquired knowledge and clinical skills through the completion of a formal program of study approved by the Oklahoma Board of Nursing Registration and has obtained professional certification through the appropriate National Board recognized by the Oklahoma Board of Nursing.
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Advanced Practice Registered Nurse services are limited to the scope of their practice as defined in 59 Okla. Stat. § 567.3a and corresponding rules and regulations at OAC 485:10-5-1 through 10-16-9.

"Behavioral Health Home or BHII" means a specifically organized entity that functions within a currently ODMHAS certified mental health treatment program organization to promote enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness. BHII's ensure comprehensive team-based health care, meeting physical, mental health, and substance use disorder care needs. Health care is delivered utilizing a whole-person, patient-centered, coordinated care model for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). Care coordination is provided for all aspects of the individual's life and for transitions of care the individual may experience.

"Case management services" means planned referral, linkage, monitoring and support, and advocacy provided in partnership with a consumer to assist that consumer with self sufficiency and community tenure and take place in the individual's home, in the community, or in the facility, in accordance with a service plan developed with and approved by the consumer and qualified staff.

"Children's Health Home Specialist" means an individual within the children's Behavioral Health Home interdisciplinary team that will provide support, coaching and activities that promote good physical and mental health to individuals, families and groups. The focus of the Children's Health Home Specialist will include nutrition, healthy living habits, exercise, and preventing and/or managing chronic health conditions. Children's Health Home Specialists must be credentialed by ODMHAS as a Behavioral Health Aide or higher and complete training in Well Power or credentialed as a Wellness Coach through ODMHAS.

"Clinical privileging" means an organized method for treatment facilities to authorize an individual permission to provide specific care and treatment services to consumers within well-defined limits, based on the evaluation of the individual's license, education, training, experience, competence, judgment, and other credentials.

"Community-based Structured Crisis Center" or "CBSCC" means a program of non-hospital emergency services for mental health and substance abuse crisis stabilization as authorized by 43A O.S. §3-317, including, but not limited to, observation, evaluation, emergency treatment and referral, when necessary, for inpatient psychiatric or substance abuse services. This service is limited to CMHC's and Comprehensive Community Addiction Recovery Centers (CCARCs) who are certified by the Department of Mental Health and Substance Abuse Services or facilities operated by the Department of Mental Health and Substance Abuse Services.

"Community mental health center" or "CMHC" means a facility offering a comprehensive array of community-based mental health services, including but not limited to, inpatient treatment, outpatient treatment, partial hospitalization, emergency care, consultation and education; and, certain services at the option of the center, including, but not limited to, prescreening, rehabilitation services, pre-care and aftercare, training programs, and research and evaluation.

"Consumer" means an individual, adult, adolescent, or child, who has applied for, is receiving or has received evaluation or treatment services from a facility operated or certified by ODMHAS or with which ODMHAS contracts and includes all persons referred to in OAC Title 450 as client(s) or patient(s) or resident(s) or a combination thereof.

"Consumer advocacy" includes all activities on behalf of the consumer to assist with or facilitate resolution of problems in the acquisition of resources or services needed by the consumer.

"Contract" means a document adopted by the governing authority of a treatment facility and any other organization, facility, or individual, which specifies services, personnel, or space to be provided by the program, as well as the monies to be expended in exchange.

"Co-occurring disorder" (COD) means any combination of mental health symptoms and substance abuse symptoms or diagnoses that affect a consumer and are typically determined by the current Diagnostic and Statistical Manual of Mental Disorders.

"Co-occurring disorder capability" means the organized capacity within any type of program to routinely screen, identify, assess, and provide properly matched interventions to consumers with co-occurring disorders.

"Co-occurring disorder enhanced" means that the program (or subunit of the program) provides a specialized service designed for individuals with co-occurring disorders, usually with a higher level of available service capacity or intensity for the co-occurring substance use disorder than would be the case in a comparable co-occurring disorder capable program.

"Crisis Diversion" means an 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.

"Crisis Intervention" means actions taken, and services provided to address emergency psychological, physiological, and safety aspects of alcohol, drug-related, and mental health crises.

"Crisis stabilization" means emergency, psychiatric, and substance abuse services for the resolution of crisis situations and may include placement of an individual in a protective environment, basic supportive care, and medical assessment, and, if needed, referral to an ODMHAS certified facility having nursing and medical support available.

"Critical incident" or "Incident" means an occurrence or set of events inconsistent with the routine operation of a facility, service setting; or otherwise routine care of a consumer. Critical incidents specifically include but are not necessarily limited to the following: adverse drug events; self destructive behavior; deaths and injuries to consumers; staff and visitors; medication errors; residential consumers that are missing or considered in to have eloped; neglect or abuse of a consumer; fire; unauthorized disclosure of information; damage to or theft
of property belonging to consumers or the facility; other unex-
pected occurrences; or events potentially subject to litigation. An incident may involve individuals or results.

"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, religious, sexual orientation, and/or social group.

"Discharge criteria" means individualized measures by which a program and the consumer determine readiness for discharge or transition from services being provided by that facility. These may reference general guidelines as specified in facility policies or procedures and/or in published guidelines including, but not limited to, the current ASAM criteria for individuals with substance use disorders, but should be individualized for each consumer and articulated in terms of consumer behaviors, resolutions of specific problems, and attainment of goals developed in partnership with the participant and the provider.

"DSM" means the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"Emergency detention" means the detention of a person who appears to be a person requiring treatment in a facility approved by the Commissioner of Mental Health and Substance Abuse Services as appropriate for such detention after the completion of an emergency examination, either in person or via telemedicine, and a determination that emergency detention is warranted as defined in Title 43A O.S. Section 5-206.

"Emergency examination" means the examination of a person who appears to be a mentally ill person, an alcohol-dependent person, or a drug-dependent person and a person requiring treatment, and whose condition is such that it appears that emergency detention may be warranted by a licensed mental health professional to determine if emergency detention of the person is warranted.

"Emergency services" means twenty-four (24) hour capability for assessment, intervention, and resolution of a consumer's crisis or emergency provided in response to unanticipated, unscheduled emergencies requiring prompt intervention to resolve immediate, overwhelming problems that severely impair the individual's ability to function or remain in the community and may include placement of the individual in a protective environment, withdrawal management, individual and group consultation, and medical assessment.

"Evidence based practice" means programs or practices that are supported by research methodology and have produced consistently positive patterns of results when replicated within the intent of the published guidance.

"Face-To-Face" for the purposes of the delivery of behavioral health care, means a face-to-face physical contact and in-person encounter between the health care provider and the consumer, including the initial visit. The use of telemedicine shall be considered a face-to-face encounter.

"Facilities or Facility" means entities as described in Title 43A O.S. § 1-103(7), community mental health centers, residential mental health facilities, community based structured crisis centers, certified services for the alcohol and drug dependent, programs of assertive community treatment, eating disorder treatment, gambling addiction treatment, and narcotic treatment programs.

"Family" means the parents, brothers, sisters, other relatives, foster parents, guardians, and others who perform the roles and functions of family members in the lives of consumers.

"Hospital Liaison" means an individual within the Behavioral Health Home interdisciplinary team that works closely with hospital staff to assess the suitability of transition plans for consumers enrolled in a Behavioral Health Home. Hospital Liaisons will also work with other long term, residential facilities to plan for coordination of care during and after the consumer's residential stay. Hospital Liaisons must be certified by ODMH&AS as a Behavioral Health Case Manager I or II and complete trainings as required by ODMH&AS.

"Licensed Behavioral Health Professional" or "LBHP" means:

(A) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry;

(B) An Advanced Practice Registered Nurse 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 certified in a psychiatric mental health specialty;

(C) A Clinical Psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists;

(D) A Physician Assistant who is licensed in good standing in Oklahoma and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions;

(E) A practitioner with a license to practice in the state in which services are provided by one of the following licensing boards:

(i) Psychology;

(ii) Social Work (clinical specialty only);

(iii) Professional Counselor;

(iv) Marriage and Family Therapist;

(v) Behavioral Practitioner; or

(vi) Alcohol and Drug Counselor;

(C) 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

(D) A physician assistant who is licensed in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or therapy functions.

"Licensed mental health professional" or "LMHP" as defined in Title 43A §1-103(11).

"Licensure candidate" means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision
requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:

(A) Psychology;
(B) Social Work (clinical specialty only);
(C) Professional Counselor;
(D) Marriage and Family Therapist;
(E) Behavioral Practitioner; or
(F) Alcohol and Drug Counselor.

"Linkage" refers to the communication and coordination with other service providers to assure timely appropriate referrals between the CMHC and other providers.

"Medically necessary" means health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

"Medication error" means an error in prescribing, dispensing or administering medication, regardless if the error reached the consumer, e.g., omission of prescribed drugs, giving drugs not prescribed, prescribing inappropriate drugs, prescribing or administering incorrect dosages, incorrectly filling or labeling prescriptions, incorrectly transcribing medication orders.

"Nurse Care manager" means a Licensed Practical Nurse (LPN) or a Registered Nurse (RN).

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"Oklahoma Administrative Code" or "OAC" means the publication authorized by 75 O.S. § 256 known as The Oklahoma Administrative Code or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A) (1) (a) and maintained in the Office of Administrative Rules.

"Peer Recovery Support Specialist" or "PRSS" means an individual who meets the qualifications and is certified as a PRSS pursuant to OAC 450:53.

"Performance Improvement" or "PI" means an approach to the continuous study and improvement of the processes of providing health care services to meet the needs of consumers and others. Synonyms, and near synonyms include continuous quality improvement, continuous improvement, organization-wide quality improvement and total quality management.

"Primary Care Practitioner (PCP)" means a licensed physician, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA) licensed in the State of Oklahoma.

"Program of Assertive Community Treatment" or "PACT" is a clinical program that provides continuous treatment, rehabilitation, and support services to persons with mental illness in settings that are natural to the consumer.

"Progress notes" mean a chronological written description of services provided to a consumer, resident, client, or patient that documents, utilizing acceptable documentation practices, the consumer’s response related to the intervention plan or services provided.

"Psychiatric Residential Treatment Facility" or "PRTF" means a non-hospital facility that provides inpatient psychiatric services to individuals under the age of twenty-one (21).

"Psychological-Social evaluations Psychosocial assessments" are in-person interviews conducted by professionally trained personnel designed to elicit historical and current information regarding the behavior and experiences of an individual, and are designed to provide sufficient information for problem formulation and intervention.

"Psychotherapy" or "Therapy" means a goal directed process using generally accepted clinical approaches provided face-to-face by a qualified service provider with consumers in individual, group or family settings to promote positive emotional or behavioral change.

"Recuperative Support Specialist" or "RSS" means an individual who has completed the ODMHSAS RSS training and has passed the ODMHSAS RSS exam.

"Rehabilitation Services" means face-to-face individual or group services provided by qualified staff to develop skill necessary to perform activities of daily living and successful integration into community life.

"Resident" means a person residing in a community living program certified by ODMHSAS.

"Residential treatment" means a structured, 24-hour supervised treatment program for individuals who are mentally ill with a minimum of twenty-one (21) hours of therapeutic services provided per week with the emphasis on stabilization and rehabilitation for transfer to a less restrictive environment. Stay in the program is time limited.

"Restraint" refers to manual, mechanical, and chemical methods that are intended to restrict the movement or normal functioning of a portion of an individual’s body.

"Risk Assessment" means a clinical function that aims to determine the nature and severity of the mental health problem, determine which service response would best meet the needs of the consumer, and how urgently the response is required.

"Screening" means the process to determine whether the person seeking assistance needs further comprehensive assessment.

"Sentinel event" is a type of incident that is an unexpected occurrence involving the death or serious physical or psychological injury to a consumer, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a consumer. These events signal the need for immediate investigation and response. Sentinel events include, but are not limited to: suicide, homicide, criminal activity, assault and other forms of violence, including domestic violence or sexual assault, and adverse drug events resulting in serious injury or death.

"Service Intensity" means the frequency and quantity of services needed, the extent to which multiple providers or agencies are involved, and the level of care coordination required.

"Service plan" or "Treatment plan" means the document used during the process by which a qualified service provider and the consumer together and jointly identify and rank problems, establish agreed-upon immediate short-term and long-term goals, and decide on the treatment process and resources to be utilized.
"Socialization" means all activities, which encourage interaction and the development of communication, interpersonal, social and recreational skills and can include consumer education.

"SoonerCare" means Oklahoma's Medicaid program.

"Supportive services" refers to assistance with the development of problem solving and decision making skills to maintain or achieve optimal functioning within the community and can include consumer education.

"Systems of Care values" means a philosophy, which embraces a family driven, child centered model of care that integrates and coordinates the efforts of different agencies and providers to individualize care in the least restrictive setting that is clinically appropriate.

"Tobacco" means any nicotine delivery product or device that is not approved by the U.S. Food and Drug Administration (FDA) for the purpose of nicotine dependence treatment, including, but not limited to cigarettes, cigars, snuff, chewing tobacco, electronic cigarettes and vaping devices.

"Trauma informed capability" means the capacity for a facility and all its programs to recognize and respond accordingly to the presence of the effects of past and current traumatic experiences in the lives of its consumers.

"Volunteer" means any person who is not on the program's payroll, but provides services and fulfills a defined role within the program and includes interns and practicum students.

"Wellness" means the condition of good physical, mental and emotional health, especially when maintained by an appropriate diet, exercise, and other lifestyle modifications.

"Wellness Coach" means an individual who is actively working on personal wellness and who is designated to collaborate with others to identify their personal strengths and goals within the eight dimensions of wellness (spiritual, occupational, intellectual, social, physical, environmental, financial, and emotional).

(A) In order to qualify to be a Wellness Coach, individuals shall:

(i) Have a behavioral health related associates degree or two years of experience in the field and/or have an active certification and/or license within the behavioral health field (e.g. PRSS, Case Management, LBHP, LPN, etc.); and

(ii) Complete the ODMHSAS Wellness Coach Training Program and pass the examination with a score of 80% or better.

(B) Wellness Coach roles and responsibilities include:

(i) Role model wellness behaviors and actively work on personal wellness goals;

(ii) Apply principles and processes of coaching when collaborating with others;

(iii) Facilitate wellness groups;

(iv) Conduct motivational interventions;

(v) Practice motivational interviewing techniques;

(vi) Provide referrals to community resources for nutrition education, weight management, Oklahoma Tobacco Helpline, and other wellness-related services and resources;

(vii) Create partnerships within local community to enhance consumer access to resources that support wellness goals;

(viii) Raise awareness of wellness initiatives through educational in-service and community training;

(ix) Elevate the importance of wellness initiatives within the organization;

(x) Promote a culture of wellness within the organization for both consumers and staff;

(xi) Respect the scope of practice and do not practice outside of it, referring people to appropriate professionals and paraprofessionals as needed.

"Wraparound approach" means a team-based planning and implementation process to improve the lives of children with complex needs and their families by developing individualized plans of care. The key characteristics of the process are that the plan is developed by a family centered team, is individualized based on the strengths and culture of the child and their family, and is driven by needs rather than services.

SUBCHAPTER 3. ORGANIZATION STRUCTURE AND ADMINISTRATIVE OPERATIONS

PART 1. SERVICES AND FACILITY ORGANIZATION

450:27-3-3. Organizational and facility description [REVOKED]

(a) The program shall have a written organizational description which is reviewed annually by its governing authority and minimally includes descriptions of:

(1) Population(s) to be served;

(2) The overall program mission statement, and,

(3) The annual goals and objectives for the program, including the goal of continued progress for the agency in providing recovery oriented, culturally competent, and trauma informed services.

(b) The provider's governing authority shall review and approve the mission statement and annual goals and objectives and document their approval.

(c) The provider shall make the organizational description, mission statement and annual goals available to staff.

(d) The provider shall make the organizational description, mission statement and annual goals available to the general public upon request.

(e) Compliance with OAC 450:27-3-3 shall be determined by a review of the facility's target population definition, facility policies and procedures, mission statement, written plan for professional services and any other supporting documentation.
450:27-3-1. Organizational and facility description; program components [REVOKED]
(a) Each behavioral health provider shall have in writing, by program component or service, the following:
(1) Description of specific services by program component, including the philosophy of recovery-oriented and person-centered service delivery;
(2) Descriptions of qualifications required of staff providing treatment and related services;
(3) Admission and exclusionary criteria that identify the types of consumers for whom the services with the program component are primarily intended; and,
(4) Program component goals and objectives, including making progress toward trauma informed, and culturally competent service delivery; and
(b) Compliance with OAC 450:27-3-3.1 shall be determined by a review of the facility’s target population definition; facility policies and procedures; written plan for professional services; and, any other supporting documentation.

450:27-3-4. Technology [REVOKED]
(a) The agency shall have a written plan regarding the use of technology and systems to support and advance effective and efficient service and business practices. The plan shall include, but not be limited to:
(1) Hardware and software,
(2) Security,
(3) Confidentiality,
(4) Backup policies,
(5) Assistive technology,
(6) Disaster recovery preparedness,
(7) Virus protection,
(b) Compliance with this Section shall be determined by a review of the facility policies, performance improvement plans and technology and system plan.

450:27-3-5. Tobacco-free campus [REVOKED]
(a) The facility shall provide a tobacco-free campus for its employees, consumers and visitors. Possession and use of any tobacco product is prohibited on the grounds of the facility by employees, consumers, volunteers and visitors.
(b) Facility will visibly post signs on the property notifying consumers, employees and visitors that the visible possession and use of tobacco products is prohibited.
(c) Facility employees shall not share tobacco or tobacco replacement products with consumers.
(d) The facility shall offer assistance to employees who are tobacco users while he or she is employed by the facility. The assistance shall include, but is not limited to, the provision of information on the health impact of continued tobacco use; the integrated assessment of consumer’s tobacco use into standard practice; referrals to tobacco cessation programs such as the Oklahoma Tobacco Helpline; the provision of or access to FDA approved prescription and/or non-prescription medications for the treatment of nicotine dependence when available; the delivery of evidence-based behavioral interventions for tobacco use cessation by counselors and other clinicians; and provision of appropriate follow up to facilitate cessation intervention and prevent relapse.
(e) The facility shall always inquire of the consumers’ tobacco use status and be prepared to offer treatment upon request of the consumer.
(f) Compliance with this Section shall be determined by visual observation; posted signs; consumer and staff interviews; and a review of the facility’s policy, procedures and other supporting documentation provided.

PART 3. HUMAN RESOURCES ORGANIZATION [REVOKED]

450:27-3-21. Personnel policies and procedures [REVOKED]
(a) The facility shall have written personnel policies and procedures approved by the governing authority.
(b) Current and complete copies of personnel policies and procedures shall be available to staff at each service location.
(c) All employees shall have access to personnel policies and procedures, as well as other rules and regulations governing the conditions of their employment.
(d) Compliance with 450:27-3-21 shall be determined by a review of written personnel policies and procedures, and other supporting documentation provided.

450:27-3-22. Job descriptions [REVOKED]
(a) There shall be job descriptions for all positions. The descriptions must set forth minimum qualifications and duties of each position retained to perform services for the facility, including fulltime, part time, and contractual employees as well as consultants.
(b) Employees and consultants shall have access to and individually be knowledgeable about their own job descriptions and related accountabilities.
(c) Compliance with 450:27-3-22 shall be determined by a review of written job descriptions for all facility positions, interviews with staff, and other supporting documentation provided.

450:27-3-23. Volunteers [REVOKED]
(a) If volunteers are utilized, the program will have specific policies and procedures to define the purpose, scope, training, supervision related to the use of volunteers.
(b) A qualified staff member shall be assigned as the volunteer coordinator.
(c) Policies and procedures for volunteers and the services they perform shall be initially approved by the governing authority and upon revision.
(d) Volunteers are required to receive in-service training pursuant to 27-3-26.
(e) Compliance with 450:27-3-23 shall be determined by a review of volunteer policies and procedures; designation of a volunteer coordinator; written orientation plan; orientation program; written goals and objectives; volunteer personnel files; and volunteer records.
450:27-3-24. Staff qualifications [REVOLED]
(a) The facility shall maintain, for each staff who provides clinical services, documentation of qualifications or training specific to the clinical services they provide within the facility.
(b) Documentation shall be organized within a clinical privileging framework that is based on policies and procedures approved by the governing authority.
(c) Compliance with 450:27-3-24 shall be determined by a review of staff personnel files and other supporting documentation provided.
(d) Failure to comply with 450:27-3-24 will result in the initiation of procedures to deny, suspend and/or revoke certification.

450:27-3-25. Staff development [REVOLED]
(a) The facility shall have a written plan for the professional growth and development of all staff.
(b) This plan shall include, but not be limited to:
   (1) new employee orientation;
   (2) in-service training and education programs; and
   (3) mechanisms for insuring outside continuing educational opportunities for staff members.
(c) The results of performance improvement activities, facility licensing, accrediting, and audit findings and recommendations shall be addressed and documented in the staff development and clinical privileging processes.
(d) Staff competency development shall be aligned with the organization's goals and incorporate a training plan, training activities, and supervision designed to improve competencies of all staff.
(e) Staff education and in-service training programs shall be evaluated by the provider at least annually.
(f) Compliance with 450:27-3-25 shall be determined by a review of the staff development plan, clinical privileging processes, documentation of in-service training programs; and other supporting documentation provided.

450:27-3-26. Annually required in-service training for all employees and volunteers [REVOLED]
(a) The facility shall arrange for and document in-service training for each employee/volunteer upon hire and annually thereafter on the following topics:
   (1) Fire and safety;
   (2) Most current version of the ODMHSAS Bill of Rights;
   (3) Confidentiality;
   (4) Cultural Competence; and
   (5) Impact of trauma;
   (6) AIDS and HIV precautions and infection control;
   (7) Oklahoma Child Abuse Reporting and Prevention Act, 10 O.S. §§ 7101-7115;
   (8) Person and family-centered services;
   (9) Expectations regarding professional conduct;
   (10) The prevention of violence in the workplace; and
   (11) Age- and developmentally-appropriate trainings, where applicable.
(b) Compliance with 450:27-3-26 shall be determined by a review of in-service training; personnel records; and other supporting written information provided.

450:27-3-27. Clinical supervision [REVOLED]
(a) Clinical supervision is a vital component of the provision of quality treatment. Clinical supervision shall be provided for those delivering direct services and shall be provided by persons knowledgeable of clinical services as determined by the program.
(b) All facilities shall have written policies and procedures, operational methods, and documentation of the provision of clinical supervision for all direct treatment and service staff. For facilities that employ only one service provider, supervision will be in the form of clinical consultation from a qualified service provider in the same field. These policies shall include, but are not limited to:
   (1) Credentials required for the clinical supervisor;
   (2) Specific frequency for case reviews with treatment and service providers;
   (3) Methods and time frames for supervision of individual, group, and educational treatment services; and
   (4) Written policies and procedures defining the program's plan for appropriate counselor to consumer ratio, and a plan for how exceptions may be handled.
(c) Ongoing clinical supervision should address:
   (1) The appropriateness of treatment selected for the consumer;
   (2) Treatment effectiveness as reflected by the consumers meeting their individual goals; and
   (3) The provision of feedback that enhances the clinical skills of service providers.
(d) Compliance with this Section may be determined by a review of the following:
   (1) Policies and procedures;
   (2) Clinical services manuals;
   (3) Clinical supervision manuals;
   (4) Documentation of clinical supervision;
   (5) Personnel records;
   (6) Interviews with staff; and
   (7) Other facility documentation.
(e) Failure to comply with this Section will result in the initiation of procedures to deny, suspend and/or revoke certification.

PART 5. SAFETY AND RISK MANAGEMENT

450:27-3-41. Health and Safety; facility environment [REVOLED]
(a) The facility shall obtain an annual fire and safety inspection from the State Fire Marshall or local authorities which documents approval for occupancy and use at each site where services are provided.
(b) The facility shall appoint a safety officer.
(c) Facility grounds shall be maintained in a manner to provide a safe environment for consumers, personnel, and visitors.
Permanent Final Adoptions

(d) First aid supplies and firefighting equipment shall be maintained in appropriately designated areas within the facility.
(e) The staff shall know the exact location of and how to use first aid supply kits and firefighting equipment.
(f) The facility shall post written plans and diagrams noting emergency evacuation routes in case of fire, and shelter locations in case of severe weather, at each site where services are provided.

(29) There shall be an emergency power system to provide lighting throughout each location where consumers receive services.
(h) Compliance with 450:27-3-41 shall be determined by visual observation, posted evacuation plans, a review of the provider’s annual fire and safety inspection report, and a review of policy, procedures, and other supporting documentation provided.

450:27-3-42. Health and Safety; emergency procedures [REVOKED]

(a) The facility shall have an emergency preparedness program to assure continuation of necessary services in the event of disasters or related emergencies.
(b) The emergency preparedness program shall be evaluated annually and be updated as needed.
(c) The facility shall ensure there is a written plan to cope with internal and external disasters including, but not limited to, tornadoes, fires, and chemical spills.
(d) Compliance with 450:27-3-42 shall be determined by visual observation, posted plans, and, a review of policy, procedures and other supporting documentation provided.

PART 7. SPECIAL POPULATIONS [REVOKED]

450:27-3-61. Americans with Disabilities Act of 1990 [REVOKED]

(a) Under Titles 11 and 111 of the ADA, the facility shall comply with the “Accessibility Guidelines for Buildings and Facilities (ADAAG) for alterations and new construction.” United States government facilities are exempt for the ADA as they shall comply with the “Uniform Federal Accessibility Standards (UFAS)” effective August 7, 1984. Also available for use in ensuring quality design and accessibility is the American National Standards Institute (ANSI) A117.1 “American National Standard for Accessible and Usable Buildings and Facilities.”
(b) State and local standards for accessibility and usability may be more stringent than ADA, UFAs, or ANSI A117.1. The facility shall assume responsibility for verification of all applicable requirements and comply with the most stringent standards.
(c) The facility shall have written policy and procedures providing or arranging for services for persons who fall under the protection of the Americans With Disabilities Act of 1990 and provide documentation of compliance with applicable Federal, state, and local requirements. A recommended reference is the “Americans With Disabilities Handbook” published by the U.S. Equal Employment Opportunities Commission and the U.S. Department of Justice.
(d) Compliance with 450:27-3-61 shall be determined through a review of facility written policy and procedure; and any other supporting documentation.

450:27-3-62. Human Immunodeficiency Virus (HIV), and Acquired Immunodeficiency Syndrome (AIDS) [REVOKED]

(a) The facility shall have a policy of non-discrimination against persons with HIV infection or AIDS.
(b) All facilities shall observe the Universal Precautions For Transmission of Infectious Diseases as set forth in, “Occupational Exposure to Bloodborne Pathogens” published by the (U.S.) Occupational Safety Health Administration (OSHA); and

(4) There shall be written documentation the above-referenced Universal Precautions are the policy of the facility;
(5) In-service training regarding the Universal Precautions shall be a part of employee orientation and, at least once per year, is included in employee in service training.
(c) Compliance with 450:27-3-62 is determined by reviews of facility policy and procedure and in-service training records, schedules, or other documentation.

SUBCHAPTER 5. QUALITY MANAGEMENT OF OPERATIONS

PART 1. OPERATIONS TO SUPPORT CONTINUOUS PROGRAM MANAGEMENT [REVOKED]

450:27-5-1. Information analysis and planning [REVOKED]

(a) The facility shall have a defined and written plan to solicit, collect, analyze and use input from consumers and other stakeholders to create and evaluate services that meet or exceed their expectations. This should also include, but is not limited to, information from:

(1) Consumers;
(2) Governing Authority;
(3) Staff;
(4) Stakeholders;
(5) Outcomes management processes and
(6) Quality record review
(b) The information analysis plan shall define a continuously operating system to collect data and information no less frequently than quarterly to effectively manage the organization.
(c) Information collected shall be analyzed to improve consumer services and organizational performance as referenced in 450:27-5-2.
(d) The facility shall prepare an end of year management report, which shall include but not be limited to:

(1) an analysis of the information gathered and
(2) performance improvement program findings;

(2) The management report shall be communicated and made available to, among others:

(1) the governing authority;

(2) facility staff; and

(3) funders/payers, if and when requested.

(f) Compliance with OAC 450:27-5-1 shall be determined by a review of information gathered; facility goals and objectives; and other supporting documentation provided.

450:27-5-2. Performance improvement program

[REVOKED]

(a) The facility shall have an ongoing performance improvement program designed to objectively and systematically monitor, evaluate and improve the quality of consumer care.

(b) The facility shall appoint a performance improvement officer.

(c) The Performance improvement program shall also address the fiscal management of the organization.

(d) The facility shall have an annual written plan for performance improvement activities. The plan shall include but not be limited to:

(1) Outcomes management specific to each program component which minimally measures:

(A) efficiency;

(B) effectiveness; and

(C) consumer satisfaction.

(2) A quarterly quality consumer record review to evaluate and ensure, among others:

(A) the quality of services delivered;

(B) the appropriateness of services; and

(C) patterns of service utilization; and

(D) consumers are provided an orientation to services and actively involved in making informed choices regarding the services they receive;

(E) assessments are thorough, timely, and complete;

(F) treatment goals and objectives are based on, at a minimum, an assessment findings, and

(i) consumer input;

(G) services provided related to the treatment plan goals and objectives;

(H) services are documented as prescribed by policy; and

(I) the service plan is reviewed and updated as prescribed by policy.

(3) Clinical privileging and;

(4) Review of critical and unusual incidents and consumer grievances and complaints.

(2) The facility shall monitor the implementation of the performance improvement plan on an ongoing basis and make adjustments as needed.

(4) Performance improvement findings shall be communicated and made available to, among others:

(1) the governing authority;

(2) facility staff; and

(3) consumers.

(4) stakeholders; and

(5) funders/payers, as requested.

(g) Compliance with 450:27-5-2 shall be determined by a review of the written program evaluation plan; written program evaluations (annual and/or special or interim); program goals and objectives; and other supporting documentation provided.

PART 5. OPERATIONS FOR PROTECTION OF CONSUMER RIGHTS

450:27-5-41. Confidentiality of mental health and drug or alcohol abuse treatment information

[REVOKED]

(a) Facility confidentiality policy, procedures and practices must comply with federal and state law, guidelines, and standards, and with OAC 450:15-2-20-1, OAC 450:15-3-60, as applicable.

(b) Compliance with 450:27-5-41 shall be determined review of facility policies, on-site observation, and review of clinical documentation.

SUBCHAPTER 7. CLINICAL SERVICES

PART 3. ADDITIONAL OR OPTIONAL SERVICES

450:27-7-34. Day treatment services for children and adolescents

(a) Day treatment services are designed for non-residential consumers who spend only a part of a twenty-four (24) hour period in the program.

(1) Hours of operation shall be held during periods which make it possible for consumers to receive a minimum of three (3) hours of treatment and services each day for five (5) days each week in the program, excluding time spent in fulfillment of academic educational activities as required by law; and,

(2) Services provided shall be co-occurring disorders capable and include, at a minimum, the following:

(A) Weekly individual therapy, group, and family therapy;

(B) Social skills development through activities which encourage interaction and the development of communications and interpersonal skills;

(C) Integrated attention to decision making and healthy skill building regarding substance use, including nicotine and caffeine;

(D) Recreation and leisure activities;

(E) Emergency services;

(F) Habilitation services;

(G) Referral to other resources when indicated by treatment goals and objectives; and,

(H) Provide, or arrange for, academic education as required by state or federal law.
(b) Compliance with 450:27-7-34 shall be determined by on-site observation; and a review of the following: clinical records, policy and procedures, and program descriptions.

PART 5. CLINICAL DOCUMENTATION

450:27-7-41. Clinical record content, screening, intake and assessment, documentation
(a) The facility shall complete a face-to-face screening with each individual to determine appropriateness of admission in accordance with 450:27-7-2. Screening services.
(b) The facility shall document the face-to-face screening conducted how the consumer was assisted to identify goals, how the consumer received integrated screening to identify both immediate and ongoing needs and how the consumer was assisted to determine appropriateness of admission, and/or to access other appropriate services.
(c) Each consumer admitted for treatment for co-occurring services shall be assessed by a qualified professional demonstrating competency in the use of ASAM criteria, according to ASAM criteria, which includes a list of symptoms for all six dimensions and each level of care, to determine a clinically appropriate placement in the least restrictive level of care. Facilities must ensure that a consumer's refusal of a particular service does not preclude the consumer from accessing other needed co-occurring treatment services. Should the service provider determine the consumer's needs cannot be met within the facility, clinical assessments and referrals for the consumer shall be documented.
(d) Upon determination of appropriate admission, consumer demographic information shall be collected, as defined by facility policies and procedures.
(e) For persons admitted to service, the facility shall complete a psychological-social-psychosocial assessment which gathers sufficient information to assist the consumer develop an individualized service plan.
(f) An intake assessment update, to include date, identifying information, source of information, present needs, present life situation, current level of functioning, and what consumer wants in terms of service, is acceptable as meeting requirements of 450:27-7-41 only on re-admissions within one (1) year of previous admission at the facility.
(g) Compliance with 450:450:27-7-41 shall be determined by a review of the following: psychological-social-psychosocial assessment instruments; consumer records; case management assessments; interviews with staff and consumers; policies and procedures and other facility documentation.

450:27-7-46. Discharge summary [REVOKED]
(a) A discharge summary shall document the consumer’s progress made in treatment; response to services rendered; and recommendation for any referrals, if deemed necessary. It shall include a discharge plan which lists written recommendations, and specific referrals for implementing aftercare services, including medications. Aftercare plans shall be developed with the knowledge and cooperation of the consumer, when possible.
(b) A discharge summary shall be entered in each consumer’s record within fifteen (15) calendar days of discharge from facility services.
(c) In the event of death of a consumer, in lieu of a discharge summary, a summary statement including applicable information shall be documented in the record.
(d) Compliance with 450:27-7-46 shall be determined by a review of closed consumer records.

450:27-7-47. Incident reporting; documentation and notification [REVOKED]
(a) The facility shall document the occurrence of critical or similar incidents, as defined in facility policy and in accordance with OAC 450:27-3-43.
(b) Incident reports shall minimally include:
   (1) the facility, name and signature of the person(s) reporting the incident;
   (2) the name(s) of the consumer(s), staff member(s) or property involved;
   (3) the time, date and physical location of the critical incident;
   (4) the time and date the incident was reported and name of the staff person within the facility to whom it was reported;
   (5) a description of the incident;
   (6) resolution or action taken, date action taken, and signature of appropriate staff; and
   (7) severity of each injury, if applicable. Severity shall be indicated as follows:
      (A) No off-site medical care required or first aid care administered on-site;
      (B) Medical care by a physician or nurse or follow-up attention required; or
      (C) Hospitalization or immediate off-site medical attention was required;
(b) Incidents shall be reported to ODMHSA within specific timeframes, as follows:
   (1) Incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax or other approved modalities that assure submission to ODMHSA Provider Certification within twenty-four (24) hours of the incident being documented.
   (2) Incidents involving allegations against staff, reports of consumer abuse, or sentinel events shall be reported to ODMHSA immediately via telephone or fax, but not more than twenty-four (24) hours of the incident. If reported by telephone, the report shall be followed with a written report within twenty-four (24) hours.
(c) Compliance with 450:27-7-47 shall be determined by a review of facility policy and procedures; critical incident reports at the facility and those submitted to ODMHSA, performance improvement program documents and reports, and staff interviews.
SUBCHAPTER 9. BEHAVIORAL HEALTH HOME [REVOKED]

450:27-9-1. Program description and purpose [REVOKED]
(a) The purpose of this Subchapter is to set forth, in addition to all other applicable rules, rules regulating program requirements, activities, and services for Mental Illness Service Programs who opt to deliver services through a Behavioral Health Home model.
(b) The purpose of BHHS within the mental health delivery array is to promote enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness, including adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). Care must be delivered using an integrated team that will comprehensively address physical, mental health, and substance use disorder treatment needs.
(c) The BHH must maintain facility policies and program descriptions that clearly describe that the purpose of the BHH is to improve the health status of individuals with Serious Mental Illness and/or Serious Emotional Disturbance by integrating behavioral and primary health care and promoting wellness and prevention.
(d) The BHH must provide program descriptions and demonstrate evidence that the following functions are implemented.
   (1) Quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
   (2) Coordinated access to:
      (A) High-quality health care services informed by evidence-based clinical practice guidelines;
      (B) Preventive and health promotion services, including prevention of mental illness and substance use disorders;
      (C) Mental health and substance abuse services;
      (D) Comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
      (E) Chronic disease management, including self-management support to individuals and their families;
      (F) Individual and family supports, including referral to community, social support, and recovery services; and,
      (G) Long-term care supports and services;
   (3) Person-centered care plans for each individual that coordinates and integrates all of his or her clinical and non-clinical health care-related needs and services;
   (4) Proper and continuous use of health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
   (5) A quality improvement program, which collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management on individual level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
(e) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:27-9-2. Target populations [REVOKED]
(a) The BHH must be established to serve only the following target populations:
   (1) Adults with a serious mental illness(SMI);
   (2) Children with a serious emotional disturbance (SED); or
   (3) Both.
(b) Organizational documents must clearly describe the target population(s) to be served by the BHH.
(c) Target population descriptions should not be interpreted as to limit access to individuals based on funding sources, including not limiting access to those who are uninsured but otherwise meet the target population criteria. Although not required, BHHS are encouraged to identify funding in order to provide BHH services to individuals who meet the target population criteria but do not have Medicaid.
(d) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:27-9-3. Outreach and engagement [REVOKED]
(a) The BHH must have policies and procedures to describe how outreach and engagement activities will occur to identify individuals within the target population(s) who could benefit from BHH services.
(b) The BHH must have memoranda of agreements to arrange for outreach and engage in settings outlined further in these rules in Section 450:24.9-24.
(c) Facility records will identify which staff members are responsible for specific elements of outreach and engagement.
(d) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:27-9-4. Structure of Behavioral Health Home and administrative staff [REVOKED]
(a) The BHH policies must describe how it is organized within one of the following structures:
   (1) In-house model where the behavioral health agency is directly providing primary care performed by a qualified employee, or purchasing through a contract, or
(2) Co-located partnership model where the behavioral health agency arranges for primary care services to be provided onsite, establishing written agreements with external primary care providers; or
(3) Facilitated referral model, where most primary care services are not provided onsite at the facility; however, the facility has processes in place to ensure the coordination of care that is provided offsite.

(b) In the event the BHH does not directly provide the full array of required services, there must be organizational procedures and clinical records to document that the BHH has otherwise ensured the services are coordinated on behalf of each consumer.

c) The facility operating the BHH will have policies and program descriptions to define how the BHH will operate a team dedicated to provide the range of specific services articulated elsewhere in this Subchapter.

d) The facility shall verify the health home director for adults meets or exceeds the following qualifications:
(1) Possess a Bachelor's degree from an accredited university and have at least two years' experience in health administration;
(2) Possess a Master's degree from an accredited university in a health or social services related field;
(3) Be licensed as a Registered Nurse with the Oklahoma Board of Nursing; or
(4) Be licensed as a Physician or be licensed as a Nurse Practitioner.

e) The BHH shall verify the Project Director for children possesses a Bachelor's degree in the field of social or human sciences from an accredited university, has at least three years' work experience in the social service field and has a minimum of one year experience in an administrative position.

(f) The BHH will adhere to the following ratios in terms of the full-time equivalent (FTE) for the health home director.
(1) The BHH shall maintain a health home director at a ratio of 1 FTE per 500 BHH participants. BHHs with less than 500 participants shall maintain a health home director at a minimum of 0.5 FTE.
(2) A health home requiring a health home director and health home nurse care manager of 0.5 FTE each may employ 1 FTE individual to serve in both roles, provided that individual meets the requirements for both positions.

(g) Compliance with this Section will be determined by on-site observation, review of organizational documents, signed agreements, personnel records, job descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:27-9.5. Treatment team; general requirements [REVOKED]

(a) The BHH must designate an interdisciplinary treatment team that is responsible, with each consumer's input and guidance, to direct, coordinate, and manage the care and services to be provided or arranged for by the BHH.
(b) The interdisciplinary team must identify for each consumer a specific licensed behavioral health professional (LBHP) or licensure candidate on the to lead the process of the initial comprehensive assessment and plan and to provide therapy services if indicated on the integrated plan. This will ensure that each consumer's needs are assessed, and that the active treatment plan is implemented as indicated.

c) Compliance with this Section will be determined by on-site observation, review of organizational documents, signed agreements, activity reports, and clinical records.

450:27-9.6. Treatment team; adult team [REVOKED]

(a) Each BHH team serving adults shall include, the following positions, unless otherwise arranged as permitted in (b) below:
(1) Health Home Director;
(2) Nurse Care Manager;
(3) Consulting Primary Care Physician, Advanced Practice Registered Nurse, or Physician Assistant;
(4) Licensed Psychiatric Consultant;
(5) License Behavioral Health Professional;
(6) Certified Behavioral Health Care Manager II;
(7) Hospital Liaison/Health Home Specialist; and
(8) Wellness Coach credentialed through ODMHSAS.

(b) Variations from the above staff pattern on a continuous basis, must be approved in advance by the ODMHSAS Commissioner or a designee.

c) If the health team experiences difficulty in recruiting staff to fill any of the above positions, a recruitment and contingency plan to maintain essential services, will be submitted to the ODMHSAS Director of Provider Certification for approval.

(d) The facility must have written policies and procedures defining the program's plan for staff to consumer ratio for each adult BHH team and a plan for how exceptions will be handled.

e) Staffing ratios must be regularly monitored and evaluated within the facilities performance improvement activities.

(f) Compliance with this Section will be determined by on-site observation, review of organizational documents, personnel records, staffing schedules, and clinical records.

450:27-9.7. Treatment team; children and adolescent team [REVOKED]

(a) Each BHH team serving children and adolescents shall include, the following positions, unless otherwise arranged as permitted in (b) below:
(1) Care Coordinator (CM II Wraparound Facilitator);
(2) Health Home Director;
(3) Licensed Psychiatric Consultant;
(4) Licensed Nurse Care Manager (RN or LPN);
Peer to Peer Family/Youth Support Provider;
(6) Children's Health Home Specialist; and
(7) Consulting Primary Care Practitioner.

(b) Variations from the above staff pattern on a continuous basis must be approved in advance by the ODMHSAS Commissioner or a designee.

c) If the health team experiences difficulty in recruiting staff to fill any of the above positions, a recruitment and contingency plan to maintain essential services, will be submitted to the ODMHSAS Director of Provider Certification for approval.

d) The facility must have written policies and procedures defining the program's plan for staff-to-consumer ratio for each child and/or adolescent BHH team and a plan for how exceptions will be handled.

(e) Staffing ratios must be regularly monitored and evaluated within the facilities performance improvement activities.

(f) Compliance with this Section will be determined by on-site observation, review of organizational documents, personnel records, staffing schedules, and clinical records.

450:27-9-8. Required services [REVOKED]

(a) The BHH must have policies and clear descriptions to delineate each specific service provided by the BHH.

(b) The BHH must provide the following services within the framework described in 450:27-9-1:

1. Comprehensive Care Management;
2. Care Coordination;
3. Health Promotion;
4. Comprehensive Transitional Care;
5. Individual and Family Support services; and
6. Referral to Community and Social Support Services.

(c) Program descriptions, personnel and privileging records, and other organizational documents will specify which staff members are qualified to provide each BHH service.

(d) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.


(a) The BHH must have procedures and agreements in place to facilitate referral for other medical services needed beyond the scope of the BHH.

(b) Referral documents and releases of information shall comply with applicable privacy and consumer consent requirements.

c) Clinical documentation will track referrals to and use of specialists.

(d) Compliance with this Section will be determined by on-site observation, review of organizational documents, signed agreements, outcome monitoring and other performance improvement activity reports, and clinical records.

450:27-9-10. Admission [REVOKED]

(a) The facility must determine the extent to which each consumer's needs and preferences can be adequately addressed within the array of required BHH services.

(b) An integrated screening and assessment approach in accordance with OAC 450:27-7-2 will be used to determine clinical eligibility for BHH services.

(c) Facility policies and procedures must assure that adults who meet the criteria for a SMI or children who meet the criteria for a SED are eligible for BHH services.

(d) The facility must obtain informed consent specific to enrollment in the BHH.

1. The consent must be specific to the extent that it permits the BHH team members to share information relevant to the delivery of BHH services.

2. The process for obtaining consent must educate the consumer of their right to choose among qualified BHHs or to opt out of the BHH service.

3. The BHH must obtain consent for a child in state custody from the Child Welfare or Juvenile Justice worker.

4. The BHH consent can be integrated into the facility's overall consent to treat as long as the requirements above are met.

(e) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:27-9-11. Initial assessment [REVOKED]

(a) A Licensed Behavioral Health Professional (LBHP) or Licensure Candidate, acting within his or her state scope of practice requirements, must complete the initial assessment for health home services in accordance with the standard in OAC 450:27-7-3 for consumers who have not been assessed by the facility within the past 6 months.

(b) In addition to the items required in 27-7-3, the initial assessment for Health Home services must include at a minimum, the following:

1. The admitting diagnosis as well as other diagnoses;

2. The source of referral;

3. The reason for admission as well as stated by the client or other individuals who are significantly involved; and

4. A list of current prescriptions and over-the-counter medications as well as other substances the client may be taking.

(e) The BHH should provide access to an appropriate health care professional and a health screening within 72 hours of placement for children entering foster care.

(d) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.
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(a) A comprehensive assessment must be completed by the interdisciplinary team performing within each team member's scope of practice consistent with each consumer's immediate needs and include a written narrative in each of the following areas:
   (1) Psychiatric and substance abuse history, mental status, and a current DSM diagnosis;
   (2) Medical, dental, and other health needs;
   (3) Education and/or employment;
   (4) Social development and functioning;
   (5) Activities of daily living; and
   (6) Family structure and relationships.
(b) The BHHI must provide or arrange for a functional assessment for all children using a tool approved by ODMHSAS. Assignment to high intensity Wraparound or Resource coordination intensity of care must be determined by clinically informed decision making by LHPI or Licensure Candidate.
(c) The comprehensive assessment must be updated as needed but no less than every six (6) months.
(d) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:27-9.13. Integrated care plan [REVOKED]
(a) The BHHI must develop a consumer directed, integrated active care plan for each enrolled consumer that reflects input of the team, (including the involvement of the consulting primary care physician or APRN in managing the medical component of the plan), and others the consumer chooses to involve.
(b) The plan shall clearly address physical and behavioral health goals, consumer preferences, and the overall health and wellness needs of the consumer.
(c) The plan must be documented and complete within thirty (30) working days of admission to the BHHI.
(d) The BHHI must provide for each consumer and primary caregiver(s), as applicable, education and training consistent with the consumer and caregiver responsibilities as identified in the active treatment plan and relative to their participation in implementing the plan of care.
(e) Compliance with this Section will be determined by on-site observation, review of organizational documents, personnel records, staffing schedules, and clinical records.

(a) The integrated care plan must address all services necessary to assist the client in meeting his or her physical and behavioral health goals, and include the following:
   (1) Consumer diagnoses, relative to behavioral and physical health conditions assessed by and addressed by the BHHI in terms of direct services provided and/or conditions for which the individual is referred elsewhere for treatment.
   (2) Treatment goals, including preventive/primary care services;
   (3) Interventions, including follow up with necessary medical providers;
   (4) A detailed statement of the type, duration, and frequency of services, including primary medical and specialty care, social work, psychiatric nursing, counseling, and therapy services, necessary to meet the consumer's specific needs;
   (5) Medications, treatments, and individual and/or group therapies;
   (6) As applicable, family psychotherapy with the primary focus on treatment of the consumer's conditions; and
   (7) The interdisciplinary treatment team's documentation of the consumer's or representative's and/or primary caregiver's (if any) understanding, involvement, and agreement with the care plan.
(b) Compliance with this Section will be determined by on-site review of clinical records and supported documentation.

450:27-9.15. Review of plan [REVOKED]
(a) The BHHI will review, revise, and document the individualized integrated care plan as frequently as the consumer's conditions require, but no less frequently than every six (6) months.
(b) A revised active plan must include information from the consumer's initial evaluation and comprehensive assessments and updates, the progress toward goals specified in the written care plan, and changes, as applicable, in goals.
(c) Compliance with this Section will be determined by outcome monitoring, performance improvement activity reports.

(a) If the BHHI serves children or adolescents with SED, care coordination must be delivered with a single point of accountability to ensure that medically necessary services and supports are accessed, coordinated, and delivered in strength based, individualized, family driven, youth guided, and ethnically, culturally and linguistically relevant manner.
(b) The BHHI will document that delivery of specific services and supports are guided by the needs, strengths and culture of the child and family, developed through a wraparound care planning process consistent with System of Care values.
(c) Program policies and descriptions will define the wraparound approach and related values as identified in (a) and (b) above and stipulate these must be followed by staff to develop care coordination plans.
(d) Care plans and other clinical records reflect implementation of services based on the foundations described in (a) through (c).
(e) Compliance with this Section will be determined by review of policies and procedures, staff training logs, outcome monitoring, performance improvement activity reports, clinical records, and related documentation.

(a) When medication services are provided as a component of the BHH services, medication administration, storage and control, and consumer reactions shall be regularly monitored.

(b) Facilities shall assure proper storage and control of medications, immediate response if incorrect or overdoses occur, and have appropriate emergency supplies available if needed.

(1) Written procedures for medication administration shall be available and accessible in all medication storage areas, and available to all staff authorized to administer medications.

(2) All medications shall be kept in locked, non-consumer accessible areas. Conditions which shall be considered in medication storage are light, moisture, sanitation, temperature, ventilation, and the segregation and safe storage of poisons, external medications, and internal medications.

(3) Telephone numbers of the state poison centers shall be immediately available in all locations where medications are prescribed, administered, and stored.

(c) The facility shall make available access to pharmacy services to meet consumers’ pharmacological needs that are addressed by the BHH physicians and other BHH licensed prescribers. Provision of services may be made through agreement with another program, through a pharmacy in the community, or through their own Oklahoma licensed pharmacy.

(d) Compliance with this Section will be determined by on-site observation and a review of the following: written policy and procedures, clinical records, written agreements for pharmacy services, State of Oklahoma pharmacy license and PI records.


(a) The BHH must assist members to participate in the implementation of their comprehensive care plan.

(b) This must include, but not be limited to providing health education specific to a member’s chronic conditions; development of self-management plans with the individual; support to improve social networks; and providing health-promoting lifestyle interventions. Health promoting lifestyle interventions include, but are not limited to substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and increasing physical activity; and assisting to understand and self-manage chronic health conditions.

(c) In addition, BHHs that serve children and adolescents must provide child-specific health promotion activities. These include but are not limited to education regarding the importance of immunizations and screenings, child physical and emotional development; linking each child with screening in accordance with the EPSDT periodicity schedule; monitoring usage of psychotropic medications through report analysis and follow-up with outliers; identifying children in need of immediate or intensive care management for physical health needs; and, providing opportunities and activities for promoting wellness and preventing illness, including the prevention of chronic physical health conditions.

(d) Compliance with this Section will be determined by review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:27-9-20. Discharge or transfer from Behavioral Health Home [REVOKED]

(a) The BHH shall, on behalf of any consumer that transfers to another facility, forward the following within fifteen (15) days as permitted by privacy and confidentiality and if requested:

(1) The BHH discharge summary; and

(2) The consumer’s clinical record.

(b) For consumers who initiate BHH service and later decline those services, or are discharged from a BHH based on non-adherence to care plans, the BHH must forward to the primary health care provider of record, if any, and if requested by the consumer:

(1) The BHH discharge summary; and

(2) The consumer’s clinical record.

(e) As applicable to (a) and/or (b) above, the BHH discharge summary shall include the following:

(1) A summary of the services provided, including the consumer’s symptoms, treatment and recovery goals and preferences, treatments, and therapies.

(2) The client’s current active treatment plan at time of discharge.

(3) The client’s most recent physician orders.

(4) Any other documentation that will assist in post-discharge continuity of care.

(d) A completed discharge summary shall be entered in each consumer’s record within fifteen (15) days of the consumer completing or discontinuing services.

(e) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.


(a) The BHH must have procedures and agreements in place to facilitate referral for other medical services needed by consumers beyond the scope of the BHH, as well as to assist the consumer to obtain services that are needed following discharge from the BHH.

(b) The BHH will also document referrals to community and social support services to facilitate access to formal and informal resources beyond the scope of services covered by SoonerCare, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith-based organizations, etc.
Permanent Final Adoptions

(e) The BHH will develop contracts or memoranda of understandings (MOUs) with regional hospital(s), Psychiatric Residential Treatment Facilities (PRTF) or other system(s) to ensure a formalized structure for transitional care planning to include communication of inpatient admissions and discharges of BHH participants.

(1) Transitional care will be provided by the BHH for existing BHH consumers who have been hospitalized or placed in other non-community settings, such as psychiatric residential treatment facilities, as well as to newly identified, potential BHH consumers who are entering the community.

(2) The BHH team will collaborate with all parties involved including the facility, primary care physician, and community providers to ensure a smooth discharge and transition into the community and prevent subsequent readmission(s).

(3) Transitional care is not limited to institutional transitions, but applies to all transitions that will occur throughout the development of the enrollee and includes transition from and to school-based services and pediatric services to adult services.

(4) The BHH will document transitional care provided in the clinical records.

(d) Compliance with this Section will be determined by on-site observation, review of organizational documents, contracts, MOUs, and clinical records.

450:27-9-22. Consumer (patient care) registries and population health management [REVOKED]

(a) The BHH must implement clinical decision support mechanisms, including but not limited to point-of-care reminders, following nationally published evidence-based guidelines for:

(1) A mental health or substance use disorder;
(2) A chronic medical condition;
(3) An acute condition;
(4) A condition related to unhealthy behaviors; and
(5) Well child or adult care.

(b) BHH must have descriptions of programs in place to demonstrate how it encourages healthier lifestyles for BHH members, including increased physical activity, better nutrition, avoidance of behavioral risks, and wider use of preventive care.

(e) The BHH shall electronically submit data to a health home information management system, subject to prior approval by the Director of ODMHSAS Provider Certification, which will act as a consumer registry, care management device and outcomes measurement tool.

(d) The BHH shall utilize information provided through the approved information system for the purpose of enrollment and discharge tracking, compliance, quality assurance, and outcome monitoring.

(e) Compliance will be determined by on-site observation, review of information available through an approved information system, and consultation with the ODMHSAS Decision Support Services and ODMHSAS Information Services Division.

450:27-9-23. Electronic health records and data sharing [REVOKED]

(a) BHH shall have a functioning electronic health record (EHR) system that meets Meaningful Use standards, as defined in the Medicare and Medicaid Incentive Programs, or have a facility approved written plan with timeframes to obtain one.

(b) The BHH shall document a plan to work with health information organizations to share referrals, continuity of care documents, lab results, and other health information and develop partnerships that maximize the use of Health Information Technology (HIT) across all treating providers.

(c) Compliance with (a) will be determined by review of documentation that certifies the electronic health record meets Meaningful Use standards or documentation of a plan to obtain one with implementation timeline.

(d) Compliance with (b) will be determined by on-site observation, review of information available through an approved information system documenting that BHH consumers' records have been accessed and shared through a Health Information Exchange (HIE), and consultation with the ODMHSAS Decision Support Services and ODMHSAS Information Services Division.

450:27-9-24. Performance measurement and quality improvement [REVOKED]

(a) There shall be an ongoing performance improvement program designed to objectively and systematically monitor, evaluate and improve the quality of consumer care related to BHH operations.

(b) The BHH performance improvement activities must:

(1) Focus on high risk, high volume, or problem-prone areas;
(2) Consider incidence, prevalence, and severity of problems;
(3) Give priority to improvements that affect behavioral outcomes, client safety, and person-centered quality of care.

(e) Performance improvement activities must also track adverse client events, analyze their causes, and implement preventive actions and mechanisms.

(d) The program must use quality indicator data, including client care, and other relevant data in the design of its program.

(e) The BHH must use the data collected to monitor the effectiveness and safety of services and quality of care and identify opportunities and priorities for improvement.

(f) The functions and processes outlined in (a) through (e) shall be evidenced in a annual written plan for performance improvement activities. The plan shall include but not be limited to:

(1) Outcomes management processes which include measures required by CMS and the State and may also include measures from the SAMHSA National Outcomes Measures, NCQA, and HEDIS as required to document improvement in population health.
(2) Quarterly record review to minimally assess:
   (A) Quality of services delivered;
   (B) Appropriateness of services;
   (C) Patterns of service utilization;
   (D) Treatment goals and objectives based on assessment findings and consumer input;
   (E) Services provided which were related to the goals and objectives;
   (F) Patterns of access to and utilization of specialty care; and
   (G) The care plan is reviewed and updated as prescribed by policy.
(3) Review of critical incident reports and consumer grievances or complaints.
(g) Compliance with this Section will be determined by a review of the written program evaluation plan, program goals and objectives and other supporting documentation provided.

[OAR Docket #21-437; filed 6-14-21]

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**TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES**

**CHAPTER 50. STANDARDS AND CRITERIA FOR CERTIFIED BEHAVIORAL HEALTH CASE MANAGERS**

[OAR Docket #21-438]

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PERMANENT final adoption

**RULES:**
450:50-1-1 [AMENDED]
Subchapter 3. Behavioral Health Case Manager Certification Application
450:50-3-1 [AMENDED]
450:50-3-2 [AMENDED]
450:50-3-3 [AMENDED]
450:50-3-5 [AMENDED]
Subchapter 5. Behavioral Health Case Manager Certification Training and Web-Based Competency Exams
450:50-5-1 [AMENDED]
450:50-5-4 [AMENDED]
450:50-5-5 [AMENDED]
Subchapter 7. Rules of Professional Conduct
450:50-7-1 [AMENDED]
450:50-7-2 [AMENDED]
450:50-7-3 [REVOKED]

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**FINAL ADOPTION:**
June 11, 2021

**EFFECTIVE:**
September 15, 2021

**SUPERSEDED EMERGENCY ACTIONS:**
n/a

**INCORPORATIONS BY REFERENCE:**
n/a

**GIST/ANALYSIS:**
The proposed rule revisions to Chapter 50 amend language to clarify application requirements and certification criteria for certified behavioral health case managers. Revisions include clarification regarding transcript submissions, employment requirements and criteria regarding criminal convictions.

**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., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 15, 2021:**

**SUBCHAPTER 1. GENERAL PROVISIONS**

**450:50-1-2. Definitions**
The following words or terms, when used in this Chapter, shall have the following meaning unless the context clearly indicates otherwise.

"Behavioral health related field" means a field of study that is listed on the Department's Approved Degree List or includes a minimum of thirty-six (36) hours of behavioral health related coursework, as determined by the Department.

"Board" means the State Board of Mental Health and Substance Abuse Services.

"Case management services" means the application of principles and practices of linking, advocacy and referral, planned referral, linkage, monitoring and support, and advocacy provided in partnership with a consumer to support the consumer in self-sufficiency and community tenure. Services take place in the individual's home, in the community, or in a facility, in accordance with the service plan developed with and approved by the consumer and qualified staff.

"Certified Behavioral Health Case Manager I (CM I)" means any person who is certified by the Department of Mental Health and Substance Abuse Services (ODMHSAS) to offer behavioral health case management services as an employee of a mental health facility or drug or alcohol treatment facility that is operated by the Department or contracts with the State to provide behavioral health services.

"Certified Behavioral Health Case Manager II (CM II)" means any person who is certified by ODMHSAS to offer behavioral health case management services and behavioral health rehabilitation services (BHR) psychosocial rehabilitation (PSR) services as an employee of a mental health facility or drug or alcohol treatment facility that is operated by the Department or contracts with the State to provide behavioral health services.
"Commissioner" means the Commissioner of Mental Health and Substance Abuse Services.

"Consumer" means an individual who is receiving or has received services (evaluation or treatment) from a facility operated or certified by ODMHSAS or with which ODMHSAS contracts and includes all persons referred to in Title 450, Chapters 16, 17, 18, 19, 22, and 24 of the Oklahoma Administrative Code as client(s) or patient(s) or resident(s) or a combination thereof means an individual, adult, adolescent, or child, who has applied for, is receiving or has received evaluation or treatment services from a facility operated or certified by ODMHSAS or with which ODMHSAS contracts and includes all persons referred to in OAC Title 450 as client(s) or patient(s) or resident(s) or a combination thereof.

"Department" or "ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"Documented experience" means volunteer or work experience that can be verified in writing by either a current or past supervisor or human resources department.

"Exam approval letter" means an official letter issued by ODMHSAS that authorizes applicants to take the relevant exam once the necessary training has been completed by the applicant.

"Experience" means twenty (20) or more hours work or volunteer experience per week, over the course of time indicated, with persons living with mental illness and/or substance use disorder.

"Licensed mental health professional" or "LMHP" as defined in Title 43A §1-103 (11).

"Psychosocial rehabilitation" or "PSR" means curriculum-based education and skills training performed to improve an individual's ability to function in the community. PSR provides an array of services that focus on long term recovery and maximization of self-sufficiency, role functioning, and independence, as distinguished from the symptom stabilization function of acute care.

"Web-Based Competency Exam" as prescribed by the Department is a competency exam certain individuals must pass to become certified as a Behavioral Health Case Manager.

"36-Months Experience" means twenty (20) or more hours work or volunteer experience per week over the course of time indicated with persons living with mental illness and/or substance abuse.

SUBCHAPTER 3. BEHAVIORAL HEALTH CASE MANAGER CERTIFICATION APPLICATION

450:50-3-1. Qualifications for certification
(a) Each applicant for certification as a behavioral health case manager shall:

1. Be currently employed within six (6) months from the date the application was submitted at a mental health facility, or a drug or alcohol treatment facility that is operated by the Department or contracts with the State to provide behavioral health services, employed by a tribe or tribal facility that provides behavioral health services or employed by an Oklahoma Department of Veterans Affairs or a United States Department of Veterans Affairs facility;
2. Possess good moral turpitude;
3. Be at least 21 years of age; and
4. Otherwise comply with rules promulgated by the Board implementing 43A O. S. § 3-318.
(b) In addition to the qualifications specified by subsection (a) of this rule, an applicant for a certification as a Certified Behavioral Health Case Manager must meet either (1) or (2) below:

1. Certified Behavioral Case Manager II (CM II):
   A. A Bachelor's or Master's degree in Education or a behavioral health related field earned from a regionally accredited college or university recognized by the United States Department of Education (USDE); or
   B. A current license as a registered nurse in the State of Oklahoma with experience in behavioral health care; or
   C. A Bachelor's or Master's degree in any field and that shows proof of active progression toward obtaining a clinical licensure Master's or Doctoral degree at the master's or doctoral degree level. The degree must be granted from a regionally accredited college or university recognized by the USDE.
2. Certified Behavioral Health Case Manager I (CM I) must meet the requirements in (A) or (B) below:
   A. 60 college credit hours;
   B. A high school diploma, or equivalent, from a regionally accredited institution recognized by the United States Department of Education with a total of 36 months of direct, documented experience working with persons who live with mental illness and/or substance abuse issues.

450:50-3-2. Applications for certification
(a) Applications for certification as a Certified Behavioral Health Case Manager shall be submitted electronically to the Department on a form and in a manner prescribed by the Commissioner or designee.
(b) Depending on the type of CM certification that the applicant is applying for; the application shall include the following items:

1. CM II must include (A), (B), (C) and (F) and either (D) or (E) as applicable:
   A. Application form completed in full according to its instructions;
   B. Official college or university transcript(s) or an electronic copy submitted to the Department by the college or university. An unofficial transcript may be accepted if the document can be substantiated by the Department;
(C) Oklahoma State Bureau of Investigation (OSBI) name-based criminal history report. The report must be an official OSBI. If there is an incident of stolen identity, a Criminal History Record Theft number and letter must be submitted with the application:
(D) Documentation of current licensure as a registered nurse in the State of Oklahoma, if applicable;
(E) Current certification or Children’s Certificate in Psychiatric Rehabilitation from USPRA. A current certificate from the United States Psychiatric Rehabilitation Association (USPRA) as a Certified Psychiatric Rehabilitation Practitioner (CPRP) or Certified Child and Family Resiliency Practitioner (CFRP), if applicable; and
(F) Fees.
(2) CM I must include (A), (B), (E) and either (C) or (D):
(A) Application form completed in full according to its instructions.
(B) Oklahoma State Bureau of Investigation criminal history report.
(C) Official College or university transcript(s) or an electronic copy submitted to the Department by the college or university. An unofficial transcript may be accepted if the document can be substantiated by the Department.
(D) Official high school transcript(s) or an electronic copy submitted to the Department by the high school and verification of work experience or volunteer experience. An unofficial transcript may be accepted if the document can be substantiated by the Department.
(i) Verification shall only be submitted using a Department approved form. Verification of work and/or volunteer experience shall be submitted using the agency’s letterhead and must be completed by the supervisor of the Human Resources Department where the work or volunteer experience was obtained.
(ii) Verification form(s) must be sent to the Department directly from the employer or volunteer agency.
(iii) Volunteer work must be time spent directly with persons who have a mental illness, co-occurring or substance abuse disorder.
(E) Fees.
(c) Each CM II applicant is required to submit his or her transcript with the initial application. If the transcript does not list a degree on the Approved Degree List and the applicant does meet any of the qualifications of 450:50-3-1(b)(1)(B) through 450:50-3-1(b)(1)(D), a review of the transcript is required. The Department will review the transcript to determine if a minimum of thirty-six (36) hours of behavioral health related course work was completed. If, after Department review, it is determined the minimum requirement is not met, the applicant will not be eligible to continue application for CM II but will be eligible to continue application for CM I if all other requirements are met.
(d) An application must be submitted and approved by the Department prior to attending any web-based or face-to-face Certified Behavioral Health Case Manager certification training.
(e) Applications shall only be valid for a period up to six (6) months from the date of application.
(f) The applicant is not considered certified until verification of employment, exam approval results, and proof of the applicable Behavioral Health Case Management training has been submitted.
(g) Applicants shall have no violations of moral turpitude or misconduct as set forth in these rules during time of application process.
(h) An applicant, who meets the requirements for certification and otherwise complied with this Chapter, shall be eligible for certification.

**450:50-3-3. Duration of certification**

(a) **Issuance.** ODMHSAS will issue an appropriate certification to all applicants who successfully complete the requirements for certification as specified in this Chapter.
(b) **Renewal.** Unless revoked, certification issued pursuant to this Chapter must be renewed by June 30 of the calendar year following twelve (12) months of continuous certification and annually thereafter. Renewal is accomplished by submitting:
   (1) the renewal application;
   (2) an annual report of continuing education units with accompanying documentation;
   (3) proof of certification or licensure as a CPRP or RN as a Certified Psychiatric Rehabilitation Practitioner (CPRP) or Child and Family Resiliency Practitioner (CFRP) or licensure as a registered nurse, if applicable; and
   (4) the renewal fee.
(c) **Suspension and Reinstatement.** Certifications not renewed by the renewal deadline will be suspended. A suspended certification may be renewed by submitting required fees and documentation of continuing education within six (6) months of the date of suspension. Suspended certifications not renewed within this six (6) month timeframe will be reinstated. The individual must then wait a period of sixty (60) days and submit a new application for certification and successfully complete the requirements for initial certification as specified in this Chapter.

**450:50-3-5. Fitness of applicants**

(a) The purpose of this section is to establish the fitness of the applicant as one of the criteria for approval of certification as a Certified Behavioral Health Case Manager and to set forth the criteria by which the Commissioner will determine the fitness of the applicants.
(b) The substantiation of any of the following items related to the applicant may be, as the Commissioner or designee, determines the basis for the denial of or delay of certification of the applicant:
Permanent Final Adoptions

(1) Lack of necessary skills and abilities to provide adequate services;
(2) Misrepresentation on the application or other materials submitted to the Department;
(3) Any convictions for violent offenses or moral turpitude;
(4) Any felony convictions; or
(5) Any conviction of a crime involving a child or vulnerable adult;

(a) Certified Behavioral Health Case Managers must comply by the Department.

(b) Certified Behavioral Health Case Managers shall retain documents verifying attendance for all continuing education required by the Department, including but not limited to:

(i) Certification of attendance for a training program approved by the Department;

(ii) Certification of completion of CEUs.

(c) The Department shall obtain document(s) necessary to determine the fitness of an applicant.

(d) The Department may require explanation of negative references prior to issuance of certification.

SUBCHAPTER 5. BEHAVIORAL HEALTH CASE MANAGER CERTIFICATION TRAINING AND WEB-BASED COMPETENCY EXAMS

450:50-5.1. Case management certification training requirements

(a) The purpose of this section is to delineate the training requirements for each of the classifications of Certified Behavioral Health Case Managers (CMs).

(b) The Department shall have the authority and responsibility for providing case management and behavioral health rehabilitation services training classes on a regular basis but no less than six times during the year.

(c) Certified Behavioral Health Case Managers I (CM I) must complete two days of case management training as specified by the Department.

(d) Certified Behavioral Health Case Manager II (CM II) Training requirements:

1. Complete the behavioral health case management web-based training as specified by the Department;

2. Applicants who have not received a certificate in children’s psychiatric rehabilitation from the US Psychiatric Rehabilitation Association (USPRA) or a CPRP, must complete the behavioral health rehabilitation web-based training as specified by the Department;

This requirement does not apply to applicants who are Certified Psychiatric Rehabilitation Practitioner (CPRPs) or Child and Family Resiliency Practitioner (CFRP).

(e) Candidates who have not received a certificate in children’s psychiatric rehabilitation or certification through USPRA, must complete two days of face-to-face behavioral health rehabilitation training. Complete behavioral health rehabilitation training as specified by the Department. This requirement does not apply to applicants who are Certified Psychiatric Rehabilitation Practitioner (CPRPs) or Child and Family Resiliency Practitioner (CFRP).

(f) Case management certification training must be completed within six (6) months of the date of application from the date the application was submitted. Once the six (6) month period has ended, an applicant that has not completed the training must wait a period of sixty (60) days before reapplying, and then submit a new application.

450:50-5.4. Continuing education requirements

(a) Certified Behavioral Health Case Managers must complete twelve (12) hours continuing education per year and submit documentation of the continuing education to ODMHSAS annually for consideration.

(b) Continuing education is acceptable when it provides information to enhance delivery of behavioral health case management and behavioral health rehabilitation services and:

1. Meets the requirements for LPC, LMFT, LBP, LCSW, LMSW, CADC, LADC, or CME continuing education;

2. Is an undergraduate or graduate course in a behaviorally related field and pertains to direct interaction with consumers (three hours of course work is equal to twelve (12) hours of CEUs).

3. The ODMHSAS Director of Community Based Services or designee shall approve all in-house/agency trainings that are provided for the intent of submitting towards case management CEUs (unless they meet the requirement in 450:50-5.4(b)(2). Certified case managers shall not submit more than three (3) hours of these approved CEUs annually towards their required minimum.

(c) Certified Behavioral Health Case Managers must complete, as part of their required twelve (12) hours annually, three (3) hours of ethics training every year. Ethics training must meet the requirements for LPC, LMFT, LBP, LCSW, CADC, LADC or CME ethics training; and annually, three (3) hours of training related to Strengths-Based/Recovery Principles.

(d) Certified Behavioral Health Case Managers shall retain documents verifying attendance for all continuing education hours claimed for the reporting period. Documentation shall be submitted upon the request of the Department. Acceptable verification documents include:

1. An official continuing education validation form furnished by the presenter; or
(2) A letter or certificate from the organization sponsoring the training verifying name of program, presenter, number of hours attended, participant's name, and approval by licensure board; or
(3) An official grade transcript verifying completion of the undergraduate or graduate course. Ethics or Strengths based curriculum training must be verified with a course syllabus or other information submitted with official transcript.
(c) Failure to complete the continuing education requirements and submit the required documentation by the renewal date renders the certification in suspension, and results in the loss of all rights and privileges of a Certified Behavioral Health Case Manager. The Certified Behavioral Health Case Manager certification may be reinstated during a period of no longer than six (6) months following the suspension date. The Certified Behavioral Health Case Manager has the right to renew the certificate by payment of renewal fees ($15.00) and late renewal fees ($25.00) and documentation of obtaining twelve (12) hours of continuing education.

450:50-5-5. Web-based competency exams
(a) Successful completion of web-based competency exams for behavioral health rehabilitation and behavioral health case management is required prior to certification as CM II. Applicants certified through USPRA and applicants to be a CM I need only successfully complete the web-based competency exam for behavioral health case management.
(b) The web-based competency exam shall not be administered until all application and training requirements are met and approval from ODMHSAS has been received.
(c) Applicants shall comply with the rules of the examination process as outlined by the contracted testing site.
(d) Applicants who fail to complete and pass the web-based competency exam within six (6) months of the date of application the application was submitted must reapply and re-complete the required training.

SUBCHAPTER 7. RULES OF PROFESSIONAL CONDUCT

450:50-7-1. Responsibility and scope of practice
(a) Certified Behavioral Health Case Managers shall be dedicated to advancing the welfare of individuals, and children and their families. Certified Behavioral Health Case Managers shall not participate in, condone, or be associated with dishonesty, fraud, deceit or misrepresentation, and shall not exploit their relationships with the consumers for personal advantage, profit, satisfaction, or interest.
(b) Certified Behavioral Health Case Managers shall practice only within the boundaries of their individual certifications and competence based on their education, training, supervised experience, state and national accreditations and licenses.
(c) Certified Behavioral Health Case Managers shall only use the title if employed by the state or a private or nonprofit behavioral health services provider contracting with the state to provide behavioral health services. As an employee of a state or a private or nonprofit behavioral health provider, reimbursement for services rendered will not be collected outside of the agency's system of service reimbursement.
(d) Certified Behavioral Health Case Managers may not practice any of the following professions or use the following titles unless also licensed or accredited by the appropriate authority: physician, psychologist, clinical social worker, professional counselor, marital and family therapist, behavioral practitioner or alcohol and drug counselor.
(e) Certified Behavioral Health Case Managers shall not directly or indirectly suggest that they are allowed to provide "therapy" or "counseling" services unless licensed or accredited by the appropriate authority to provide therapy and/or counseling services.
(f) Certified Behavioral Health Case Managers shall not directly or indirectly suggest that they are allowed to provide "therapy" or "counseling" services unless licensed or accredited by the appropriate authority to provide therapy and/or counseling services.
(g) Certified Behavioral Health Case Managers shall not directly or indirectly suggest that they are allowed to provide "therapy" or "counseling" services unless licensed or accredited by the appropriate authority to provide therapy and/or counseling services.
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(z) Certified Behavioral Health Case Managers shall not directly or indirectly suggest that they are allowed to provide "therapy" or "counseling" services unless licensed or accredited by the appropriate authority to provide therapy and/or counseling services.

to do so puts the consumer at grave risk. Case Managers will be obligated to explain the limits of confidentiality initially in the professional working relationship.

(3) If the demands of an affiliated organization for whom the Certified Behavioral Health Case Manager is working, is in conflict with these ethics, the issues must be clarified and resolved to allow adherence to the Rules of professional Conduct code set forth in this chapter.

(a) Certified Behavioral Health Case Managers shall provide services with populations and in areas only within the boundaries of their competence, based on education, training, supervised experience, consultation, study or professional experience.

(1) Certified Behavioral Health Case Managers that delegate or assign work to employees, supervisee, or assistants must take reasonable steps to see that such person performs the services competently.
(2) Certified Behavioral Health Case Managers are eligible to provide services within the scope of their certifications that would not lead to conflict of interest, exploitation of relationship, loss of objectivity and based on education, training or experience.
(3) Certified Behavioral Health Case Managers shall provide clients at the beginning of service written, accurate and complete information regarding the extent and nature of the services available to them, to include fees and manner of payment.
(4) Certified Behavioral Health Case Managers shall not solicit the clients of one’s agency for private practice or to change service locations.
(5) Certified Behavioral Health Case Managers shall not commit fraud and shall not represent that she or he performed services which they did not perform.

450:50-7-2. Consumer welfare
(a) Certified Behavioral Health Case Managers shall not, in the rendering of their professional services, participate in, condone, and promote discrimination on the basis of race, color, age, gender, sexual orientation, religion, disability, and or limitation behavioral health condition or national origin.
(b) Certified Behavioral Health Case Managers must be aware of their influential positions with respect to consumers and not exploit the trust and dependency of consumers. Certified Behavioral Health Case Managers shall refrain from dual relationships with consumers because of the potential to impair professional judgment and to increase the risk of harm to consumers. Examples of such relationships include, but are not limited to familial, social, financial, business, and professional or close personal relationships with consumers.

(1) Certified Behavioral Health Case Managers shall not have any type of sexual contact with consumers and shall not provide case management services to persons with whom they have had a sexual relationship.
(2) Certified Behavioral Health Case Managers shall not engage in sexual contact with former consumers.
(3) Certified Behavioral Health Case Managers shall not knowingly enter into a close personal relationship, or engage in any business or financial dealings with a former client for five (5) years after the termination of the case management relationship.

(c) If a Certified Behavioral Health Case Manager determines that she or he is unable to be of professional assistance to a consumer, the Certified Behavioral Health Case Manager shall refer the consumer to appropriate sources when indicated. If the consumer declines the referral the Certified Behavioral Health Case Manager shall terminate the relationship and document the consumer’s decision.

(d) Certified Behavioral Health Case Managers shall report any violation of professional conduct by a Certified Behavioral Health Case Manager as outlined in this chapter.

e) The Department shall conduct itself in a manner to intervene in an immediate action to protect a consumer(s) according to the guidelines and rules provided, to prevent further detriment to any consumer.

450:50-7-3. Reimbursement for services rendered
[REVOKED]

Certified Behavioral Health Case Managers shall practice within the scope of their individual certifications only if employed by the State or a private or nonprofit behavioral health services provider contracting with the State to provide behavioral health services. An employee of a state or a private or nonprofit behavioral health provider reimbursement for services rendered will not be collected outside of the agency’s system of service reimbursement.

[OAR Docket #21-438; filed 6-14-21]

TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
CHAPTER 55. STANDARDS AND CRITERIA FOR PROGRAMS OF ASSERTIVE COMMUNITY TREATMENT

[OAR Docket #21-439]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:

450:55-1-1 [AMENDED]
450:55-1-2 [AMENDED]

Subchapter 7. Confidentiality [REVOKED]
450:55-7-1 [REVOKED]

Subchapter 11. Organizational Management
450:55-11-1 [REVOKED]
450:55-11-2 [REVOKED]

Subchapter 13. Performance Improvement and Quality Management [REVOKED]
450:55-13-1 [REVOKED]
450:55-13-2 [REVOKED]

Subchapter 15. Personnel [REVOKED]
450:55-15-1 [REVOKED]
450:55-15-2 [REVOKED]

Subchapter 17. Staff Development and Training [REVOKED]
450:55-17-1 [REVOKED]
SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 15, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS

450:55-1.  Purpose
(a) This Chapter implements 43A O.S. § 3-319, which authorizes the Board of Mental Health and Substance Abuse Services, or the Commissioner upon delegation by the Board, to certify programs of assertive community treatment. Section 3-319 requires the Board to promulgate rules and standards for certification of facilities or organizations that desire to be certified.
(b) The rules regarding the certification procedures including applications, fees and administrative sanctions are found in the Oklahoma Administrative Code, Title 450, Chapter 1, Subchapters 5 and 9.
(c) Rules outlining general certification qualifications applicable to facilities and organizations certified under this Chapter are found in OAC 450:1-9-5 through OAC 450:1-9-5.3.

450:55-1.2.  Definitions
The following words or terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Advanced Practice Nurse" or "APN" means an individual who is a licensed registered nurse with current certification of recognition to practice as an Advanced Practice Nurse issued by the Oklahoma Board of Nursing.

"Advance Practice Registered Nurse" means a registered nurse in good standing with the Oklahoma Board of Nursing, and has acquired knowledge and clinical skills through the completion of a formal program of study approved by the Oklahoma Board of Nursing Registration and has obtained professional certification through the appropriate National Board recognized by the Oklahoma Board of Nursing. Advance Practice Registered Nurse services are limited to the scope of their practice as defined in 39 Okla. Stat. § 567.3a and corresponding rules and regulations at OAC 485:10-5-1 through 10-16-9.

"Behavioral Health Home" or "BHH" means a specifically organized entity that functions within a currently ODMH-SAS certified mental health treatment program organization to promote enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness. BHHs ensure comprehensive team-based health care, meeting physical, mental health, and substance use disorder care needs. Health care is delivered utilizing a whole person, patient centered, coordinated care model for adults with serious mental illness (SMI). Care coordination is provided for all aspects of the individual's life and for transitions of care the individual may experience.

"Certified behavioral health case manager" means any person who is certified by the Department of Mental Health and Substance Abuse Services to offer behavioral health case management services as one of the three (3) classifications
of case management within the confines of a mental health facility or drug or alcohol treatment facility that is operated by the Department or contracts with the State to provide behavioral health services.

"Certified Peer Recovery Support Specialists" or "C-PRSS" means any person who is certified by the Department of Mental Health and Substance Abuse Services to offer behavioral health services as provided in this Chapter.

"Community-based Structured Crisis Center" or "CBSCC" means a program of non-hospital emergency services for mental health and substance abuse crisis stabilization including, but not limited to, observation, evaluation, emergency treatment and referral, when necessary, for inpatient psychiatric or substance abuse services. This service is limited to CMHC's who are certified by the Department of Mental Health and Substance Abuse Services or facilities operated by the Department of Mental Health and Substance Abuse Services.

"Clinical privileging" means an organized method for treatment facilities to authorize an individual permission to provide specific care and treatment services to consumers within well-defined limits, based on the evaluation of the individual’s license, education, training, experience, competence, judgment and other credentials.

"Consumer" means an individual who has applied for, is receiving, or has received evaluation or treatment services from a facility operated or certified by ODMHAS or with which ODMHAS contracts and includes all persons referred to in OAC Title 450 as client(s) or patient(s) or resident(s) or a combination thereof.

"Co-occurring disorder" means any combination of mental health and substance abuse symptoms or diagnoses in a client.

"Co-occurring disorder capability" means the organized capacity within any type of program to routinely screen, identify, assess, and provide properly matched interventions to individuals with co-occurring disorders.

"Credentialed Recovery Support Specialist" is a member of the PACT team who is working as a Recovery Support Specialist and has completed the ODMHAS approved training and testing is certified by the Department of Mental Health and Substance Abuse Services to offer behavioral health services in accordance with Chapter 53 of Title 450.

"Crisis intervention" means an immediately available service to meet the psychological, physiological and environmental needs of individuals who are experiencing a mental health or substance abuse crisis.

"Crisis stabilization" means emergency psychiatric and substance abuse services for the resolution of crisis situations and may include placement of an individual in a protective environment, basic supportive care, and medical assessment and, if needed, referral to an ODMHASCertified facility having nursing and medical support available.

"Critical incident" means an occurrence or set of events inconsistent with the routine operation of the facility, or the routine care of a consumer. Critical incidents specifically include but are not necessarily limited to the following: adverse drug events; self-destructive behavior; deaths and injuries to consumers, staff and visitors; medication errors; consumers that are absent without leave (AWOL); neglect or abuse of a consumer; fire; unauthorized disclosure of information; damage to or theft of property belonging to a consumer or the facility; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or results.

"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, religious, sexual orientation, and/or social group.

"DSM" means the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"FTE" means an employee, or more than one, who works the time equivalent to the number of hours per week, month or year of one (1) employee working full-time.

"Governing Agency" means the facility or specific community based behavioral health provider under which the PACT program is operated.

"Historical time line" means a method by which a specialized form is used to gather, organize and evaluate historical information about significant events in a consumer's life, experience with mental illness, and treatment history.

"Hospital liaison" means an individual within the Behavioral Health Home interdisciplinary team that works closely with hospital staff to assess the suitability of transition plans for consumers enrolled in a Behavioral Health Home. Hospital Liaisons will also work with other long term, residential facilities to plan for coordination of care during and after the consumer's residential stay. Hospital liaisons must be certified by ODMHAS as a Behavioral Health Case Manager I or II and complete trainings as required by ODMHAS.

"Individual Treatment Team" or "ITT" means the primary case manager and a minimum of two other clinical staff on the PACT team who are responsible to keep the consumer's treatment coordinated, monitor their services, coordinate staff activities and provide information and feedback to the whole team.

"Licensed Behavioral Health Professional" or "LBHP" means: 1) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry. 2) Practitioners with a license to practice in the state in which services are provided by one of the following licensing boards: (A) Psychology; (B) Social Work (clinical specialty only); (C) Professional Counselor; (D) Marriage and Family Therapist; (E) Behavioral Practitioner; or (F) Alcohol and Drug Counselor. 3) 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. 4) A Physician Assistant who is licensed in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.
(A) An Allopathic or Osteopathic Physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry;

(B) An Advanced Practice Registered Nurse 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 certified in a psychiatric mental health specialty;

(C) A Clinical Psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists;

(D) A Physician Assistant who is licensed in good standing in Oklahoma and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions;

(E) A practitioner with a license to practice in the state in which services are provided by one of the following licensing boards:

(i) Social Work (clinical specialty only);

(ii) Professional Counselor;

(iii) Marriage and Family Therapist;

(iv) Behavioral Practitioner; or

(v) Alcohol and Drug Counselor.

"Licensed mental health professional" or "LMHP" as defined in Title 43A §1-103 (11).

"Licensure candidate" means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:

(A) Psychology;

(B) Social Work (clinical specialty only);

(C) Professional Counselor;

(D) Marriage and Family Therapist;

(E) Behavioral Practitioner; or

(F) Alcohol and Drug Counselor.

"Linkage services" means the communication and coordination with other service providers pursuant to a valid release that assure timely appropriate referrals between the PACT program and other providers.

"Longitudinal Face Sheet" means a process that is used to track a PACT consumer's specific demographic, personal contact, treatment history and other relevant information from the time of admission until discharge.

"Licensed Practical Nurse" or "LPN" means an individual who is currently licensed by the Oklahoma Board of Nursing to provide a directed scope of nursing practice.

"Medically necessary" means health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

"Nurse Care manager" means a Licensed Practical Nurse (LPN) or a Registered Nurse (RN).

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"Oklahoma Administrative Code" or "OAC" means the publication authorized by 75 O.S. § 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A) (1) (a) and maintained in the Office of Administrative Rules.

"Performance Improvement" or "PI" means an approach to the continuous study and improvement of the processes of providing health care services to meet the needs of consumers and others. Synonyms, and near synonyms include continuous performance improvement, continuous improvement, organization-wide performance improvement and total quality management.

"Persons with special needs" means any person with a condition which is considered a disability or impairment under the "American with Disabilities Act of 1990" including, but not limited to the deaf and hearing impaired, visually impaired, physically disabled, developmentally disabled, persons with disabling illness, persons with mental illness. See "Americans with Disabilities Handbook," published by U.S. Equal Employment Opportunity Commission and U.S. Department of Justice.

"PICIS" is a comprehensive management information system based on national standards for mental health and substance abuse databases. It is a repository of diverse data elements that provide information about organizational concepts, staffing patterns, consumer profiles, program or treatment focus, and many other topics of interest to clinicians, administrators and consumers. It includes unique identifiers for agencies, staff and consumers that provide the ability to monitor the course of consumer services throughout the statewide DMHSAS network. PICIS collects data from hospitals, community mental health centers, substance abuse agencies, domestic violence service providers, residential care facilities, prevention programs, and centers for the homeless which are operated or funded in part by DMHSAS.

"Primary Care Practitioner (PCP)" means a licensed physician, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA) licensed in the State of Oklahoma.

"Primary Case Manager" is a certified behavioral health case manager assigned by the team leader to coordinate and monitor activities of the ITT, has primary responsibility to write the treatment plan and make revisions to the treatment plan and weekly schedules.

"Program Assistant" is a member of the PACT team providing duties supportive of the Team and may include organizing, coordinating, and monitoring non-clinical operations of the PACT, providing receptionist activities and coordinating communication between the team and consumers.

"Program of Assertive Community Treatment" or "PACT" means a clinical program that provides continuous treatment, rehabilitation and support services to persons with mental illness in settings that are natural to the consumer.

"Progress notes" mean a chronological description of services provided to a consumer, the consumer's progress, or lack of, and documentation of the consumer's response related to the intervention plan.

"Recovery Support Specialist" is a member of the PACT team who is or has been a recipient of mental health services for a serious mental illness and is willing to use and share his or
her personal, practical experience, knowledge, and first-hand insight to benefit the team and consumers.

"Risk Assessment" means a clinical function that aims to determine the nature and severity of the mental health problem, determine which service response would best meet the needs of the consumer, and how urgently the response is required.

"Service Intensity" means the frequency and quantity of services needed, the extent to which multiple providers or agencies are involved, and the level of care coordination required.

"SoonerCare" means Oklahoma's Medicaid program.

"Team Leader" is the clinical and administrative supervisor of the PACT team who also functions as a practicing clinician. The team leader is responsible for monitoring each consumer's clinical status and response to treatment as well as supervising all staff and their duties as specified by their job descriptions.

"Trauma informed" means the capacity for a facility and all its programs to recognize and respond accordingly to the presence of the effects of past and current traumatic experiences in the lives of its consumers.

"Urgent Recovery Clinic" means a facility certified by ODMHSAS pursuant to OAC 450:23 that offers services aimed at the assessment and immediate stabilization of acute symptoms of mental illness, alcohol and drug abuse, and emotional distress. URCs offer triage crisis response, crisis intervention, crisis assessment, crisis intervention plan development, and linkage and referral to other services.

"Wellness Coach" means an individual who is actively working on personal wellness and who is designated to collaborate with others to identify their personal strengths and goals within the eight dimensions of wellness (spiritual, occupational, intellectual, social, physical, environmental, financial, and emotional).

(A) In order to qualify to be a Wellness Coach, individuals shall:

(i) Have a behavioral health related associate degree or two years of experience in the field and/or have an active certification and/or license within the behavioral health field (e.g. PRSS, Case Management, LBHP, LPN, etc.); and

(ii) Complete the ODMHSAS Wellness Coach Training Program and pass the examination with a score of 80% or better.

(B) Wellness Coach roles and responsibilities include:

(i) Role model wellness behaviors and actively work on personal wellness goals;

(ii) Apply principles and processes of coaching when collaborating with others;

(iii) Facilitate wellness groups;

(iv) Conduct motivational interventions;

(v) Practice motivational interviewing techniques;

(vi) Provide referrals to community resources for nutrition education, weight management, Oklahoma Tobacco Helpline, and other wellness-related services and resources;

(vii) Create partnerships within local community to enhance consumer access to resources that support wellness goals;

(viii) Raise awareness of wellness initiatives through educational in-service and community training;

(ix) Elevate the importance of wellness initiatives within the organization;

(x) Promote a culture of wellness within the organization for both consumers and staff;

(xi) Respect the scope of practice and do not practice outside of it, referring people to appropriate professionals and paraprofessionals as needed.

SUBCHAPTER 7. CONFIDENTIALITY

[REVOKED]

450:55-7-1. Confidentiality, mental health consumer information and records [REVOKED]

Confidentiality policy, procedures and practices must comply with federal and state law, guidelines, and standards, and with OAC 450:15-3-20.1 and OAC 450:15-30.60.

SUBCHAPTER 11. ORGANIZATIONAL MANAGEMENT

450:55-11-1. Organizational description [REVOKED]

(a) The parent organization under which the PACT operates shall clarify formal management and reporting responsibilities related to the PACT within the parent organization's overall structure.

(b) The PACT's parent organization shall approve the mission statement and annual goals and objectives for the PACT and document their approval.

(c) The PACT or parent organization shall have a written organizational description which is reviewed annually and minimally includes:

(1) The overall target population for whom services will be provided specifically including those individuals with co-occurring disorders;

(2) The specific geographic area in which PACT services are to be provided;

(3) The overall mission statement; and

(4) The PACT program's annual goals and objectives.

(d) There shall be documentation verifying these documents are available to the general public upon request.

(e) Compliance with 450:55-11-1 shall be determined by on-site observation and a review of organizational charts, and the PACT policy and procedures.

450:55-11-2. Program organization [REVOKED]

(a) The parent organization under which the PACT operates shall vest authority with a team leader who shall be responsible
for ensuring the PACT team meets the following organizational requirements.

(1) Each PACT shall have a written plan for professional services, which shall contain the following:
   (A) Services description and philosophy;
   (B) The identification of the professional staff organization to provide these services;
   (C) Written admission and exclusionary criteria to identify the type of consumers for whom the services are primarily intended;
   (D) The specific geographic area in which PACT services are to be provided;
   (E) Written goals and objectives; and

(2) There shall be a written statement of the procedures and plans for attaining the organization's goals and objectives. These procedures and plans shall define specific tasks, including actions regarding the organization’s co-occurring capability, set target dates and designate staff responsible for carrying out the procedures and plans.

(b) Compliance with 450:55-11-2 shall be determined by a review of the following—PACT target population definition, PACT policy and procedures, written plan for professional services, other stated required documentation and any other supporting documentation.

SUBCHAPTER 13. PERFORMANCE IMPROVEMENT AND QUALITY MANAGEMENT [REVOKED]

450:55-13-1. Performance improvement program [REVOKED]

(a) There shall be an ongoing PACT or parent organization performance improvement program designed to objectively and systematically monitor, evaluate and improve the quality of consumer care related to PACT.

(b) The performance improvement program shall also address the fiscal management of the organization.

(c) There shall be an annual written plan for performance improvement activities. The plan shall include but not be limited to:

(1) Outcome management processes specific to each program component: minimally measuring:
   (A) Efficiency;
   (B) Effectiveness; and
   (C) Consumer satisfaction.

(2) A quarterly record review to minimally assess:
   (A) Quality of services delivered;
   (B) Appropriateness of services;
   (C) Patterns of service utilization;
   (D) Consumers, relevant to their orientation to the PACT and services being provided;
   (E) The thoroughness, timeliness, and completeness of the assessment;
   (F) Treatment goals and objectives are based on assessment findings and consumer input;
   (G) Services provided were related to the goals and objectives;
   (H) Services are documented as prescribed by policy; and
   (I) The treatment plan is reviewed and updated as prescribed by policy;

(3) Clinical privileging;

(4) Fiscal management and planning shall include:
   (A) An annual budget that is approved by the governing authority and reviewed at least annually;
   (B) The organization's capacity to generate needed revenue to produce desired consumer and other outcomes; and
   (C) Monitoring of consumer records to ensure among others, documented dates of services provided coincide with billed service encounters; and,

(5) Review of critical incident reports and consumer grievances or complaints.

(d) The PACT of parent organization shall monitor the implementation of the performance improvement plan on an ongoing basis and make adjustments as needed.

(e) Performance improvement findings shall be communicated and made available to, among others:
   (1) The governing authority;
   (2) PACT staff; and
   (3) ODMHSAS if and when requested.

(f) Compliance with 450:55-13-1 shall be determined by a review of the written program evaluation plan, written program evaluations annual, special or interim, program goals and objectives and other supporting documentation provided.

450:55-13-2. Incident reporting [REVOKED]

(a) There shall be written policies and procedures for PACT or the parent organization, to include PACT, requiring documentation and reporting of critical incidents.

(b) The documentation for critical incidents shall contain:

(1) The facility name and name and signature of person(s) reporting the incident;
(2) The name of consumer(s), staff person(s), or others involved in the incident;
(3) The time, place and date the incident occurred;
(4) The time and date the incident was reported and name of the person within the PACT or parent organization to whom it was reported;
(5) Description of the incident;
(6) The severity of each injury, if applicable. Severity shall be indicated as follows:
   (A) No off-site medical care required or first aid administered on-site;
   (B) Medical care by a physician or nurse or follow-up attention required; or
   (C) Hospitalization or immediate off-site medical attention was required;
(7) Resolution or action taken, date action taken, and signature of PACT program director.

(c) The PACT or parent organization shall report critical incidents to ODMHSAS with specific timeframes as follows:
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450:55-15-1. Personnel policies and procedures [REVOKED]
(a) The PACT shall have written personnel policies and procedures approved by the parent organization.
(b) All employees shall have access to personnel policies and procedures, as well as other rules and regulations governing the conditions of their employment.
(c) The PACT or parent organization shall develop, adopt, and maintain policies and procedures to promote the objectives of the program and provide for qualified personnel during all hours of operation to support the functions of the center and provide quality care.
(d) Compliance with 450:55-15-1 shall be determined by a review of written personnel policies and procedures and other supporting documentation provided.

(a) The PACT or parent organization shall have written job descriptions for all PACT positions setting forth minimum qualifications and duties of each position.
(b) All job descriptions shall include an expectation of core competencies in relation to individuals with co-occurring disorders.
(c) Compliance with 450:55-15-2 shall be determined by a review of written job descriptions for all center positions and other supporting documentation provided.

SUBCHAPTER 17. STAFF DEVELOPMENT AND TRAINING [REVOKED]

450:55-17-1. Orientation and training [REVOKED]
(a) Each PACT or parent organization shall develop and implement an orientation and training program that all new PACT staff shall complete prior to providing services. The orientation shall minimally include a review of the following:
(1) Oklahoma Administrative Code, Title 450:55;
(2) PACT policies and procedures; and
(3) Job responsibilities specified in job description.
(b) Compliance with 450:55-17-1 shall be determined by a review of personnel files, clinical privileging records and other supporting documentation provided.

450:55-17-2. Staff development [REVOKED]
(a) The PACT or parent organization shall have a written plan for the professional growth and development of all PACT administrative, professional clinical, and support staff.
(b) This plan shall include but not be limited to:
(1) Orientation procedures;
(2) In-service training and education programs, including co-occurring disorder competencies;
(3) Availability of professional reference materials; and
(4) Mechanisms for insuring outside continuing educational opportunities for staff members.
(c) The results of performance improvement activities and accrediting and audit findings and recommendations shall be addressed by and documented in the staff development processes.
(d) Staff competency development shall be aligned with the organization’s goals related to co-occurring capability, and incorporate a training plan, training activities, and supervision designed to improve co-occurring core competencies of all staff.
(e) Staff education and in-service training programs shall be evaluated at least annually by the agency.
(f) Compliance with 450:55-17-2 shall be determined by a review of the staff development plan, documentation of in-service training programs and other supporting documentation provided.

450:55-17-3. In-service [REVOKED]
(a) In-service presentations shall be conducted yearly and shall be required for all employees upon hire and annually thereafter on the following topics:
(1) Fire and safety;
(2) Infection Control and universal precautions;
(3) Techniques and philosophies addressing appropriate non-violent interventions for potentially physical interpersonal conflicts, staff attitudes which promote dignity and enhanced self esteem, keys to effective communication skills, verbal and non-verbal interaction and non-violent intervention;
(4) Consumer’s rights and the constraints of the Mental Health Consumer’s Bill of Rights;
(5) Confidentiality;
(6) Oklahoma Child Abuse Reporting and Prevention Act, 10 O.S. §§ 7101 et seq. and Protective Services for the Elderly and for Incapacitated Adults Act, 43A O.S. §§ 10-101 et seq.;
(7) Facility policy and procedures;
(8) Cultural competency;
(9) Co-occurring disorder competency and treatment principles;
(10) Trauma informed; and
(11) Age and developmentally appropriate trainings, where applicable.

(b) Staff providing clinical services shall have a current cardiopulmonary resuscitation certification.

(c) Compliance with 450:55-17.3 shall be determined by a review of in-service training records, personnel records and other supporting written information provided.

**SUBCHAPTER 19. FACILITY ENVIRONMENT**

450:55-19-1. Facility environment

(a) The PACT or parent organization shall obtain an annual fire and safety inspection from the State Fire Marshall or local authorities which documents approval for continued occupancy. Compliance with 450:55-19-1 shall be determined by a review of the PACT or parent organization's annual fire and safety inspection report.

(b) PACT staff shall know the exact location, contents and use of first aid supply kits and firefighting equipment and fire detection systems. All firefighting equipment shall be annually maintained in appropriately designated areas within the facility.

(c) Written plans and diagrams noting emergency evacuation routes in case of fire, and shelter locations in case of severe weather shall be posted.

(d) Facility grounds shall be maintained in a manner which provides a safe environment for consumers, personnel, and visitors.

(e) The PACT's or parent organization shall appoint a safety officer.

(f) The PACT or parent organization shall have a written emergency preparedness program for the PACT that is designed to provide for the effective utilization of available resources so PACT consumer care can be continued during a disaster. The PACT or parent organization shall evaluate the emergency preparedness program annually and update as needed.

(g) Policies for the use and control of personal electrical equipment shall be developed and implemented.

(h) The PACT or parent organization shall have a written plan to respond to internal and external disasters. External disasters include, but are not limited to, tornadoes, explosions, and chemical spills.

(i) Facilities occupied by PACT on behalf of the parent organization shall be inspected annually by designated fire and safety officials of the municipality who exercise fire and safety jurisdiction in the facility's location.

(j) The PACT or parent organization shall have a written Infection Control Program and staff shall be knowledgeable of Center for Disease Control (CDC) Guidelines for Tuberculosis and of the Blood Borne Pathogens Standard, location of spill kits, masks, and other personal protective equipment.

(k) The PACT or parent organization shall have a written Hazardous Communication Program and staff shall be knowledgeable of chemicals in the workplace, location of Material Safety Data Sheets, personal protective equipment, and toxic or flammable substances shall be stored in approved locked storage cabinets.

(l) Compliance with 450:55-19-1 shall be determined by visual observation, posted evacuation plans and a review of policy and procedures, regulatory or internal inspection reports, training documentation and other supporting documentation provided.

In addition to the requirements set forth in OAC 450:9-1-5.2(a), the PACT program shall:

(1) Have a written Infection Control Program and staff shall be knowledgeable of Center for Disease Control (CDC) Guidelines for Tuberculosis and of the Blood Borne Pathogens Standard, location of spill kits, masks, and other personal protective equipment; and

(2) Have a written Hazardous Communication Program and staff shall be knowledgeable of chemicals in the workplace, location of Material Safety Data Sheets, personal protective equipment; and toxic or flammable substances shall be stored in approved locked storage cabinets.

**SUBCHAPTER 21. GOVERNING AUTHORITY [REVOKED]**

450:55-21-1. Documents of authority [REVOKED]

(a) There shall be a duly constituted authority and governance structure for assuring legal responsibility and for requiring accountability for performance and operation of the PACT within the structure of the parent organization.

(b) The governing authority shall have written documents of its source of authority, which shall be available to the public upon request.

(c) The governing body's bylaws, rules or regulations shall identify the chief executive officer who is responsible for the structure under which the PACT is organized the control, utilization and conservation of its physical and financial assets and the recruitment and direction of the staff.

(d) The source of authority document shall state:

(1) The eligibility criteria for governing body membership;
(2) The number and types of membership;
(3) The method of selecting members;
(4) The number of members necessary for a quorum;
(5) Attendance requirements for governing body membership;
(6) The duration of appointment or election for governing body members and officers; and
(7) The powers and duties of the governing body and its officers and committees or the authority and responsibilities of any person legally designated to function as the governing body.

(e) There shall be an organizational chart setting forth the structure of the organization.

(f) Compliance with 450:23-11-1 shall be determined by a review of the following—bylaws, articles of incorporation, written document of source of authority, minutes of governing
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beard meetings, job description of the CEO and the written organizational chart.

SUBCHAPTER 23. SPECIAL POPULATIONS
[REVOKED]

[REVOKED]
(a) Under Titles 11 and 111 of the ADA, the PACT or parent organization shall comply with the "Accessibility guidelines for Buildings and Facilities (ADAAG) for alterations and new construction." United States government facilities are exempt for the ADA as they shall comply with the Uniform Federal Accessibility Standards (UFAS), effective August 7, 1984. Also available for use in assuring quality design and accessibility is the American National Standards Institute (ANSI) A117.1 "American National Standard for Accessible and Usable Buildings and Facilities".
(b) State and local standards for accessibility and usability may be more stringent than ADA, UFAs, or ANSI A117.1. The PACT or parent organization shall assume responsibility for verification of all applicable requirements and comply with the most stringent standards.
(c) The PACT or parent organization shall have written policy and procedures for providing or arranging for services for persons who fall under the protection of the Americans with Disabilities Act of 1990 and provide documentation of compliance with applicable Federal, state, and local requirements. A recommended reference is the "Americans with Disabilities Handbook" published by the U.S. Equal Employment Opportunity Commission and the U.S. Department of Justice.
(d) Compliance with 450:55-23-1 shall be determined through a review of facility written policy and procedure and any other supporting documentation.

450:55-23-2. Human Immunodeficiency Virus (HIV), and Acquired Immunodeficiency Syndrome (AIDS) [REVOKED]
(a) A policy of non-discrimination against persons with HIV infection or AIDS shall be adopted and in force in the policy and procedure of the PACT or parent organization.
(b) All PACT staff shall observe the Universal Precautions For Transmission of Infectious Diseases as set forth in "Occupational Exposure to Blood-Borne Pathogens" published by the United States Occupational Safety Health Administration (OSHA).
(1) There shall be written documentation the aforesaid Universal Precautions are the policy of the PACT or parent organization and
(2) In-service regarding the Universal Precautions shall be a part of employee orientation and at least once per year is included in employee in-service training.
(c) Compliance with 450:55-23-2 is determined by review of PACT policy and procedure and in-service training, on-site observation, schedules and other documentation.

SUBCHAPTER 25. BEHAVIORAL HEALTH HOME [REVOKED]

450:55-25-1. Program description and purpose
[REVOKED]
(a) The purpose of this Subchapter is to set forth, in addition to all other applicable rules, rules regulating program requirements, activities, and services for PACT Programs who opt to deliver services through a Behavioral Health Home model.
(b) The purpose of BHHs within the mental health delivery array is to promote enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness, including adults with serious mental illness (SMI). Care must be delivered using an integrated team comprehensively address physical, mental health, and substance use disorder treatment needs.
(c) The BHH must maintain facility policies and program descriptions that clearly describe that the purpose of the BHH is to improve the health status of individuals with Serious Mental Illness by integrating behavioral and primary health care and promoting wellness and prevention.
(d) The BHH must provide program descriptions and demonstrate evidence that the following functions are implemented:
(1) Quality-driven, cost effective, culturally appropriate, and person and family centered health home services;
(2) Coordinated access to:
(A) High-quality health care services informed by evidence-based clinical practice guidelines;
(B) Preventive and health promotion services, including prevention of mental illness and substance use disorders;
(C) Mental health and substance abuse services;
(D) Comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
(E) Chronic disease management, including self-management support to individuals and their families;
(F) Individual and family supports, including referral to community, social support, and recovery services; and,
(G) Long term care supports and services;
(3) Person centered care plans for each individual that coordinates and integrates all of his or her clinical and non-clinical health care related needs and services;
(4) Proper and continuous use of health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate;
and
(5) A quality improvement program, which collects and reports data that permits an evaluation of increased coordination of care and chronic disease management.
on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
(e) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:55-25-2. Target population [REVOKED]
(a) The PACT BHH must be established to serve only adults with serious mental illness (SMI).
(b) Organizational documents must clearly describe the target population(s) to be served by the BHH.
(c) Target population descriptions should not be interpreted as to limit access to individuals based on funding sources, including not limiting access to those who are uninsured but otherwise meet the target population criteria. Although not required, BHHs are encouraged to identify funding in order to provide BHH services to individuals who meet the target population criteria but do not have Medicaid.
(d) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:55-25-3. Outreach and engagement [REVOKED]
(a) The BHH must have policies and procedures to describe how outreach and engagement activities will occur to identify individuals within the target population(s) who could benefit from BHH services.
(b) The BHH must have memoranda of agreements to arrange for outreach and engage in settings outlined further in these rules in Section 450:55-25-20.
(c) Facility records will identify which staff members are responsible for specific elements of outreach and engagement.
(d) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:55-25-4. Structure of Behavioral Health Home and administrative staff [REVOKED]
(a) The BHH policies must describe how it is organized within one of the following structures:
(1) In-house model where the behavioral health agency is directly providing primary care performed by a qualified employee, or purchasing through a contract; or
(2) Co-located partnership model where the behavioral health agency arranges for primary care services to be provided onsite, establishing written agreements with external primary care providers; or
(3) Facilitated referral model, where most primary care services are not provided onsite at the facility; however, the facility has processes in place to ensure the coordination of care that is provided offsite.
(b) In the event the BHH does not directly provide the full array of required services, there must be organizational procedures and clinical records to document that the BHH has otherwise ensured the services are coordinated on behalf of each consumer.
(c) The facility operating the BHH will have policies and program descriptions to define how the BHH will operate a team dedicated to provide the range of specific services articulated elsewhere in this Subchapter.
(d) The facility shall verify the health home director for adults meets or exceeds the following qualifications:
(1) Possess a Bachelor's degree from an accredited university and have at least two years' experience in health administration;
(2) Possess a Master's degree from an accredited university in a health or social services related field;
(3) Be licensed as a Registered Nurse with the Oklahoma Board of Nursing, or
(4) Be licensed as a Physician or be licensed as a Nurse Practitioner.
(e) The BHH will adhere to the following ratios in terms of the full-time equivalent (FTE) for the health home director.
(1) The BHH shall maintain a health home director at a ratio of 1 FTE per 500 BHH participants. BHHs with less than 500 participants shall maintain a health home director at a minimum of .5 FTE.
(2) A health home requiring a health home director and health home nurse care manager of .5 FTE each may employ 1 FTE individual to serve in both roles, provided that individual meets the requirements for both positions.
(3) A health home requiring more than .5 FTE health home director, may choose to designate a lead health home director and fulfill the additional FTE requirement with key management staff who meet the requirements of (1) or (1) above.
(f) Compliance with this Section will be determined by on-site observation, review of organizational documents, signed agreements, personnel records, job descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:55-25-5. Treatment team; general requirements [REVOKED]
(a) The BHH must designate an interdisciplinary treatment team that is responsible, with each consumer’s input and guidance, to direct, coordinate, and manage the care and services to be provided or arranged for by the BHH.
(b) The interdisciplinary team must identify for each consumer a specific licensed behavioral health professional (LBHP) to lead the process of the initial assessment and plan and to provide therapy services if indicated on the integrated plan. This will ensure that each consumer’s needs are assessed, and that the active treatment plan is implemented as indicated.
(c) Compliance with this Section will be determined by on-site observation, review of organizational documents, signed agreements, activity reports, and clinical records.
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450:55-25-6. Treatment team composition [REVOKED]
(a) Each BHIH team serving adults shall include, the following positions, unless otherwise arranged as permitted in (b) below:
   (1) Health Home Director;
   (2) Nurse Care Manager;
   (3) Consulting—Primary Care—Physician, Advanced Practice Registered Nurse; or Physician Assistant;
   (4) Licensed Psychiatric Consultant;
   (5) License Behavioral Health Professional;
   (6) Certified Behavioral Health Case Manager I or II;
   (7) Hospital Liaison/Health Home Specialist; and
   (8) Wellness Coach credentialed through ODMHSAS.
(b) Variations from the above staff pattern, on a continuous basis, must be approved in advance by the ODMHSAS Commissioner or a designee.
(c) If the health team experiences difficulty in recruiting staff to fill any of the above positions, a recruitment and contingency plan to maintain essential services, will be submitted to the ODMHSAS Director of Provider Certification for approval.
(d) The facility must have written policies and procedures defining the program's plan for staffing-to-consumer ratio for each adult BHIH team and a plan for how exceptions will be handled.
(e) Staffing ratios must be regularly monitored and evaluated within the facilities performance improvement activities.
(f) Compliance with this Section will be determined by on-site observation, review of organizational documents, personnel records, staffing schedules, and clinical records.

450:55-25-7. Required services [REVOKED]
(a) The BHIH must have policies and clear descriptions to delineate each specific service provided by the BHIH.
(b) The BHIH must provide the following services within the framework described in 450:27-9.1:
   (1) Comprehensive Care Management;
   (2) Care Coordination;
   (3) Health Promotion;
   (4) Comprehensive Transitional Care;
   (5) Individual and Family Support Services; and
   (6) Referral to Community and Social Support Services.
(c) Program descriptions, personnel and privileging records, and other organizational documents will specify which staff members are qualified to provide each BHIH service.
(d) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

(a) The facility must have procedures and agreements in place to facilitate referral for other medical services needed beyond the scope of the BHIH.
(b) Referral documents and releases of information shall comply with applicable privacy and consumer consent requirements.
(c) Clinical documentation will track referrals to and use of specialists.
(d) Compliance with this Section will be determined by on-site observation, review of organizational documents, signed agreements, outcome monitoring and other performance improvement activity reports, and clinical records.

(a) The facility must determine the extent to which each consumer's needs and preferences can be adequately addressed within the array of required BHIH services.
(b) An integrated screening approach in accordance with 450:55-25-11 will be used to determine clinical eligibility for BHIH services.
(c) Facility policies and procedures must assure that adults who meet the criteria for a SMI are eligible for BHIH services. This includes individuals receiving Targeted Case Management (TCM). It will also include additional individuals who are not currently receiving care coordination.
(d) The facility must obtain informed consent specific to enrollment in the BHIH.
   (1) The consent must be specific to the extent that it permits the BHIH team members to share information relevant to the delivery of BHIH services.
   (2) The process for obtaining consent must educate the consumer of their right to choose among qualified BHIHs or to opt out of the BHIH service.
   (3) The BHIH consent can be integrated into the facility's overall consent to treat as long as the requirements above are met.
(e) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:55-25-10. Integrated screening, intake, and assessment services [REVOKED]
(a) BHIH policy and procedure shall require that a screening of each potential BHIH consumer's service needs is completed in a timely manner. An integrated screening should be welcoming and culturally appropriate, as well as maximize recognition of the prevalence of co-occurring disorders among those who typically present for services.
(b) Upon determination of appropriate admission, consumer intake, and assessment information shall include, but not be limited to, the following:
   (1) Behavioral, including substance use, abuse, and dependence;
   (2) Emotional, including issues related to past or current trauma;
   (3) Physical;
   (4) Social and recreational; and
   (5) Vocational.
(c) The consumer and family as appropriate shall be an active participant(s) in the screening, intake and assessment process.

(d) The facility shall have policy and procedures specific to each program service which dictate timeframes by when assessments must be completed and documented. In the event the consumer is not admitted and as a result, the assessment is not included in the clinical record, the policy shall specify how screening and assessment information is maintained and stored.

(e) Compliance with this Section will be determined by a review of clinical records, and policy and procedures.

450:55-25-11. Initial assessment [REVOKED]

(a) A Licensed Behavioral Health Professional (LBHP), acting within his or her state scope of practice requirements, must complete the initial assessment for health home services in accordance with the standard in OAC 450:55-5-4 for consumers who have not been assessed by the facility within the past 6 months.

(b) In addition to the items required in 55-5-4, the initial assessment for health home services must include at a minimum, the following:

1. The admitting diagnosis as well as other diagnoses;
2. The source of referral;
3. The reason for admission as well as stated by the client or other individuals who are significantly involved;
4. A list of current prescriptions and over-the-counter medications as well as other substances the client may be taking.

(c) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.


(a) A comprehensive assessment must be completed by the interdisciplinary team performing within each team member’s scope of practice consistent with each consumer’s immediate needs and include a written narrative in each of the following areas:

1. Psychiatric and substance abuse history, mental status, and a current DSM status;
2. Medical, dental, and other health needs;
3. Education and/or employment;
4. Social development and functioning;
5. Activities of daily living; and
6. Family structure and relationships.

(b) The comprehensive assessment must be regularly updated, and no less than six (6) months.

(c) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:55-25-13. Integrated care plan [REVOKED]

(a) The BHH team must develop a consumer-directed, integrated active care plan for each enrolled consumer that reflects input of the team, including the involvement of the consulting primary care physician or APRN in managing the medical component of the plan, and others the consumer chooses to involve.

(b) The plan shall clearly address physical and behavioral health goals, consumer preferences, and the overall health and wellness needs of the consumer.

(c) The plan must be documented and complete within thirty (30) working days of admission to the BHH.

(d) The BHH must provide for each consumer and primary caregiver(s), as applicable, education and training consistent with the consumer and caregiver responsibilities as identified in the active treatment plan and relative to their participation in implementing the plan of care.

(e) Compliance with this Section will be determined by on-site observation, review of organizational documents, personnel records, staffing schedules, and clinical records.

450:55-25-14. Integrated care plan; content [REVOKED]

(a) The integrated care plan must address all services necessary to assist the client in meeting his or her physical and behavioral health goals, and include the following:

1. Consumer diagnoses, relative to behavioral and physical health conditions assessed by and addressed by behavioral health in terms of direct services provided and/or conditions for which individual is referred elsewhere for treatment;
2. Treatment goals, including preventive/primary care services;
3. Interventions, including follow-up with necessary medical providers;
4. A detailed statement of the type, duration, and frequency of services, including primary, medical and specialty care, social work, psychiatric nursing, counseling, and therapy services, necessary to meet the consumer’s specific needs;
5. Medications, treatments, and individual and/or group therapies;
6. As applicable, family psychotherapy with the primary focus on treatment of the consumer’s conditions; and
7. The interdisciplinary treatment team’s documentation of the consumer’s or representative’s and/or primary caregiver’s (if any) understanding, involvement, and agreement with the care plan.

(b) Compliance with this Section will be determined by on-site review of clinical records and supported documentation.


(a) The BHH will review, revise, and document the individualized integrated care plan as frequently as the consumer’s conditions require, but no less frequently than every six (6) months.
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(b) A revised active plan must include information from the consumer's initial evaluation and comprehensive assessments and updates, the progress toward goals specified in the written care plan, and changes, as applicable, in goals.

c) Compliance with this Section will be determined by outcome monitoring, performance improvement activity reports.


(a) When medication services are provided as a component of the BHH services, medication administration, storage and control, and consumer reactions shall be regularly monitored. (b) Facilities shall assure proper storage and control of medications, immediate response if incorrect or overdoses occur, and have appropriate emergency supplies available if needed.

1) Written procedures for medication administration shall be available and accessible in all medication storage areas, and available to all staff authorized to administer medications.

2) All medications shall be kept in locked, non-consumer accessible areas. Conditions which shall be considered in medication storage are light, moisture, sanitation, temperature, ventilation, and the segregation and safe storage of poisons, external medications, and internal medications.

3) Telephone numbers of the state poison centers shall be immediately available in all locations where medications are prescribed, administered, and stored.

c) The facility shall make available access to pharmacy services to meet consumers' pharmacological needs that are addressed by the BHH physicians and other BHH licensed prescribers. Provision of services may be made through agreement with another program, through a pharmacy in the community, or through their own Oklahoma licensed pharmacy.

(d) Compliance with this Section will be determined by on-site observation and a review of the following: written policy and procedures, clinical records, written agreements for pharmacy services, State of Oklahoma pharmacy license and PI records.


(a) The BHH must assist members to participate in the implementation of their comprehensive care plan.

(b) This must include, but not be limited to providing health education specific to a member's chronic conditions; development of self-management plans with the individual; support to improve social networks, and providing health-promoting lifestyle interventions. Health promoting lifestyle interventions include, but are not limited to substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and increasing physical activity, and assisting to understand and self-manage chronic health conditions.

c) Compliance with this Section will be determined by review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:55-25-19. Discharge or transfer from Behavioral Health Home [REVOKED]

(a) The BHH shall, on behalf of any consumer that transfers to another facility, forward the following within fifteen (15) days as permitted by privacy and confidentiality and if requested:

1) The BHH discharge summary; and

2) The consumer's clinical record.

(b) For consumers who initiate BHH service and later decline those services, or are discharged from a BHH based on non-adherence to care plans, the BHH must forward to the primary health care provider of record, if any, and if requested by the consumer:

1) The BHH discharge summary; and

2) The consumer's clinical record.

c) As applicable to (a) and/or (b) above, the BHH discharge summary shall include the following:

1) A summary of the services provided, including the consumer's symptoms, treatment and recovery goals and preferences, treatments, and therapies.

2) The client's current active treatment plan at time of discharge.

3) The client's most recent physician orders.

4) Any other documentation that will assist in post-discharge continuity of care.

(d) A completed discharge summary shall be entered in each consumer's record within fifteen (15) days of the consumer completing or discontinuing services.

c) Compliance with this Section will be determined by on-site observation, review of organizational documents, program descriptions, outcome monitoring and other performance improvement activity reports, and clinical records.

450:55-25-20. Linkage and transitional care [REVOKED]

(a) The BHH must have procedures and agreements in place to facilitate referral for other medical services needed by consumers beyond the scope of the BHH, as well as to assist the consumer to obtain services that are needed following discharge from the BHH.

(b) The BHH will also document referrals to community and social support services to facilitate access to formal and informal resources beyond the scope of services covered by SoonerCare, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith-based organizations, etc.

c) The BHH will develop contracts or memoranda of understandings (MOUs) with regional hospital(s), Psychiatric Residential Treatment Facilities (PRTF) or other system(s) to ensure a formalized structure for transitional care planning, to
include communication of inpatient admissions and discharges of BHII participants.

1. Transitional care will be provided by the BHII for existing BHII consumers who have been hospitalized or placed in other non-community settings, such as psychiatric residential treatment facilities, as well as to newly identified, potential BHII consumers who are entering the community.

2. The BHII team will collaborate with all parties involved including the facility, primary care physician, and community providers to ensure a smooth discharge and transition into the community and prevent subsequent re-admission(s).

3. Transitional care is not limited to institutional transitions, but applies to all transitions that will occur throughout the development of the enrollee and includes transition from and to school-based services and pediatric services to adult services.

4. The BHII will document transitional care provided in the clinical records.

(d) Compliance with this Section will be determined by on-site observation, review of organizational documents, contracts, MOUs, and clinical records.

450:55-25.21. Consumer (patient care) registries and population health management [REVOKED]

(a) The BHII must implement clinical decision support mechanisms, including but not limited to point-of-care reminders, following nationally published evidence-based guidelines for:

1. A mental health or substance use disorder;
2. A chronic medical condition;
3. An acute condition;
4. A condition related to unhealthy behaviors; and
5. Well-care.

(b) BHII must have descriptions of programs in place to demonstrate how it encourages healthier lifestyles for BHII members, including increased physical activity, better nutrition, avoidance of behavioral risks, and wider use of preventive care.

(c) The BHII shall electronically submit data to a health home information management system, subject to prior approval by the Director of ODMHSAS Provider Certification, which will act as a consumer registry, care management device and outcomes measurement tool.

(d) The BHII shall utilize information provided through the approved information system for the purpose of enrollment and discharge tracking, compliance, quality assurance, and outcome monitoring.

(e) Compliance will be determined by on-site observation, review of information available through an approved information system, and consultation with the ODMHSAS Decision Support Services and ODMHSAS Information Services Division.

450:55-25.22. Electronic health records and data sharing [REVOKED]

(a) BHII shall have a functioning electronic health record (EHR) system that meets Meaningful Use standards, as defined in the Medicare and Medicaid Incentive Programs, or have a facility-approved written plan with timeframes to obtain one.

(b) The BHII shall document a plan to work with health information organizations to share referrals, continuity of care documents, lab results, and other health information and develop partnerships that maximize the use of Health Information Technology (HIT) across all treating providers.

(c) Compliance with (a) will be determined by review of documentation that certifies the electronic health record meets Meaningful Use standards or documentation of plan to obtain one with implementation timeline.

(d) Compliance with (b) will be determined by on-site observation, review of information available through an approved information system documenting that BHII consumers' records have been accessed and shared through a Health Information Exchange (HIE), and consultation with the ODMHSAS Decision Support Services and ODMHSAS Information Services Division.

450:55-25.23. Performance measurement and quality improvement [REVOKED]

(a) There shall be an ongoing performance improvement program designed to objectively and systematically monitor, evaluate and improve the quality of consumer care related to BHII operations.

(b) The BHII performance improvement activities must:

1. Focus on high-risk, high-volume, or problem-prone areas;
2. Consider incidence, prevalence, and severity of problems;
3. Give priority to improvements that affect behavioral outcomes, client safety, and person-centered quality of care;
4. Performance improvement activities must also track adverse events, analyze their causes, and implement preventive actions and mechanisms;
5. The program must use quality indicator data, including client care, and other relevant data in the design of its program.
6. The BHII must use the data collected to monitor the effectiveness and safety of services and quality of care and identify opportunities and priorities for improvement.

(f) The functions and processes outlined in (a) through (e) shall be evidence in an annual written plan for performance improvement activities. The plan shall include but not be limited to:

1. Outcomes management—processes which include measures required by CMS and the State and may also include measures from the SAMHSA National Outcomes Measures, NCQA, and HEDIS as required to document improvement in population health.
2. Quarterly record review to minimally assess:
   (A) Quality of services delivered;
   (B) Appropriateness of services;
   (C) Patterns of service utilization;
ADOPTION: March 26, 2021

SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:
March 29, 2021

LEGISLATIVE APPROVAL:
Approved June 11, 2021 by HJR 1046

FINAL ADOPTION:
June 11, 2021

EFFECTIVE:
September 15, 2021

SUPERSEDED EMERGENCY ACTIONS:

INCORPORATIONS BY REFERENCE:

GIST/ANALYSIS:
The proposed rule revisions to Chapter 60 amend language to remove duplicative language that is addressed under new proposed language in Chapter 1. The intent is to consolidate duplicative language to increase consistency and reduce regulatory language in accordance with Executive Order 2020-03.

CONTACT PERSON:
Melissa Miller, Policy Director and Administrative Rules Liaison, Melissa.Miller@odmhsas.org or (405) 248-9345

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 15, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS

450:60-1-1. Purpose
(a) This chapter sets forth standards for certification of eating disorders treatment programs and implements 43A O.S. § 3-320, which authorizes the Board of Mental Health and Substance Abuse Services, or the Commissioner upon delegation by the Board, to certify eating disorder treatment programs.
(b) The rules regarding the certification process including but not necessarily limited to application, fees and administrative sanctions are found in the Oklahoma Administrative Code, Title 450 Chapter 1, Subchapters 5 and 9.
(c) Rules outlining general certification qualifications applicable to facilities and organizations certified under this Chapter are found in OAC 450:1-9-5 through OAC 450:1-9-5.3.

450:60-1-2. Definitions
The following words or terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise.
"Abuse" means the causing or permitting of harm or threatened harm to the health, safety, or welfare of a consumer by a staff responsible for the consumer’s health, safety, or welfare, including but not limited to: non-accidental physical injury or mental anguish; sexual abuse; sexual exploitation; use of mechanical restraints without proper authority; the intentional use of excessive or unauthorized force aimed at hurting or injuring the consumer; or deprivation of food, clothing, shelter, or healthcare by a staff responsible for providing these services to a consumer.
"Certified Eating Disorder Treatment" or "CEDT" means programs certified by ODMHSAS to provide treatment to individuals diagnosed with an eating disorder.

"Clinical privileging" means an organized method for treatment facilities to authorize an individual permission to provide specific care and treatment services to consumers within well-defined limits, based on the evaluation of the individual's license, education, training, experience, competence, judgment and other credentials.

"Consumer" means an individual, adult or child, who has applied for, is receiving or has received evaluation or treatment services from a facility operated or certified by ODMHSAS or with which ODMHSAS contracts and includes all persons referred to in OAC Title 450 as client(s) or patient(s) or resident(s) or a combination thereof.

"Consumer advocacy" includes all activities on behalf of the consumer to assist with or facilitate resolution of problems in the acquisition of resources or services needed by the consumer.

"Critical incident" means an occurrence or set of events inconsistent with the routine operation of the facility, or the routine care of a consumer. Critical incidents specifically include but are not necessarily limited to the following: adverse drug events; self-destructive behavior; deaths and injuries to consumers, staff and visitors; medication errors; consumers who are absent without leave (AWOL); neglect or abuse of a consumer; fire, unauthorized disclosure of information; damage to or theft of property belonging to a consumer or the facility; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or results.

"Dietitian" means an individual trained and licensed in the development, monitoring, and maintenance of food and nutrition.

"Eating disorder" means anorexia nervosa, bulimia nervosa, or any other severe disturbances in eating behavior specified in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders.

"Emergency examination" means the examination by a licensed mental health practitioner of a person in treatment at the CEDT program to determine whether or not an emergency mental health condition (including, but not limited to, suicidality, homicidality, self-harm, delusions, hallucinations, or acute intoxication) exists requiring immediate treatment; further, the licensed behavioral health practitioner provides or arranges services up to and including hospitalization.

"Emergency medical services" means assessment and diagnosis of a person receiving services at the CEDT program by a qualified medical professional to determine the presence of an emergent medical condition that threatens life, limb, or functioning, or causes uncontrolled pain; further, the qualified medical professional provides or arranges care to stabilize the emergency medical condition.

"Emergency psychiatric services" means services provided by a licensed behavioral health practitioner of a person in treatment at the CEDT program to assess, diagnose, and treat mental health conditions that threaten the life or basic functioning of that person.

"Licensed Behavioral Health Professional" or "LBHP" means:

(A) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry;

(B) Practitioners with a license to practice in the state in which services are provided by one of the following licensing boards:
   (i) Psychology;
   (ii) Social Work (clinical specialty only);
   (iii) Professional Counselor;
   (iv) Marriage and Family Therapist;
   (v) Behavioral Practitioner; or
   (vi) Alcohol and Drug Counselor.

(C) 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.

(D) A Physician Assistant who is licensed in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

"Licensure candidate" means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:

(A) Psychology;

(B) Social Work (clinical specialty only);

(C) Professional Counselor;

(D) Marriage and Family Therapist;

(E) Behavioral Practitioner; or

(F) Alcohol and Drug Counselor.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"Oklahoma Administrative Code" or "OAC" means the publication authorized by 75 O.S. § 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"Performance Improvement" or "PI" means an approach to the continuous study and improvement of the processes of providing health care services to meet the needs of consumers and others. Synonyms, and near synonyms include continuous performance improvement, continuous improvement, organization-wide performance improvement and total quality management.

"Progress notes" means a chronological description of services provided to a consumer, the consumer's progress, or lack thereof, and documentation of the consumer's response related to the intervention plan.

"Psychotherapist" means an individual trained in assessing, evaluating, and treating psychological or social problems which the consumer experiences. A psychotherapist uses a
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variety of treatment modalities, including individual, group, and family therapies.

“Psychotherapy services” means the professional activity of a psychotherapist to assess, diagnose, and treat the mental disorder(s) and psychological, social, and environmental problems of individuals and families.

“Resident” means an eating disorder consumer admitted to a residential facility for eating disorder treatment.

“Residential facility” means the facility that houses CEDT program consumers during their course of treatment which provides 24 hour on-site nursing supervision and care.

“Volunteer” means any person who is not on the program’s payroll, but provides direct services and fulfills a defined role within the program and includes interns and practicum students.

SUBCHAPTER 7. FACILITY CLINICAL RECORDS

450:60-7.10. Discharge summary [REVOKED]
(a) A discharge summary shall document the consumer's progress made in treatment; response to services rendered; and recommendation for any referrals, if deemed necessary.
(b) A discharge summary shall be entered in each consumer's record within fifteen (15) days of release, discharge, or transfer from residential treatment or upon discharge from facility services.
(c) The discharge summary shall minimally include, but is not limited to:
   (1) Presenting problem at intake;
   (2) Medication summary when applicable;
   (3) Treatment provided and treatment outcome and results;
   (4) Psychiatric and physical diagnosis or the final assessment;
   (5) Discharge plan: Written recommendations, specific referrals for implementing aftercare services, including medications. Aftercare plans shall be developed with the knowledge and cooperation of the consumer, when possible;
   (6) In the event of death of a consumer: A summary statement including this information shall be documented in the record; and
   (7) Signature of staff member, professional credentials, if any, and date.

SUBCHAPTER 9. CONSUMER RECORDS AND CONFIDENTIALITY [REVOKED]

450:60-9.1. Confidentiality of mental health and drug or alcohol abuse treatment information [REVOKED]
Confidentiality policy, procedures and practices must comply with federal and state law, guidelines, and standards, and with OAC 450:15-3-20-1 and OAC 450:15-30-60.

SUBCHAPTER 13. ORGANIZATIONAL MANAGEMENT [REVOKED]

450:60-13.1. Organizational and facility description [REVOKED]
(a) The CEDT shall have a written organizational description which is reviewed annually and minimally includes:
   (1) The overall target population for whom services will be provided;
   (2) The overall mission statement; and
   (3) The annual facility goals and objectives.
(b) The CEDT’s governing authority shall review and approve the mission statement and annual goals and objectives and document their approval.
(c) The CEDT shall make the organizational description, mission statement and annual goals available to staff.
(d) The CEDT shall make the organizational description, mission statement and annual goals available to the general public upon request.
(e) Each CEDT shall have in writing, by program component or service, the following:
   (1) Philosophy and description of services;
   (2) Identity of the professional staff that provides these services;
   (3) Admission and exclusionary criteria that identify the type of consumers for whom the services are primarily intended; and
   (4) Goals and objectives.
(f) The CEDT shall have written procedures and plans for attaining the organization's goals and objectives. These procedures and plans shall define specific tasks, set target dates and designate staff responsible for carrying out the procedures and plans.
(g) Compliance with OAC 450:60-13-1 shall be determined by a review of the facility’s target population definition; facility policy and procedures; mission statement; written plan for professional services; other stated required documentation; and any other supporting documentation.

450:60-13.2. Information analysis and planning [REVOKED]
(a) The CEDT shall have a defined and written plan for conducting an organizational needs assessment which specifies the methods and data to be collected, to include, but not be limited to information from:
   (1) Consumers;
   (2) Governing Authority;
   (3) Staff;
   (4) Stakeholders;
   (5) Outcomes management processes; and
   (6) Quality record review.
(b) The CEDT shall have a defined ongoing system to collect data and information on a quarterly basis to manage the organization.
(c) Information collected shall be analyzed to improve consumer services and organizational performance.
(d) The CEDT shall prepare an end of year management report, which shall include but not be limited to:
(1) an analysis of the needs assessment process, and
(2) performance improvement program findings.
(e) The management report shall be communicated and made available to, among others:
(1) the governing authority,
(2) facility staff, and
(3) ODMHSAS if and when requested.

SUBCHAPTER 15. PERFORMANCE IMPROVEMENT AND QUALITY MANAGEMENT [REVOKED]

450:60-15-1. Performance improvement program [REVOKED]
(a) The CEDT shall have an ongoing performance improvement program designed to objectively and systematically monitor, evaluate and improve the quality of consumer care.
(b) The Performance improvement program shall also address the fiscal management of the organization.
(c) The facility shall have an annual written plan for performance improvement activities. The plan shall include but not be limited to:
(1) outcomes management specific to each program component which minimally measures:
   (A) efficiency
   (B) effectiveness and
   (C) consumer satisfaction.
(2) A quarterly quality consumer record review to evaluate and ensure, among others:
   (A) the quality of services delivered;
   (B) the appropriateness of services;
   (C) patterns of service utilization;
   (D) consumers are provided an orientation to services, and actively involved in making informed choices regarding the services they receive;
   (E) assessments are thorough, timely and complete;
   (F) treatment goals and objectives are based on, at a minimum:
      (i) assessment findings, and
      (ii) consumer input;
   (G) services provided are related to the treatment plan goals and objectives;
   (H) services are documented as prescribed by policy; and
   (I) the treatment plan is reviewed and updated as prescribed by policy.
(2) Clinical privileging and
(4) Review of critical and unusual incidents and consumer grievances and complaints.
(d) The CEDT shall monitor the implementation of the performance improvement plan on an ongoing basis and make adjustments as needed.
(e) Performance improvement findings shall be communicated and made available to, among others:
(1) the governing authority,
(2) facility staff, and
(3) ODMHSAS if and when requested.

450:60-15-2. Incident reporting [REVOKED]
(a) The facility shall have written policies and procedures requiring documentation and reporting of critical incidents.
(b) The documentation for critical incidents shall contain minimally:
(1) the facility, name and signature of the person(s) reporting the incident;
(2) the name(s) of the consumer(s), staff member(s) or property involved;
(3) the time, date and physical location of the critical incident;
(4) the time and date the incident was reported and name of the staff person within the facility to whom it was reported;
(5) a description of the incident;
(6) resolution or action taken, date action taken, and signature of appropriate staff; and
(7) severity of each injury, if applicable. Severity shall be indicated as follows:
   (A) No off-site medical care required or first aid care administered on-site;
   (B) Medical care by a physician or nurse or follow-up attention required; or
   (C) Hospitalization or immediate off-site medical attention was required;
(e) Critical incidents shall be reported to ODMHSAS Provider Certification Division within specific timeframes, as follows:
(1) Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax or mail to ODMHSAS Provider Certification within twenty-four business (24) hours of the incident.
(2) Critical incidents involving allegations constituting a sentinel event or consumer abuse shall be reported to ODMHSAS immediately, via telephone or fax, but not more than twenty-four business (24) hours of the incident. If reported by telephone, the report shall be followed with a written report within twenty-four business (24) hours of the incident.

SUBCHAPTER 17. HUMAN RESOURCES [REVOKED]

450:60-17-1. Personnel policies and procedures [REVOKED]
(a) The facility shall have written personnel policies and procedures approved by the governing authority.
(b) All employees shall have access to personnel policies and procedures, as well as other Rules and Regulations governing the conditions of their employment.
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(c) The facility shall develop, adopt, and maintain policies and procedures at each provider location to promote the objectives of the center and provide for qualified personnel during all hours of operation to support the functions of the facility and the provision of quality care.

450:60-17-2. Job descriptions [REVOKED]
There shall be job descriptions for all positions setting forth minimum qualifications and duties of each position.

450:60-17-3. Utilization of volunteers [REVOKED]
(a) In facilities where volunteers are utilized, specific policies and procedures shall be in place to define the purpose, scope, and training, supervision and operations related to the use of volunteers.
(b) A qualified staff member shall be assigned the role of, or responsibility as, the volunteer coordinator.
(c) Volunteer policies and procedures shall be reviewed by an appropriate level of authority upon revision.
(d) There shall be documentation to verify orientation of each volunteer which shall enable him or her to have knowledge of program goals and familiarity with routine procedures.
(e) Volunteers are required to receive in-service training pursuant to 60-19-3.

SUBCHAPTER 19. STAFF DEVELOPMENT AND TRAINING [REVOKED]

450:60-19-1. Staff qualifications [REVOKED]
(a) All staff who provides clinical services shall have documented qualifications or training specific to the clinical services they provide within the CEDT.
(b) Failure to comply with 450:60-19-1 will result in the initiation of procedures to deny, suspend, and/or revoke certification.

450:60-19-2. Staff development [REVOKED]
(a) The CEDT shall have a written plan for the professional growth and development of all administrative, professional and support staff.
(b) This plan shall include, but not be limited to:
(1) orientation procedures;
(2) inservice training and education programs;
(3) availability of professional reference materials; and
(4) mechanisms for insuring outside continuing educational opportunities for staff members.
(c) The results of performance improvement activities, accrediting and audit findings and recommendations shall be addressed by and documented in the staff development and clinical privileging processes.
(d) Staff education and inservice training programs shall be evaluated by the CEDT at least annually.

450:60-19-3. Annually required inservice training for all employees [REVOKED]
Inservice presentations shall be conducted each calendar year and are required for all employees on the following topics:
(1) Fire and safety;
(2) AIDS and HIV precautions and infection control;
(3) Consumer’s rights and the constraints of the Mental Health Consumer’s Bill of Rights;
(4) Confidentiality;
(5) Oklahoma Child Abuse Reporting and Prevention Act, 10 O.S. §§ 7101-7115; and
(6) Facility policy and procedures;
(7) Cultural competence;
(8) Trauma-informed; and
(9) Age-and developmentally-appropriate trainings, where applicable.

450:60-19-4. First Aid and CPR training [REVOKED]
The CEDT shall have staff during all hours of operation at each program site who maintains current certification in basic first aid and Cardiopulmonary Resuscitation (CPR).

SUBCHAPTER 21. GOVERNING AUTHORITY [REVOKED]

450:60-21-1. Documents of authority [REVOKED]
(a) There shall be a duly constituted authority and governance structure for assuring legal responsibility and for requiring accountability for performance and operation of the facility (including all components and satellites).
(b) The governing authority shall have written documents of its source of authority, which shall be available to the ODHLSAS upon request.
(c) In accordance with governing body bylaws, rules and regulations, the chief executive officer is responsible to the governing body for the overall day to day operation of the facility, including the control, utilization, and conservation of its physical and financial assets and the recruitment and direction of the staff.

(1) the source of authority document shall state:
(A) The eligibility criteria for governing body membership;
(B) The number and types of membership;
(C) The method of selecting members;
(D) The number of members necessary for a quorum;
(E) Attendance requirements for governing body membership;
(F) The duration of appointment or election for governing body members and officers;
(G) The powers and duties of the governing body and its officers and committees or the authority and responsibilities of any person legally designated to function as the governing body.
(2) There shall be an organizational chart setting forth the operational components of the facility and their relationship to one another.

SUBCHAPTER 25. SPECIAL POPULATIONS [REVOKED]

450:60-25-1. Americans with disabilities act of 1990 [REVOKED]

(a) Under Titles II and III of the ADA, the CEDTs shall comply with the "Accessibility Guidelines for Buildings and Facilities (ADAAG) for alterations and new construction." United States government facilities are exempt for the ADA as they shall comply with the "Uniform Federal Accessibility Standards (UFAS)," effective August 7, 1984. Also available for use in ensuring quality design and accessibility is the American National Standards Institute (ANSI) A117.1 "American National Standard for Accessible and Usable Buildings and Facilities."

(b) State and local standards for accessibility and usability may be more stringent than ADA, UFAS, or ANSI A 117.1. The CEDT shall assume responsibility for verification of all applicable requirements and comply with the most stringent standards.

(c) The CEDT shall have written policy and procedures providing or arranging for services for persons who fall under the protection of the Americans With Disabilities Act of 1990 and provide documentation of compliance with applicable Federal, state, and local requirements. A recommended reference is the "Americans With Disabilities Handbook" published by the U.S. Equal Employment Opportunity Commission and the U.S. Department of Justice.

450:60-25-2. Human Immunodeficiency Virus (HIV), and Acquired Immunodeficiency Syndrome (AIDS) [REVOKED]

(a) The facility shall have a policy of non-discrimination against persons with HIV infection or AIDS.

(b) All facilities shall observe the Universal Precautions For Transmission of Infectious Diseases as set forth in, "Occupational Exposure to Bloodborne Pathogens" published by the (U.S.) Occupational Safety Health Administration [OSHA]; and

(1) There shall be written documentation the aforesaid Universal Precautions are the policy of the facility;

(2) Inservice training regarding the Universal Precautions shall be a part of employee orientation and, at least once per year, is included in employee inservice training.

[OAR Docket #21-440; filed 6-14-21]
SUBCHAPTER I. GENERAL PROVISIONS

450:65-1-1. Purpose
(a) This chapter sets forth the standards and criteria to be used in the certification of Gambling Treatment Programs, and implements 43A O.S. § 3-222 which authorizes the Board of Mental Health and Substance Abuse Services, or the Commissioner upon delegation by the Board, to certify Gambling Treatment Programs.
(b) The rules regarding the certification process, including but not necessarily limited to, application process, fees and administrative sanctions are found in the Oklahoma Administrative Code, Title 450, Chapter 1.
(c) Rules outlining general certification qualifications applicable to facilities and organizations certified under this Chapter are found in OAC 450:1-9-5 through OAC 450:1-9-5.3.

450:65-1-2. Definitions
The following words or terms, when used in this chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Admission" means the acceptance of a consumer by a treatment program.
"Admission criteria" means those criteria which shall be met for admission of a consumer to gambling treatment.
"Assessment" means those procedures by which a gambling treatment program provides an on-going evaluation process with the consumer to collect his or her historical information, and identify strengths, needs, abilities, and preferences in order to determine a plan for recovery.
"Case management" means actions such as planned linkage, advocacy and referral assistance provided in partnership with a consumer to support that consumer in self-sufficiency and community tenure and may occur in the consumer's home, in the community, or in the facility.
"Certified Gambling Addiction Treatment" or "CGAT" means programs certified by ODMHSAS to provide treatment to individuals diagnosed with a problem gambling disorder.
"Clinical supervision" means an organized process, by which knowledgeable and skilled supervisors systematically and routinely provide ongoing and in-depth review of direct service providers' performance which leads to professional growth, clinical skills development and increased self-awareness.
"Community education, information, consultation and outreach" means services designed to reach the facility's target population, to promote available services, and to give trip information on problem gambling and other related issues to the general public, the target population or to other agencies serving the target population. These services include presentations to human services agencies, community organizations and individuals, other than individuals in treatment, and staff. These services may take the form of lecture presentations, films or other visual displays, and discussions in which factual information is disseminated. These presentations may be made by staff or trained volunteers.

"Consumer" means an individual, adult or adolescent, who is receiving evaluation or treatment services from a facility operated or certified by ODMHSAS or with which ODMHSAS contracts and includes all persons referred to in OAC Title 450 Chapters 16, 17, 18, 19, 23, and 65 as client(s) or patient(s) or resident(s) or a combination thereof.
"Consumer record" means the collection of written information about a consumer's evaluation or treatment that includes the admission data, evaluation, treatment or service plan, description of treatment or services provided, continuing care plan, and discharge information on an individual consumer.
"Continuing care" means providing a specific period of structured therapeutic involvement designed to enhance, facilitate and promote transition from primary treatment services to ongoing recovery.
"Contact" means any encounter with a consumer who is inquiring about or seeking services.
"Contract" means a document adopted by the governing authority of an approved treatment facility and any other organization, facility, or individual, which specifies services, personnel, or space to be provided by the program as well as the monies to be expended in exchange.
"Crisis intervention" means an immediately available service to meet the psychological, physiological and safety aspects of mental health, problem gambling, and substance abuse related crisis. These unscheduled face to face interventions are in response to emergencies to resolve acute emotional and physical dysfunction, secure appropriate placement in the least restrictive setting, provide crisis resolution, and stabilize functioning.
"Critical incident" means an occurrence or set of events inconsistent with the routine operation of a treatment facility, or the routine care of a consumer. Critical incidents specifically include but are not necessarily limited to the following: adverse drug events; self-destructive behavior; deaths and injuries to consumers, staff and visitors; medication errors; respiratory consumers that are absent without leave (AWOL); neglect or abuse of a consumer; fire; unauthorized disclosure of information; damage to or theft of property belonging to a consumer or a treatment facility; other expected occurrences or events potentially subject to litigation. A critical incident may involve multiple individuals or results.
"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, religious, sexual orientation, and/or social group.
"Department" or "ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.
"Diagnosis" means the determination of a disorder as defined by current DSM criteria.
"Discharge criteria" means general guidelines to inform the judgment of the gambling treatment professional which shall be considered in order for the consumer to be appropriately discharged from a treatment program.
"Discharge planning" means the process, begun at admission, of determining a consumer's continued need for
treatment services and of developing a plan to address ongoing consumer post-treatment and recovery needs.

"Discharge summary" means a clinical document in the gambling treatment record summarizing the consumer's progress during treatment, with goals reached, continuing needs, and other pertinent information including documentation of linkage to community services.

"Documentation" means the provision of written, dated, and authenticated evidence to substantiate compliance with CGAT standards, e.g., minutes of meetings, memoranda, schedules, notices, logs, treatment records, policies, procedures, and announcements.

"DSM" means the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"Education" means the dissemination of relevant information specifically focused on increasing the awareness of the community and the receptivity and sensitivity of the community concerning gambling issues and services. A systematic presentation of selected information to impart knowledge or instructions, to increase understanding of specific issues or programs, and to examine attitudes or behaviors which may stimulate social action or community support of the program and the consumers.

"Educational group" means groups in which information focuses on topics that impact a consumer's recovery from problem and pathological gambling. Topics should be gender and age specific and should include, but not be limited to, information regarding their diagnosis or identified problems on their treatment plan. This service may involve teaching skills in communication, relapse prevention, self-care, and social skills to promote recovery. Paraprofessionals and/or professionals in fields related to the education topic may facilitate educational groups.

"Family" means the parents, brothers, sisters, other relatives, foster parents, guardians, and others who perform the roles and functions of family members in the lives of consumers.

"Follow-up" means the organized method of systematically determining the status of consumers after they have been discharged to determine post-treatment outcomes and utilization of post-treatment referrals.

"Gambling treatment services" means treatment activities for consumers by a gambling treatment professional that include, but are not limited to, the following:

(A) Assessment and diagnostic impression, ongoing;
(B) Treatment planning and revision, as necessary;
(C) Individual, group and family therapy;
(D) Case management;
(E) Discharge planning.

"Gambling treatment professional" means an individual holding a valid NCGC I or II certification or has documented completion of at least thirty hours of ODMHSAS recognized core problem gambling training requirements and documented completion of ten hours of problem gambling specific continuing education every twelve months; and is either a Licensed Behavioral Health Professional or Licensure Candidate.

"Gambling related disorders/problems" means gambling related issues or problems which impact the normal functioning of an individual.

"Goals" means broad general statements of purpose or intent that indicate the general effect the facility or service is intended to have.

"Governing authority" means the individual or group of people who serve as the treatment facility's board of directors and who are ultimately responsible for the treatment facility's activities and finances.

"Group counseling" means a method of using various commonly accepted treatment approaches provided face-to-face by a treatment professional with two (2) or more consumers that does not consist of solely related individuals, to promote positive emotional or behavioral change. Services rendered in this setting should be guided by the consumer's treatment goals and objectives, and does not include social or daily skill development as described in educational group counseling.

"Individual therapy" means a method of using various evidence based/commonly accepted treatment approaches provided face-to-face by a gambling treatment professional with one consumer to promote positive emotional or behavioral change.

"Intervention" means a process or technique intended to facilitate behavior change.

"Levels of care" means the different options for treatment that vary according to the intensity of the services offered. Each treatment option is a level of care.

"Licensed Alcohol/Drug Abuse Counselor" or "LADC" means an individual licensed to provide substance abuse counseling pursuant to Title 59 O.S., Chapter 43B, Licensed Alcohol and Drug Counselors Act.

"Licensed mental health professional" or "LMHP" as defined in Title 43A §1-1-3(11).

"Linkage" refers to the communication and coordination with consumers and other service providers to assure timely and appropriate referrals between the CGAT program and other providers.

"Mental health services" means a wide range of diagnostic, therapeutic, and rehabilitative services used in the treatment of problem and pathological gambling, and other mental disorders including substance abuse.

"NCGC" means Nationally Certified Gambling Counselor, offered at levels I or II through the National Council on Problem Gambling.

"Neglect" means a failure to provide adequate personal care or maintenance, or access to medical care that results or may result in physical or mental injury to a consumer.

"Objectives" means a specific statement of planned accomplishments or results that are specific, measurable, attainable, realistic, and time-limited.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"Oklahoma Administrative Code" or "OAC" means the publication authorized by 75 O.S. § 256 known as The
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Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A)(1) and maintained in the Office of Administrative Rules.

"OSDH" means the Oklahoma State Department of Health.

"Outpatient services" means an organized, nonresidential treatment service in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimens.

"Paraprofessional" means a person who does not have an academic degree related to the scope of treatment or support services being provided but performs prescribed functions under the general supervision of that discipline.

"Pathological gambling diagnosis" means a persistent and recurrent maladaptive gambling behavior that disrupts personal, family, or vocational pursuits, as defined by the most recent edition of the DSM.

"Peer Recovery Support Specialist" or "PRSS" means an individual who meets the qualifications and is certified as a PRSS pursuant to OAC 450:53.

"Performance improvement" means an approach to the continuous study and improvement of the processes of providing health care services to meet the needs of consumers and others.

"Personnel record" means a chart or file containing the employment history and actions relevant to individual employee activities within an organization and may contain application, evaluation, salary data, job description, citations, credentials and training information.

"PICIS" is a comprehensive management information system based on national standards for mental health and substance abuse databases. It is a repository of diverse data elements that provide information about organizational concepts, staffing patterns, consumer profiles, program or treatment focus, and many other topics of interest to clinicians, administrators and consumers. It includes unique identifiers for agencies, staff and consumers that provide the ability to monitor the course of consumer services throughout the statewide ODMHSAS network. PICIS collects data from hospitals, community mental health centers, substance abuse agencies, domestic violence service providers, residential care facilities, prevention programs, and centers for the homeless which are operated or funded in part by ODMHSAS.

"Policy" means statements of facility intent, strategy, principle, or rules in the provision of services; a course of action leading to the effective and ethical provision of gambling treatment services.

"Procedures" means the methods by which policies are implemented.

"Problem Gambling" means a persistent and recurrent maladaptive gambling behavior that disrupts personal, family, or vocational pursuits as defined by the most recent edition of the DSM.

"Program" means a structured set of treatment activities designed to achieve specific objectives relative to the needs of consumers served by the facility.

"Program effectiveness outcome" means a written plan and operational methods of determining the effectiveness of services provided that objectively measures facility resources, activities and consumer outcomes.

"Progress notes" means a complete chronological written description of services provided to a consumer and includes the consumer's response and is written by the individual or clinical team delivering the gambling treatment services.

"Recovery" means an ongoing process of discovery and/or rediscovery that must be self-defined, individualized and may contain some, if not all, of the fundamental components of recovery as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA).

"Safety Officer" means the individual responsible for ensuring the safety policies and procedures are maintained and enforced within the facility.

"Screening" means the process to determine whether the person seeking assistance needs further assessment for problem or pathological gambling.

"Sentinel event" is a type of critical incident that is an unexpected occurrence involving the death or serious physical or psychological injury to a consumer, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a consumer. These events signal the need for immediate investigation and response. Sentinel events include, but are not limited to: suicide, homicide, criminal activity, assault and other forms of violence, including domestic violence or sexual assault, and adverse drug events resulting in serious injury or death.

"Significant others" means those individuals who are or have been, significantly involved in the life of the consumer.

"Staff privileging" means an organized method for CGAT facilities to authorize an individual permission to provide specific care and treatment services to consumers within well-defined limits, based on the evaluation of the individual's license, education, certification, training, experience, competence, judgment, and other credentials.

"Tobacco" means any nicotine delivery product or device that is not approved by the U.S. Food and Drug Administration (FDA) for the purpose of nicotine dependence treatment, including, but not limited to cigarettes, cigars, snuff, chewing tobacco, electronic cigarettes and vaping devices.

"Treatment planning" means the process by which a gambling treatment professional and the consumer together and jointly identify and rank problems, establish agreed-upon immediate short-term and long-term goals, and decide on the treatment process and resources to be utilized.

"Treatment session outpatient" means each face-to-face contact with a consumer in a therapeutic setting whether individually or in a group.

"Update" means a dated and signed review of a report, plan or document with or without revision.

"Volunteer" means any person providing direct consumer rehabilitative services and who is not on the facility payroll, but fulfills a defined role within the approved treatment facility. This includes, but is not limited to, court ordered community
services, practicum students, interns, and ministers; it excludes professionals and entities with which the facility has a written affiliation.

"Walk-through" means an exercise in which staff members of a facility walk through the CGAT program's treatment processes as a consumer. The goal is to view the agency processes from the consumer’s perspective for the purpose of removing barriers and enhancing treatment.

**SUBCHAPTER 3. GAMBLING TREATMENT SERVICES AND DOCUMENTATION**

**450:65-3-3. Assessment and diagnostic services**

(a) CGAT providers' policies and procedures shall require that an assessment of each consumer's service needs is completed within four (4) sessions of initiation of services.

(b) CGAT policy and procedure shall require that a screening of each consumer's service needs is completed in a timely manner. An integrated screening should be welcoming and culturally appropriate and shall include a screening of whether the consumer is a risk to self or others, including suicide risk factors.

(c) The following information shall be collected by the CGAT provider and recorded in each consumer's assessment, to be completed prior to implementation of the treatment plan. This shall include, but not be limited to, an assessment of the following areas and needs:

1. Behavioral, including substance use, abuse and dependence as well as other addictive disorders;
2. Emotional, including issues related to past or current trauma;
3. Physical;
4. Social and recreational; and
5. Vocational.

(d) The consumer and family member(s), when appropriate, shall be an active participant(s) in the screening and assessment process.

(e) Assessments shall be on-going and performed by staff meeting the requirements for gambling treatment professionals.

(f) Compliance with 450:65-3-1, 450:65-3-2, and 450:65-3-3 may be determined by a review of the following:

1. Policy and procedures;
2. Consumer records;
3. Interviews with staff and consumers; and
4. Other facility documentation.

**450:65-3-7. Discharge Planning [REVOKED]**

(a) Discharge planning is the process of determining a consumer’s continued need for treatment services and developing a plan to address the ongoing consumer’s recovery needs.

(b) The Discharge Summary documents in the treatment record the consumer’s identified needs at admission, initial condition and condition of the consumer at discharge, summary of current medications, when appropriate, treatment and services provided, progress during treatment, goals reached, continuing needs, and other pertinent information including documentation of linkage to aftercare. The Discharge Summary, signed by the staff member completing the summary and dated, is identified as such in the treatment record and shall be entered in each consumer's record within fifteen (15) days of the consumer's discharge.

(c) Compliance with 450:65-3-7 may be determined by a review of the following:

1. Progress notes
2. Discharge summaries;
3. Consumer records;
4. Interviews with staff and consumers; and
5. Other facility documentation.

**450:65-3-11. Consumer record system [REVOKED]**

(a) Each CGAT program shall maintain an organized system for the content, confidentiality, storage retention and disposition of consumer case records.

(b) The CGAT program shall have written policy and procedures concerning consumer records which define required documentation within the case record.

(c) Consumer records shall be contained within equipment which shall be maintained under locked and secure measures.

(d) The facility shall maintain identification and filing systems which enable prompt record location and accessibility by treatment professionals.

(e) Consumer records shall be maintained in the facility where the individual is being treated or served. In the case of temporary office space and in-home treatment services, records may be maintained in the main (permanent) office and transported in secured lock boxes or vehicle trunks to and from temporary offices and homes, when necessary. Consumer records may be permanently maintained at the facility's administrative offices; however, a working copy of the consumer record for the purposes of documentation and review of services provided must be maintained at the site in which the consumer is receiving treatment.

(f) Each facility shall have written policies and procedures which:

1. Limit access to consumer records to persons with a need to know.
2. Require consumer records be stored under lock and key.
3. With regard to closed consumer records, require:
   - Confidential storage under lock and key;
   - A stated period of retention; and
   - Records disposition and destruction under confidential conditions.

(g) EXCEPTION: With regard to 450:65-3-11 (f)(3)(B), facilities operated by ODMHAS shall comply with the provisions of the Records Disposition Schedule for said facility as approved by the Oklahoma Archives and Records Commission [67 O.S. § 305 and OAC 60:1-1-2].

(h) Compliance with 450:65-3-11 may be determined by a review of:

1. Policy and procedures;
2. Treatment records;
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450:65-3-12. Confidentiality of gambling treatment information [REVOKED]

(a) The confidentiality of all gambling treatment information and records shall be kept, recorded, released, maintained, and provided to requesting parties in accordance with all applicable state and federal laws.

(b) All facilities shall have policy and procedures protecting the confidential and privileged nature of gambling treatment information in compliance with state and federal law and which contain, at a minimum:

1. an acknowledgment that all gambling treatment information, whether recorded or not, and all communications between a physician or psychotherapist and a consumer are both privileged and confidential and will not be released without the written consent of the consumer or the consumer's legally authorized representative;

2. an acknowledgment that the identity of a consumer who has received or is receiving gambling treatment services is both confidential and privileged and will not be released without the written consent of the consumer or the consumer's legally authorized representative;

3. a procedure to limit access to gambling treatment information to only those persons or agencies actively engaged in the treatment of the consumer and to the minimum amount of information necessary to carry out the purpose for the release;

4. a procedure by which a consumer, or the consumer's legally authorized representative, may access the consumer's gambling treatment information;

5. an acknowledgement that certain state and federal law exceptions to disclosure of gambling treatment information without the written consent of the consumer or the consumer's legally authorized representative exist and the facility will release information as required by those laws; and

6. a procedure by which to notify a consumer of his or her right to confidentiality.

(e) Compliance with 450:65-3-12 may be determined by a review of:

1. facility policy and procedures;

2. facility forms;

3. consumer record reviews;

4. interviews with staff and consumers; and

5. any other supporting facility documentation.

450:65-7-4. Physical facility environment and safety [REVOKED]

(a) All facilities providing any service to persons, groups, or the community shall have written policies and procedures intended to ensure the safety and protection of all persons within the facility's physical environment (property and buildings, leased or owned).

(b) These policies and procedures shall include, but are not limited to:

1. Meeting all fire and safety regulations, code, or statutory requirements of federal, state, or local government.

2. All facilities shall have an annual fire and safety inspection from the State fire Marshal or local authorities, and shall maintain a copy of said inspection and attendant correspondence regarding any deficiency.

3. An emergency preparedness plan to provide effective utilization of resources to best meet the physical needs of consumers, visitors, and staff during any disaster (including, but not limited to fire, flood, tornado, explosion, prolonged loss of heat, light, water, air conditioning). This plan shall be evaluated annually and revised as needed.

4. Facilities shall have a designated Safety Officer.

5. Staff training and orientation regarding the location and use of all fire extinguishers and first aid supplies and equipment.

6. Emergency evacuation routes and shelter areas shall be prominently posted in all areas.

7. Fire alarm systems shall have visual signals suitable for the deaf and hearing impaired.

8. There shall be emergency power to supply lighting to pre-selected areas of the facility.

9. The maintenance of facility grounds to provide a safe environment for consumers (specific to age group[s] served), staff and visitors.

10. Storage of dangerous substances (toxic or flammable substances) in locked, safe areas or cabinets.

11. There shall be a written plan for the protection and preservation of consumer records in the event of a disaster.

(e) Compliance with 450:65-7-4 may be determined by a review of:

SUBCHAPTER 7. ORGANIZATIONAL AND FACILITY MANAGEMENT

450:65-7-2. Hygiene and sanitation [REVOKED]

CGAT programs shall provide:

1. Lavatories and toilet facilities in a minimum ratio of one per twenty persons;
450:65-7-4.1. Tobacco-free campus [REVOKED]
(a) The facility shall provide a tobacco-free campus for its employees, consumers, and visitors. Possession and use of any tobacco product is prohibited on the grounds of the facility by employees, consumers, volunteers and visitors.
(b) Facility will visibly post signs on the property notifying consumers, employees and visitors that the visible possession and use of tobacco products is prohibited.
(c) Facility employees shall not share tobacco or tobacco replacement products with consumers.
(d) The facility shall provide assistance to employees who are tobacco users while he or she is employed by the facility. The assistance shall include, but is not limited to, the provision of information on the health impact of continued tobacco use; the integrated assessment of consumer’s tobacco use into standard practice; referrals to tobacco cessation programs such as the Oklahoma Tobacco Helpline; the provision of or access to FDA-approved prescription and/or non-prescription medications for the treatment of nicotine dependence when available; the delivery of evidence-based behavioral interventions for tobacco use cessation by counselors and other clinicians; and provision of appropriate follow-up to facilitate cessation intervention and prevent relapse.
(e) The facility shall always inquire of the consumers’ tobacco use status and be prepared to offer treatment upon request of the consumer.
(f) Compliance with this Section shall be determined by visual observation; posted signs; consumer and staff interviews; and a review of the facility’s policy, procedures and other supporting documentation provided.

450:65-7-5. Critical incidents [REVOKED]
(a) The CGAT program shall have written policy and procedures for the reporting of every critical incident. Documentation of critical incidents shall minimally include:
1. The facility name and signature of the person(s) reporting the incident;
2. The name(s) of the consumer(s), staff member(s) or property involved;
3. The time, date and physical location of the incident;
4. The time and date the incident was reported and the name of the staff person within the facility to whom it was reported;
5. A description of the incident;
6. Resolution or action taken, date action was taken, and signature of appropriate staff member(s); and
7. Severity of each injury, if applicable. Severity shall be indicated as follows:
   A. No off-site medical care required or first-aid care administered on site;
   B. Medical care by a physician or nurse or follow-up attention required; or
   C. Hospitalization or immediate off-site medical attention was required.
(b) Critical incidents shall be reported to ODMHSAS as follows:
1. Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax or mail to ODMHSAS provider Certification within twenty-four (24) hours of the incident being documented;
2. Critical incidents involving allegations constituting a sentinel event or consumer abuse shall be reported to ODMHSAS immediately via telephone or fax, but not more than twenty-four (24) hours after the incident. If reported by telephone, the report shall be followed with a written report within twenty-four (24) hours.
(c) Compliance with 450:65-7-5 may be determined by a review of:
1. Policy and procedures;
2. Critical incident reports at the facility and those submitted to ODMHSAS;
3. Performance improvement program documents and reports;
4. Staff interviews; and
5. Any other relevant documentation of the facility or ODMHSAS.

450:65-7-6. Organizational and facility description [REVOKED]
(a) The facility shall have a written organizational description, which is reviewed annually and incorporates the following guidelines:
1. Target population to be served;
2. The overall mission statement of the program which shall address the manner in which the facility welcomes all consumers;
3. Annual program goals and objectives;
4. A description of each CGAT offered;
5. Identification or a description of special populations and mechanisms to address their needs; and
6. Program admission and exclusionary criteria.
(b) There shall be documentation that items (a) (1)-(6) have been approved by the facility’s governing authority.
(c) The facility shall have documentation demonstrating these documents are available and communicated to staff.
(d) The facility shall have documentation demonstrating these documents are available to the general public upon request.
(e) The facility shall have written plans for attaining the program’s goals and objectives. These plans should define specific tasks, set target dates and designate staff responsible for carrying out the plans.
(f) Compliance with 450:65-7-6 may be determined by a review of:
1. Policy and procedures;
(2) performance improvement program documents and reports;
(3) staff interviews; and
(4) any other relevant documentation of the facility or ODMHAS.

450:65-7-7. Information analysis and planning

(REVOKED)

(a) The facility shall have a defined and written plan for conducting an organizational needs assessment which specifies the methods and data to be collected, to include, but not limited to, information from:
(1) Consumers;
(2) Governing Authority;
(3) Staff;
(4) Stakeholders;
(5) Outcomes management processes; and
(6) Quality record review.
(b) The facility shall have a defined ongoing system to collect data and information on a quarterly basis to manage the organization.
(e) Information collected shall be analyzed to improve consumer services and program performance.
(d) The facility shall prepare an end of year management report, which shall include, but not be limited to:
(1) an analysis of the needs assessment process; and
(2) performance improvement program findings.
(c) The management report shall be communicated and made available to, among others:
(1) the governing authority;
(2) facility staff; and
(3) ODMHAS, as requested.
(f) Compliance with 450:65-7-7 may be determined by a review of:
(1) policy and procedures;
(2) performance improvement program documents and reports;
(3) staff interviews; and
(4) any other relevant documentation of the facility.

450:65-7-8. Performance improvement program

(REVOKED)

(a) The facility shall have an ongoing performance improvement program designed to objectively and systematically monitor, evaluate and improve the quality of consumer care in which the following is addressed:
(1) Fiscal management of the facility;
(2) Identity of a performance improvement officer; and
(3) Cultural competency.
(b) The facility shall document performance improvement activities. These activities shall include, but not be limited to:
(1) Outcomes management specific to each program;
(2) A quarterly quality record review to evaluate the quality of service delivery as evidenced by the consumer’s record;
(3) Staff Privileging;
(4) Review of critical and unusual incidents and consumer grievances and complaints;
(5) Review of policy related to cultural competence; and
(6) Activities to improve access and retention within the treatment program. The activities shall include an annual “walk-through” of the admission process. Steps of the “walk-through” include, but are not limited to:
(A) Select two staff from the facility, including one member of management, to play the roles of “consumer” and “family member”;
(B) Notify all staff prior to doing the “walk-through” exercise;
(C) Complete the admission process as defined by facility policy as a typical consumer and family member would experience;
(D) At each step, ask the staff what changes (other than hiring new staff) would make it better for the consumer and what changes would make it better for the staff. Write all ideas of the staff and participant(s) in the exercise;
(E) Documentation of the annual “walk-through” process includes, but is not limited to:
(i) The observations and feelings of participants in this exercise;
(ii) A list of the process barriers and the improvements that could be made to address these barriers;
(iii) Address the needs from both the consumer and staff perspectives; and
(iv) Identification of an area(s) for change and a description for implementing the change(s).
(c) The facility shall monitor the implementation of the performance improvement plan on an annual basis and shall make adjustments as needed.
(d) Performance improvement findings shall be communicated and made available to, among others:
(1) the governing authority;
(2) facility staff;
(3) consumers;
(4) stakeholders, and
(5) ODMHAS, as requested.
(e) Compliance with 450:65-7-8 may be determined by a review of:
(1) policy and procedures;
(2) performance improvement program documents and reports;
(3) staff interviews; and
(4) any other relevant documentation of the facility.

450:65-7-10. Technology

(REVOKED)

(a) The facility shall have a written plan regarding the use of technology and systems to support and advance effective and efficient service and business practices. The plan shall include, but not be limited to:
(1) Hardware and software;
(2) Security;
(3) Confidentiality.
(4) Backup policies;
(5) Assistive technology;
(6) Disaster recovery preparedness;
(7) Virus protection.

(b) Compliance with 450:65-7-10 shall be determined by a review of the facility policies, performance improvement plans and technology and system plan.

450:65-7-11. Annually required in-service training for all employees [REVOKED]

(a) In-service presentations shall be conducted each calendar year and are required upon hire and annually thereafter for all employees on the following topics:

(1) Fire and safety;
(2) AIDS and HIV precautions and infection control;
(3) Consumer’s rights and the constraints of the Mental Health Patient’s Bill of Rights;
(4) Confidentiality;
(5) Oklahoma Child Abuse Reporting and Prevention Act, 10 O.S. §§ 7101-7115; and
(6) Facility policy and procedures;

(7) Cultural Competence (including military culture if active duty or veterans are being served);
(8) Co-occurring disorder competency and treatment principles;
(9) Trauma informed; and
(10) Age and developmentally appropriate trainings, where applicable.

(b) All clinical staff shall have non-physical intervention training in techniques and philosophies addressing appropriate non-violent interventions for potentially physical interpersonal conflicts, staff attitudes which promote dignity and enhanced self-esteem, keys to effective communication skills, verbal and non-verbal interaction and non-violent intervention within three (3) months of being hired with annual updates thereafter.

(c) The local facility Executive Director shall designate which positions and employees, including temporary employees, will be required to successfully complete physical intervention training. An employee shall not provide direct care services to consumers until completing this training.

(d) The training curriculum for 450:65-7-10 (b) must be approved by the ODMHSA commissioner or designee in writing prior to conducting of any training pursuant to this provision.

(e) Compliance with this Section shall be determined by a review of in-service training records, personnel records, and other supporting written information provided.

[OAR Docket #21-441; filed 6-14-21]
Permanent Final Adoptions

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(S) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 15, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS

450:70-1-1. Purpose
This chapter sets forth rules regulating program requirements, activities, and services standards and criteria used in the certification of facilities and organizations providing medication assisted opioid treatment programs. The rules regarding the certification process, including, but not limited to, the application process, fees, and administrative sanctions are found in OAC 450:1, Subchapters 5 and 9. Rules outlining general certification qualifications applicable to facilities and organizations certified under this Chapter are found in OAC 450:1-9-5 through OAC 450:1-9-5.3.

450:70-1-2. Definitions
The following words or terms, when used in this chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Accreditation" means the process of review and acceptance by a nationally recognized accreditation body.

"Accreditation body" means a body that has been approved by SAMHSA to accredit opioid treatment programs using opioid agonist or partial agonist treatment medications.

"Administer" means the direct application of a prescription drug by ingestion or any other means to the body of a patient by a licensed practitioner, or the patient at the direction of, or in the presence of, a practitioner.

"Administrative withdrawal" means a patient's medically supervised withdrawal involving the gradual tapering of dose of medication over time, coinciding with the patient's usually involuntary discharge from medication assisted treatment. Administrative withdrawal typically results from non-payment of fees, violent or disruptive behavior, incarceration or other confinement.

"Approved narcotic drug" means a drug approved by the United States Food and Drug Administration for maintenance and/or detoxification of a person physiologically dependent upon opioid drugs.

"American Society of Addiction Medicine Patient Placement Criteria" or "ASAM-PPC" means the most recent clinical guide published by the American Society of Addiction Medicine to be used in matching patients to appropriate levels of care.

"ASAM criteria" means the most current edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.

"Biopsychosocial assessment" means in-person interviews conducted by a LBHP or Licensure Candidate designed to elicit historical and current information regarding the behavior and experiences of a patient, and are designed to provide sufficient information for problem formulation, intervention planning, case management needs, and formulation of appropriate substance abuse-related treatment and service planning.

"Buprenorphine" means a partial agonist, Schedule III narcotic approved for use in opioid dependence treatment.

"CARF" means the Commission on the Accreditation of Rehabilitation Facilities.

"Central registry" A document or database to which an OTP shall report patient identifying information about individuals who are applying for or undergoing medically supervised withdrawal or maintenance treatment on an approved opioid agonist or partial agonist to a central record system approved by the Commissioner or designee.

"Certification" means the process by which ODMHSAS or SAMHSA determine that an OTP is qualified to provide opioid treatment under applicable State and Federal standards.

"Chain of custody" means the process of protecting items so that movement, possession and location are secure and documented and there is no possibility for altering or otherwise tampering with the item.

"Chronic pain disorder" means an ongoing condition or disorder consisting of chronic anxiety, depression, anger and changed lifestyle, all with a variable but significant level of genuine neurologically based pain. The pain becomes the main focus of the patient's attention, and results in significant distress and dysfunction.

"Clinical Opioid Withdrawal Scale" or "COWS" means a well validated, standardized assessment instrument for evaluating the severity of a patient's withdrawal through the identification of objective and subjective symptoms and the severity of these symptoms.

"Clinical supervision" means an organized process by which knowledgeable and skilled supervisors systematically and routinely provide ongoing and in-depth review of direct service providers' performance.

"COA" means the Commission on Accreditation.

"Comprehensive maintenance treatment" is:

(A) Dispensing or administering an approved opioid agonist or partial agonist medication at stable dosage levels for a period in excess of 21 days to a patient for opioid dependence, and

(B) Providing medical, clinical and educational services to the patient with opioid dependence.

"Continuing care plan" or "discharge summary" means a written plan of recommendations and specific referrals for implementation of continuing care services, including medications, shall be prepared for each patient meeting the ASAM Patient Placement Criteria dimensional continued service criteria. Continuing care plans shall be developed with the knowledge and cooperation of the patient. This continuing care plan may be included in the discharge summary. The patient's response to the continuing care plan shall be noted in the plan, or a note shall be made that the patient was not available and why. In the event of the death of a patient, a summary statement including this information shall be documented in the record.

"Co-occurring disorder" or "COD" means any combination of mental health and substance use disorder symptoms.
or diagnoses as determined by the current Diagnostic and Statistical Manual of Mental Disorders that affect a patient.

"Courtes y Dosing" means the act of dosing a methadone or buprenorphine patient from another clinic on a short term basis due to emergency or other extraordinary circumstance.

"Critical incident" means an occurrence or set of events inconsistent with the routine operation of an approved treatment facility, or the routine care of a patient. Critical incidents specifically include but are not necessarily limited to the following: adverse drug events; self-destructive behavior; deaths and injuries (including automobile accidents) to the patient, patient family, staff and visitors; medication errors; neglect or abuse of a patient; fire; unauthorized disclosure of information; damage to or theft of property belonging to a patient or an approved treatment facility; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or results.

"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, religious, sexual orientation, and/or social group.

"DEA" means Drug Enforcement Administration.

"Discharge planning" means the process, beginning at admission of determining a consumer's continued need for treatment services and developing a plan to address ongoing consumer recovery needs.

"Diskette" means a compressed wafer form of methadone intended to be dissolved in water for consumption. For the purposes of this chapter methadone diskettes will not be considered to be the same as tablet methadone. Diskettes shall be dissolved in liquid prior to being dispensed, or dissolved in liquid by the patient in full and clear view of OTP staff before the patient may leave the clinic with the dose.

"Dispense" means preparing, packaging, compounding and labeling for delivery, a prescription drug in the course of professional practice to an ultimate user by the lawful order of a physician.

"Diversion" means the unauthorized or illegal transfer of an opioid agonist or partial agonist treatment medication.

"Diversion control plan" or "DCP" means documented procedures to reduce the possibility that controlled substances are used for any purpose other than legitimate use.

"Drug dispensing area" means the specified and secured location established by the OTP for dispensing opioid agonist or partial agonist drugs to the patients. The area shall be secure, meet all appropriate standards and be the only location within the facility where drugs are dispensed.

"Drug test" means the assessment of an individual to determine the presence or absence of illicit or non-prescribed drugs or alcohol or to confirm maintenance levels of treatment medication(s), by a methodology approved by the OTP medical director based on informed medical judgment and conforming to State and Federal law. This may include blood testing, oral-fluid and urine testing.

"Exception request process" means a process recording the justification of the need to make a change in treatment protocol for an opioid patient and submitted to SAMHSA using form SMA-168.

"FDA" Federal Food and Drug Administration.

"Federal opioid treatment standards" means the established standards of SAMHSA, CSAT and the DEA that are used to determine whether an OTP is qualified to engage in medication assisted opioid treatment.

"HIPAA" means Health Insurance Portability and Accountability Act.

"Holiday" means those days recognized by the State of Oklahoma as holidays.

"Individualized service planning" means the ongoing process by which a clinician and the patient identify and rank problems, establish agreed upon goals, and decide on the treatment process and resources to be utilized.

"Interim maintenance treatment" means maintenance treatment provided in conjunction with appropriate medical services while a patient is awaiting transfer to a program that provides comprehensive maintenance treatment.

"JC" or "TJC" means the Joint Commission.

"Licensed Behavioral Health Professional" or "LBHP" means:

(A) An Allopathic or Osteopathic Physician;

(B) An Advanced Practice Registered Nurse 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 certified in a psychiatric mental health specialty;

(C) A Clinical Psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists;

(D) A Physician Assistant who is licensed in good standing in Oklahoma and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions;

(E) A Practitioner practic er with a license to practice in the state in which services are provided by one of the following licensing boards:

(i) Psychology;

(ii) Social Work (clinical specialty only);

(iii) Professional Counselor;

(iv) Marriage and Family Therapist;

(v) Behavioral Practitioner; or

(vi) Alcohol and Drug Counselor.

(C) 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.

(D) A Physician Assistant who is licensed in good standing in the state and has received specific training.
for and is experienced in performing mental health
therapeutic, diagnostic, or counseling functions.

"Licensure candidate" means practitioners actively and
regularly receiving board approved supervision, and extended
supervision by a fully licensed clinician if board's supervision
requirement is met but the individual is not yet licensed, to
become licensed by one of the following licensing boards:
(A) Psychology;
(B) Social Work (clinical specialty only);
(C) Professional Counselor;
(D) Marriage and Family Therapist;
(E) Behavioral Practitioner; or
(F) Alcohol and Drug Counselor.

"Liquid methadone" means a liquid concentrate of
methadone meant to be mixed with water for ingestion.

"Lock box" means a container with a combination lock
or key lock entry system for securing take home medications.
The box must have the ability to lock and should be secure
effort to thwart access by children.

"Long-term care facilities" means a facility or institu-
tion that is licensed, certified or otherwise qualified as a
nursing home or long term care facility by the state in which
methadone or buprenorphine treatment services are rendered.
This term includes skilled, intermediate, and custodial care
facilities which operate within the terms of licensure.

"Long-term detoxification treatment" means detoxifi-
cation treatment for a period of more than 30 days but less than
180 days.

"Medical director" means a physician, licensed to prac-
tice medicine in Oklahoma, who assumes responsibility for the
administration of all medical services performed by an OTP,
either by performing them directly or by delegating specific
responsibility to authorized program physicians and healthcare
professionals functioning under the medical director's direct
supervision, unless otherwise indicated in this chapter. This
includes ensuring the program is in compliance with all fed-
eral, state, and local laws and regulations regarding the medical
treatment of dependence on an opioid drug.

"Medical withdrawal" means a condition created by
administering an opioid agonist or partial agonist treatment
medication in decreasing doses to an individual to alleviate ad-
verse physical or psychological effects of withdrawal from the
continuous or sustained use of an opioid drug and as a method
of bringing the individual to a drug-free state.

"Medication unit" means a satellite facility established
as part of, but geographically separate from, an OTP from
which appropriately licensed practitioners dispense or admin-
ister an opioid agonist or partial agonist treatment medication
or collect samples for drug testing or analysis. No medical or
clinical interventions related to OTP treatment can be con-
ducted at this site.

"Non-oral methadone" means an injectable form of
methadone not allowed for use by an OTP.

"Nurse practitioner" means a registered nurse who is
prepared through advanced education and clinical training, to
provide a wide range of health care services.

"ODMHSAS" means the Oklahoma Department of Men-
tal Health and Substance Abuse Services.

"Oklahoma Administrative Code" or "OAC" means
the publication authorized by 75 O.S. § 256 known as The
Oklahoma Administrative Code, or, prior to its publication, the
compilation of codified rules authorized by 75 O.S. § 256(A)
(1) (a) and maintained in the Office of Administrative Rules.

"OBNDD" means the Oklahoma Bureau of Narcotics and
Dangerous Drug Control.

"Oklahoma state-issued identification card" means a
photo identification card issued by the Oklahoma Department
of Motor Vehicles for use in identification.

"Opioid agonist or partial agonist treatment medi-
cation" means a prescription medication, such as methadone,
buprenorphine or other substance scheduled as a narcotic under
the Federal Controlled Substances Act (21 U.S.C. Section 811)
that is approved by the U.S. Food and Drug Administration for
use in the treatment of opiate addiction or dependence.

"Opioid antagonist" means a drug that has an affinity for and
stimulates physiologic activity at cell receptors in the central
nervous system normally stimulated by opioids. Methadone is
an opioid agonist.

"Opioid agonist or partial agonist treatment medica-
tion" means a prescription medication, such as methadone,
buprenorphine or other substance scheduled as a narcotic under
the Federal Controlled Substances Act (21 U.S.C. Section 811)
that is approved by the U.S. Food and Drug Administration for
use in the treatment of opiate addiction or dependence.

"Opioid antagonist" means a drug that binds to cell
receptors in the central nervous system that normally are bound
by opioid psychoactive substances and that blocks the activity
of opioids at these receptors without producing the physiologic
activity produced by opioid agonists. Naltrexone is an opioid
agonist.

"Opioid dependence" means a cluster of cognitive, be-
havioral, and physiological symptoms in which an individual
continues use of opioids despite significant opioid-induced
problems. Opioid dependence is characterized by repeated
self-administration resulting in opioid tolerance, withdrawal
symptoms, and compulsive drug-taking. Dependence may
occur with or without the physiological symptoms of tolerance and
withdrawal.

"Opioid drug" means any of a class of drugs also called
narcotics, having a dependence-forming or dependence-sus-
taining liability similar to morphine. Originally a term for
synthetic narcotics only, but for the purposes of this chapter
and unless otherwise specified, currently used to describe
both opium based and synthetic narcotics. These drugs have
analgesic or sedative effects.

"Opioid partial agonist" means a drug that binds to, but
incompletely activates, opiate receptors in the central nervous
system, producing effects similar to those of an opioid agonist
but, at increasing doses, does not produce as great an agonist
effect as do increased doses of an agonist. Buprenorphine is a
partial opioid agonist.

"Opioid treatment" means the dispensing of opioid
agonist or partial agonist treatment medication, along with a
comprehensive range of medical and rehabilitative services,
when clinically necessary, to an individual to alleviate the
adverse medical, psychological, or physical effects incident
to opioid dependence. This term encompasses detoxification
treatment, short-term detoxification treatment, long-term
detoxification treatment, maintenance treatment or comprehensive maintenance treatment, interim maintenance treatment and treatment provided in medication units, long term care facilities or hospitals.

"Opioid Treatment Program (OTP)" An organization which has been certified by ODHMSAS to provide opioid treatment whose certification has not been suspended, revoked, or surrendered to the department, referred to in statute as an Opioid Substitution Treatment Program.

"Pain management" means the successful management of chronic pain or a chronic pain disorder.

"Patient record" or "medical record" means the collection of written information about a patient's evaluation or treatment that includes the intake data, evaluation, service plan, description of services provided, medications as prescribed, continuing care plan, and discharge information on an individual patient.

"Parenteral" means injected, infused or implanted, used to describe drug administration other than oral or anal.

"Peak test" see Peak and Trough.

"Peak and trough test" means a therapeutic monitoring of serum methadone levels to determine the most appropriate dosing strategy for the individual patient, requiring at least two blood samples be drawn. The initial sample taken immediately prior to the daily dose and twenty four hours after the previous day's dose allowing the lowest level or "trough" to be identified. The second sample taken four hours after dosing allows the highest level or "peak" to be identified.

"Physician assistant" means a licensed or certified mid-level medical practitioner who works under the supervision of a licensed physician (MD) or osteopathic physician (DO).

"Program physician" A licensed physician who provides medical treatment and counsel to the patients of an OTP while under the supervision of the medical director.

"Program sponsor" A person named in the application for an OTP permit who is responsible for the operation of the OTP and who assumes responsibility for all its employees, including any practitioners, staff, or other persons providing medical, rehabilitative, or therapy services at the program or any of its medication units. The program sponsor need not be a licensed physician but shall employ a licensed physician for the position of medical director.

"Psychotherapy" or "Therapy" means a goal directed process using generally accepted clinical approaches provided face-to-face by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate with consumers in individual, group, or family settings to promote positive, emotional, or behavioral change.

"Rehabilitation Services" means face-to-face individual or group services provided by qualified staff to develop skill necessary to perform activities of daily living and successful integration into community life. Rehabilitation services must be provided by a Licensed Behavioral Health Professional (LBHP), Licensure Candidate, Certified Alcohol and Drug Counselor (CADC) or Certified Behavioral Health Case Manager II (CM II).

"SAMHSA" means the Substance Abuse and Mental Health Services Administration.

"Sentinel event" means a type of critical incident that is an unexpected occurrence involving the death or serious injury to a consumer, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a consumer. These events signal the need for an immediate investigation and response. Sentinel events include, but are not limited to: suicide, homicide, criminal activity, assault and other forms of violence, including domestic violence or sexual assault, and adverse drug events (including medication overdoses by patients and associates of patients) resulting in serious injury or death.

"Service Provider" means a person who is allowed to provide services for those with substance use disorders within the regulation and scope of their certification level or license.

"Short-term detoxification treatment" means detoxification treatment for a period not in excess of 30 days.

"State Opioid Treatment Authority" or "SOTA" is the agency designated by the Governor or other appropriate official designated by the Governor to exercise the responsibility and authority within the State or Territory for governing the treatment of opioid dependence with an opioid drug. For Oklahoma it is the Oklahoma Department of Mental Health and Substance Abuse Services.

"STD" means sexually transmitted disease.

"Street outreach" means methods of direct intervention/prevention with high risk populations for HIV, HCV, tuberculosis and other infectious and communicable diseases.

"Tablet methadone" means methadone in a tablet form intended to be taken orally. For the purposes of this chapter diskettes will not be considered to be tablet methadone. Tablet methadone is not allowed for use by an OTP.

"Take-home privilege or take home medication" means one or more doses of an opioid agonist or partial agonist treatment medication dispensed to a patient for use off the premises.

"Therapeutic hour(s)" means the amount of time in which the patient was engaged with a service provider in identifying, addressing, and/or resolving those issues that have been identified in that patients treatment plan.

"Transient consumer" means a methadone or buprenorphine patient from another geographic location requiring "courtesy dosing".

"Trough test" see Peak and Trough.

"Urine analysis (UA)" means a urine sample taken to determine if metabolites are present indicating the use of drugs.

"Withdrawal treatment" means either administrative withdrawal, or medical titration and withdrawal from any drug or medication until the patient has achieved a drug free state.

SUBCHAPTER 2. FACILITY INFRASTRUCTURE REQUIREMENTS [REVOKED]
Permanent Final Adoptions

450:70-2-1. Physical facility environment and safety [REVOKED]

(a) All facilities providing medication-assisted opioid treatment service shall have written policies and procedures intended to ensure the safety and protection of all persons within the facility’s physical environment (property and buildings, leased or owned).

(b) These policies and procedures shall include, but are not limited to:

1. Meeting all fire and safety regulations, code and statutory requirements of federal, state, or local government.
2. All OTPs shall have an annual fire and safety inspection approving continued occupancy from the State Fire Marshal, or local authorities, and shall maintain a copy of said inspection and attendant correspondence regarding the clearing of any deficiencies.
3. An emergency preparedness plan to provide effective utilization of resources to best meet the physical needs of patients, visitors, and staff during any disaster (including, but not limited to: fire, flood, tornado, explosion, prolonged loss of heat, light, water, and/or air conditioning).

A. This plan shall include procedures facilitating the transfer of patients in the event the OTP is unable to open.
B. This plan shall be evaluated annually, and revised as needed.

4. A designated Safety Officer.
5. Staff training and orientation regarding the location and use of all fire extinguishers and first aid supplies and equipment and an emergency preparedness plan.
6. Emergency evacuation routes and shelter areas shall be prominently posted in all areas.
7. There shall be emergency power to supply lighting to preselected areas of the facility.
8. The maintenance of facility grounds to provide a safe environment for consumers (specific to age group[s] served), staff and visitors.
9. Storage of dangerous substances (toxic or flammable substances) in locked, safe areas or cabinets.
10. A written plan for the protection and preservation of consumer records in the event of a disaster.

Compliance with 450:70-2-1 may be determined by a review of:

1. Facility policies and procedures.
2. Fire and safety inspection reports and correspondence.
3. Disaster plans.
4. Any other supporting facility documentation, and
5. Interviews with staff and consumers.

(2) Sewage discharge into a municipal sewerage system or collected, treated and disposed of in an independent sewerage system.
(3) Solid waste disposal through public systems or in a manner approved by the local agency having jurisdiction and the Oklahoma State Department of Health or Department of Environmental Quality, as necessary.
(4) Water obtained from an approved public water supply or tested at least quarterly and treated as necessary, thereby maintaining a determination as an approved water supply by the authority having jurisdiction and the Oklahoma Department of Health or Department of Environmental Quality, as indicated by the building permit.
(5) The facility shall have proof of regular inspections and treatment by a licensed pest control operator.
(6) Housekeeping services so that a hygienic environment is maintained in the facility.

(b) Compliance with 450:70-2-2 may be determined by:

1. A review of utility/garbage bills,
2. Water testing results,
3. Pest inspection and
4. Other related documents.

450:70-2-3. Tobacco-free campus [REVOKED]

(a) The facility shall provide a tobacco-free campus for its employees, consumers and visitors. Possession and use of any tobacco product is prohibited on the grounds of the facility by employees, consumers, volunteers, and visitors.

(b) Facility will visibly post signs on the property notifying consumers, employees and visitors that the visible possession and use of tobacco products is prohibited.

(c) Facility employees shall not share tobacco or tobacco replacement products with consumers.

(d) The facility shall offer assistance to employees who are tobacco users while he or she is employed by the facility. The assistance shall include, but is not limited to, the provision of information on the health impact of continued tobacco use; the integrated assessment of consumer’s tobacco use into standard practice; referrals to tobacco cessation programs such as the Oklahoma Tobacco Helpline; the provision of or access to FDA-approved prescription and/or non-prescription medications for the treatment of nicotine dependence when available; the delivery of evidence-based behavioral interventions for tobacco use cessation by therapists and other clinicians; and provision of appropriate follow-up to facilitate cessation intervention and prevent relapse.

(e) The facility shall always inquire of the consumers’ tobacco use status and be prepared to offer treatment upon request of the consumer.

(f) Compliance with this Section shall be determined by visual observation; posted signs; consumer and staff interviews; and a review of the facility’s policy, procedures and other supporting documentation provided.

SUBCHAPTER 3. FACILITY RECORD SYSTEM
PART 1. RECORD SYSTEM

450:70-3-2. Patient record system [REVOKED]
(a) Each OTP shall maintain an organized system for the content, confidentiality, storage retention and disposition of patient records.
(b) The OTP shall have written policies and procedures concerning patient records which define required documentation within the patient record.
(c) Patient records shall be maintained in a locked and secure manner.
(d) The OTP shall maintain identification and filing systems which enable prompt record location and accessibility by service providers.
(e) Patient records shall be maintained in the facility where the individual is being treated or served. In the case of temporary office space or satellites, records may be maintained in the main (permanent) office or transported in secured lock boxes to and from temporary offices or satellites, when necessary. Patient records may be permanently maintained at the OTPs administrative offices, however, a working copy of the patient record for the purposes of documentation and review of services provided must be maintained at the site in which the patient is receiving treatment.
(f) The OTP shall have policies which govern the storage, retention, and disposition of patient records, including electronic records. These policies shall be compatible with protection of patient's rights against confidential information disclosure at a later date, and compliant with applicable state and federal law.
(g) Compliance with 450:70-3-2 may be determined by:
(1) A review of policies and procedures;
(2) Treatment records;
(3) Performance improvement guidelines;
(4) Interviews with staff; and
(5) Other facility documentation.

450:70-3-4. Confidentiality of drug or alcohol abuse or mental health treatment information [REVOKED]
Confidentiality policy, procedures and practices must comply with federal and state law, guidelines, and standards, and with OAC 450:15-2-20.1 and OAC 450:15-60.

PART 7. SERVICE PLANNING

450:70-3-8. Individualized service planning
(a) Upon completion of the admission evaluation, an individualized service plan shall be developed by a LBHP or licensure candidate. Service plans completed by a licensure candidate must be co-signed by a fully licensed LBHP. The individualized service plan shall include, but not be limited to:
(1) Presenting problems or diagnosis;
(2) Strengths, needs, abilities, and preferences of the patient;
(3) Goals for treatment with specific, measurable, attainable, realistic and time-limited;
(4) Type and frequency of services to be provided;
(5) Dated signature of primary service provider;
(6) Description of patient's involvement in, and responses to, the service plan, and his or her signature and date;
(7) Individualized discharge criteria or maintenance;
(8) Projected length of treatment;
(9) Measurable long and short term treatment goals;
(10) Primary and supportive services to be utilized with the patient;
(11) Type and frequency of therapeutic activities in which patient will participate;
(12) Documentation of the patient's participation in the development of the plan; and
(13) Staff who will be responsible for the patient's treatment.
(b) The service plan shall be based on the patient's presenting problems or diagnosis, intake assessment, biopsychosocial assessment, and expectations of their recovery.
(c) Frequency of services shall be determined by mutual agreement between the facility treatment team and the patient.
(d) Service plans shall be completed by the fourth (4) therapy or rehabilitation service visit after admission.
(e) The service plan review should occur according to the time frame required by the agency but, no less often than every six (6) months; and further, is required by any of the following situations:
(1) Change in goals and objectives based upon patient's documented progress, or identification of any new problem;
(2) Change in primary therapist or rehabilitation service provider assignment;
(3) Change in frequency and types of services provided;
(4) Critical incident reports;
(5) Sentinel events; or
(6) Phase change.
(f) Each patient accepted for treatment shall be assessed initially and periodically by qualified personnel to determine the most appropriate combination of services and treatment. The service plan also must identify the frequency and intensity of services to be provided.
(g) The plan must be reviewed and updated to reflect that patient's personal history, current needs for medical, social, and psychological services, and current needs for education, vocational rehabilitation, and employment services. Service plan updates shall be completed by an LBHP or licensure candidate. Service plan updates completed by a licensure candidate must be co-signed and dated by a fully licensed LBHP.
(h) The OTP will provide adequate and appropriate therapy or rehabilitation services to each patient as clinically necessary. This therapy shall be provided by a program LBHP or Licensure Candidate. Rehabilitation services must be provided by a LBHP, Licensure Candidate, CADC or CMII.
(i) Compliance with 450:70-3-8 may be determined by:
PART 11. DISCHARGE

450:70-3-10.1. Discharge summary/continuing care plan [REVOKED]
(a) The discharge summary shall at a minimum include:
   (1) Presenting problem(s) at intake;
   (2) Initial condition and condition of patient at discharge;
   (3) Medication summary, if the patient is taking medications;
   (4) Treatment and services provided, and a summary of treatment outcomes;
   (5) Specific referrals for continuing services and needed resources;
   (6) The patient’s response to the services received or an explanation explaining no response; and
   (7) The signature of the staff member completing the summary, and the date.
(b) A discharge summary shall be entered in each patient’s record within fifteen (15) days of discharge.
(c) The OTP shall have written policy and procedure stating that following admission, the results of a single drug test shall not be the sole basis to determine significant treatment decisions.
(d) Compliance with 450:70-4-8.2 may be determined by:
   (1) A review of policies and procedures,
   (2) Treatment records,
   (3) Interviews with staff, and
   (4) Other facility documentation.

450:70-4-9. Information analysis and planning [REVOKED]
(a) The OTP shall have a defined and written plan for conducting an organizational needs assessment which specifies the methods and data to be collected, to include, but not limited to information from:
   (1) Patients;
   (2) Governing Authority;
   (3) Staff;
   (4) Stakeholders;
   (5) Outcomes management processes; and
   (6) Quality record review.
(b) The OTP shall have a defined ongoing system to collect data and information on a quarterly basis to manage the organization.
(c) Information collected shall be analyzed to improve patient services and program performance.
(d) The OTP shall prepare an end of year management report, which shall include, but not be limited to:
   (1) an analysis of the needs assessment process; and
   (2) performance improvement program findings.
(e) The management report shall be communicated and made available to, among others:
   (1) the governing authority;
   (2) facility staff; and
   (3) ODMHSAS, as requested.
(f) Compliance with 450:70-4-9 may be determined by:
   (1) A review of program evaluation plans;
   (2) Written annual program evaluations;
   (3) Special or interim program evaluations;
   (4) Program goals and objectives; and
   (5) Other supporting documentation provided.

SUBCHAPTER 4. SERVICES SUPPORT AND ENHANCEMENT

PART 3. ORGANIZATIONAL AND FACILITY MANAGEMENT

450:70-4-8.2. Drug testing - Required substance identification
(a) The OTP shall have written policy and procedure stating drug screens will follow federal guidelines and will, at a minimum, test for the following substances:
   (1) Opioids;
   (2) Methadone;
   (3) Amphetamines;
   (4) Cocaine;
   (5) Benzodiazepines; and
   (6) Barbiturates.
(b) The OTP shall have written policy and procedure stating drug testing shall include other drugs as may be indicated by the patient's abuse patterns. In addition, if any other drug or drugs have been determined by a program to be abused in that program's locality, or as otherwise indicated, each test or analysis must include any such drugs.
(c) The OTP shall have written policy and procedure stating that following admission, the results of a single drug test shall not be the sole basis to determine significant treatment decisions.
(d) Compliance with 450:70-4-8.2 may be determined by:
   (1) A review of policies and procedures,
   (2) Treatment records,
   (3) Interviews with staff, and
   (4) Other facility documentation.
(3) An annual review and revision as appropriate of all program policies and procedures;
(4) The performance improvement activities shall support increased access to and retention in treatment. Improve the current process;
(5) Staff privileging; and
(6) Review of critical and unusual incidents, sentinel events, patient grievances and complaints.

(c) The OTP shall monitor the implementation of the performance improvement plan on an ongoing basis and shall make adjustments as needed.

(f) Performance improvement findings shall be communicated and made available to, among others:
   (1) the governing authority;
   (2) facility staff;
   (3) patients;
   (4) stakeholders, and
   (5) ODMHSAS, as requested.

(g) Compliance with 450:70-4.10 shall be determined by:
   (1) A review of the written program evaluation plan;
   (2) Written program evaluations (annual and/or special or interim);
   (3) Program goals and objectives (and other supporting documentation provided), and
   (4) Other facility documentation.

450:70-4.11. Critical incidents [REVOKED]

(a) The OTP shall have written policy and procedures for the reporting of every critical incident. Documentation of critical incidents shall minimally include:
   (1) The facility name and signature of the person(s) reporting the incident;
   (2) The name(s) of the patient(s), staff member(s), or property involved;
   (3) The time, date and physical location of the incident;
   (4) The time and date the incident was reported and the name of the staff person within the facility to whom it was reported;
   (5) A description of the incident;
   (6) Resolution or action taken, description of the action taken, date action was taken, and signature of appropriate staff member(s); and
   (2) Severity of each injury, if applicable. Severity shall be indicated as follows:
       (A) No off-site medical care required or first aid care administered on site;
       (B) Medical care by a physician or nurse or follow up attention required; or
       (C) Hospitalization or immediate off site medical attention was required.

(b) Critical incidents shall be reported to ODMHSAS as follows:
   (1) Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off site medical attention shall be delivered via fax or mail to ODMHSAS Provider Certification within twenty-four (24) hours of the incident being documented.

(2) Critical incidents involving allegations constituting a sentinel event or patient abuse shall be reported to ODMHSAS immediately via telephone or fax, but not more than twenty-four (24) hours of the incident. If reported by telephone, the report shall be followed with a written report within twenty-four (24) hours.

(e) Compliance with 450:70-4.11 shall be determined by:
   (1) A review of facility policies and procedures;
   (2) Critical incident reports at the facility, and those submitted to ODMHSAS;
   (3) Performance improvement program documents and reports;
   (4) Staff interviews, and
   (5) Any other relevant documentation of the facility or ODMHSAS.

SUBCHAPTER 6. SUBSTANCE USE DISORDER TREATMENT SERVICES

PART 3. PHASES OF TREATMENT SERVICES

450:70-6.17.2. Service phases - General

(a) The OTP shall have written policy and procedure describing structured phases of treatment and rehabilitation to support patient progress and to establish requirements regarding patient attendance and service participation. The requirements listed below for each phase indicate minimum requirements and the frequency and extent of treatment and rehabilitation services may be increased, based on individual patient need and unless otherwise indicated in this chapter.

(1) Advancement in phase and/or increased take-home privilege shall not occur without significant compliance with all current treatment plan goals.

(2) Advancement in phase and/or increased take-home privilege shall not occur if there are consistent or consecutive positive urine drug screens.

(3) Reduction in phase and/or decreased take-home privilege shall occur if there are consistent or consecutive positive urine drug screens and/or substantial non-compliance with the individualized service plan.

(4) For patients to be eligible for Phase IV or above they must be:

   (A) be employed full time,
   (B) be a full time student (at least twelve (12) semester hours),
   (C) be retired, or
   (D) have proof of disability.

(5) Prior to the patient advancing in Phase and/or receiving take-home medication, the patient shall demonstrate a level of stability as evidenced by:

   (A) absence of alcohol and other drug abuse,
   (B) regularity of program attendance,
   (C) absence of significant behavior problems,
   (D) absence of recent criminal activities, and
   (E) employment, actively seeking employment or attending school if not retired, disabled, functioning
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as a homemaker, or otherwise producing evidence of economic stability.

(6) If an OTP is providing doses to a patient receiving residential level of care (ASAM Level 3) substance use disorder services, the required minimum services listed for each phase may be delivered by the residential level of care substance use disorder provider. The OTP shall document the provision of these services and the provider delivering such services in the service plan.

(b) Compliance with 450:70-6-17.2 may be determined by:
   (1) A review of policies and procedures,
   (2) Treatment records, and
   (3) Other facility documentation.

[OAR Docket #21-442; filed 6-14-21]

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

[OAR Docket #21-487]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 3. Open Records Act
475:1-3-1. Open Records Act [AMENDED]
Subchapter 5. Administrative Actions
475:1-5-11. Surrender of Registration in Lieu of Administrative Action [AMENDED]

AUTHORITY:
The Director of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control; 63 O.S. §§ 2-301, 2-309H

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January 25, 2021

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August 26, 2021

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n/a

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
The adopted rule changes require warehouse locations to be included on the registration. The adopted amendments clarify that Schedule 1 medical marijuana researchers applying for a registration are subject to the same standards as required by the Oklahoma Medical Marijuana Authority (OMMA). The adopted rules require any registrant to update their registration information within fourteen (14) days of any change. The adopted rules are needed because in the absence of the rule changes, OBNDD rules make it more difficult for medical marijuana researchers to obtain a registration. The current OBNDD rules have more stringent requirements for medical marijuana researchers and the changes align with OMMA requirements. It could also cause confusion due to the lack of consistency. Also, in the absence of these rule amendments, controlled substances could be housed somewhere that does not have the same security protocols and is not subject to inspection, which could result in diversion.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(S) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 3. OPEN RECORDS ACT

475:1-3-1. Open Records Act
Title 51 Okl.St.Ann. § 24(A)(2) states: "Thus, it is the public policy of the State of Oklahoma that the people are vested with the inherent right to know and be fully informed about their government. The purpose of this act is to ensure and facilitate the public right of access to and review of government records so they may efficiently and intelligently exercise their inherent political power." Since § 24(A)(3) of the same title defines the OBN as a law enforcement agency, § 24(A)(8) specifies records must be made available to the public, if kept.

In compliance with this act, the OBN has promulgated the following rules:

(1) Information requests can be made and will be processed from 8:30 A.M. to 5:00 P.M. Monday through Friday (except for authorized holidays).

(2) Information retrieval shall be conducted by OBN personnel to maintain the security of the agency.

(3) A fee of $0.20 per page will be assessed as direct costs of document reproduction, unless the request for information is such that requires an extensive use of OBN personnel to search the records, at which time $0.50 per page will be charged. Payment can be made by money order, cashier's check or cash. Cash payment will not be accepted through the mail.

(4) The supervisor of OBN's Communications and Records Section, OBN Attorney(s), or the OBN Public Information Officer, or OBN Director designee shall be authorized to release the records.

(5) The rules set out in this Chapter shall not alter any existing OBN policy about providing information to other state or law enforcement agencies.

(6) The policy of this Section shall not alter any existing policy about how long records are retained by OBN and shall not change the existing policy regarding release of information about juveniles.

SUBCHAPTER 5. ADMINISTRATIVE ACTIONS
475:1-5-11. Surrender of Registration in Lieu of Administrative Action

(a) Any registrant of the OBN may surrender the registration in lieu of administrative action at any time before such action is taken. In such case, the registrant will waive the right to reapply for an OBN registration for a period of six (6) months from the effective date of the surrender. In such case, the OBN Director may approve or deny any application from the registrant following this six (6) month period based on the impact issuing the requested registration may have on the general public safety. A surrender of an OBN registration made in lieu of further administrative action shall be reported to the National Practitioner Data Bank pursuant to 45 CFR §60.1 et seq., if required.

(b) In the event an individual practitioner’s registration is revoked, suspended, or surrendered, either voluntarily or following administrative action, he or she may not, at any time, utilize the registration of another individual and/or institution. Any effort to utilize the registration of another may be considered an unlawful dispensation, administration, distribution, and/or prescription of a controlled dangerous substance as set forth under Title 63 of the Oklahoma Statutes.

[OAR Docket #21-487; filed 6-15-21]

TITLE 475. OKLAHOMA STATE BUREAU OF NARCOTICS AND DANGEROUS DRUGS CONTROL
CHAPTER 10. REQUIREMENTS FOR REGISTRATION
[OAR Docket #21-488]

RULEMAKING ACTION: PERMANENT final adoption
RULES:
475:10-1-4. Separate registration [AMENDED]
475:10-1-17. Applications for scientific research in Schedule I substances [AMENDED]
475:10-1-21. Change of business address to registrant details [AMENDED]

AUTHORITY: The Director of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control; 63 O.S. §§ 2-301, 2-309H

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GIST/ANALYSIS:
The adopted rules update the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control’s (OBNDD) statutory enforcement authority and removes outdated language. The amendments specify that the section applies to all registrants. Additionally, the amendments give flexibility to the Director by giving any designee the ability to fulfill open records requests. The adopted rules are needed to keep the statutory references and language accurate and, in the absence of these rules, the public health and safety would be at risk because there would be a lack of understanding on who is able to surrender their registration in lieu of administrative action.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

475:10-1-4. Separate registration

(a) Every person or entity who engages in, or who proposes to engage in, more than one group of independent activities shall obtain a separate registration for each group of activities, except as provided by this subsection. Any person or entity, when registered to engage in the group of activities described in each paragraph of this subsection, shall be authorized to engage in the coincident activities described in that subparagraph without obtaining a registration to engage in such coincident activities; provided that, unless specifically exempted, the registrant complies with all requirements and duties prescribed by law for persons or entities registered to engage in such coincident activities.

(1) A person or entity registered to manufacture any controlled dangerous substance or basic class of controlled dangerous substances shall be authorized to distribute that substance or class, but is not authorized to distribute any substance or class which the registrant is not registered to manufacture.

(2) A person or entity registered to manufacture any controlled dangerous substance listed in Schedules I through V shall be authorized to conduct chemical analysis and preclinical research (including quality control analysis) with narcotic and non-narcotic controlled dangerous substances listed in those schedules which the registrant is authorized to manufacture.

(3) A registrant authorized to conduct analytical laboratory activities with controlled dangerous substances shall be authorized to manufacture such substances for analytical or instructional purposes, to distribute such substances to other registrants authorized to conduct analytical laboratory activities, institutional instructional activities, or scientific research with such substances and to persons or entities exempted from registration provided such distribution is made in conformance with state law.

(4) A person registered or authorized to conduct scientific research with controlled dangerous substances listed in Schedules I through V shall be authorized to conduct analytical laboratory activities with controlled dangerous substances.
substances listed in those schedules in which he/she is authorized to conduct scientific research, to manufacture such substances if and to the extent that such manufacturing is set forth in the protocol filed with the application for registration, to distribute such substances to other persons or entities registered or authorized to conduct analytical laboratory activities, institutional instructional activities, or scientific research with such substances, and to persons or entities exempted from registration provided such distribution is made in conformance with state law, and to conduct instructional activities with controlled dangerous substances.

(5) Physicians, dentists, podiatrists, veterinarians, optometrists and other qualified persons who are authorized to carry on their respective activities under the laws of the State of Oklahoma and who are registered with the OBN to dispense, prescribe, and/or administer controlled dangerous substances shall be authorized to conduct instructional activities with those substances.

(6) Trainers or handlers of a canine controlled dangerous substance detector who, in the ordinary course of their profession, desire to possess any controlled dangerous substance for training said canine.

(b) The following locations shall not be deemed to be principal places where controlled dangerous substances are manufactured, distributed, dispensed, and/or prescribed:

1. A warehouse where controlled dangerous substances are stored by or on behalf of a registered person, unless such substances are distributed directly from such warehouse to registered locations, other than the registered location from which the substances were delivered, or to persons. The warehouse location shall be included on the registration application but may be fee exempt at the discretion of the Director.

2. An office used by agents of a registrant where sales of controlled dangerous substances are solicited, made, or supervised but which neither contain such substances (other than substances for display purposes or lawful distribution as samples only) nor serves as a distribution point for filling sales orders.

3. An office used by a practitioner (who is registered at another location) where controlled dangerous substances are prescribed but neither administered nor otherwise dispensed as a regular part of the professional practice of the practitioner at such office, and where no supplies of controlled dangerous substances are maintained.

475:10-1-17. Applications for scientific research in Schedule I substances

(a) In the case of an application to conduct scientific research with controlled dangerous substances listed in Schedule I, the Director may process the application and protocol and forward a copy of each to an independent expert selected by the Director within seven (7) days after receipt. The independent expert shall promptly advise the Director concerning the qualification of the applicant.

(b) An applicant whose protocol is defective shall be notified by the Director within seven (7) days after receipt of such protocol from the independent expert, and he/she shall be required to correct the existing defects before consideration shall be given to his/her submission.

(c) After the independent expert finds that the applicant is qualified and competent and the protocol meritorious, the Director shall be notified. The Director shall issue a Certificate of Registration within ten (10) days after receipt of this notification unless he/she determines that the application should be denied pursuant to the Uniform Controlled Dangerous Substances Act or OAC 475.

(d) If the independent expert finds that the protocol is not meritorious and/or the applicant is not qualified or competent, said designated authority shall notify the Director. The Director shall notify the applicant of said findings and his/her final decision, after which time the applicant may submit written request to the Director within thirty (30) days for a hearing to show cause why the application should not be denied.

(e) Except, Schedule I medical marijuana researchers shall submit the documentation, with their application, as required by 63 O.S. §427.19 et seq and 63 O.S. § 427.20 et seq.

475:10-1-21. Change of business address

The registrant shall notify the Registration Division of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control in writing, sent via U.S. certified mail, return receipt requested, or through the registrant's online account, within fourteen (14) calendar days of any change of their business (mailing or physical) address information on the current registration.

[OAR Docket #21-488; filed 6-15-21]
AUTHORITY: The Director of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control; 63 O.S. §§ 2-301, 2-309H

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GIST/ANALYSIS:
The adopted rule clarifies how someone can transfer controlled substances to another registration and that the registration is not transferable. The adopted rules are needed because in the absence of the rule amendments there could exist confusion on how to properly transfer controlled substances, increasing the risk of diversion.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

475:35-1.3. Distribution upon discontinuance or transfer of business

(a) Any registrant desiring to discontinue business activities altogether or with respect to controlled dangerous substances (without transferring such business activities to another person) shall return for cancellation of his/her Certificate of Registration. Any controlled dangerous substances in his/her possession shall be disposed of in accordance with Title 21 Code of Federal Regulations, part 1317. Schedule I and I Controlled Substances shall be disposed pursuant to standards set forth in 63 Okla. St. Ann. §429.

(b) Any registrant desiring to discontinue business activities altogether or with respect to controlled dangerous substances (by transferring such business activities to another person) shall submit in person or by registered or certified mail, return receipt requested, to the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control (OBN) at least fourteen (14) days in advance of the date of the proposed transfer (unless the Director waives this time limitation in individual instances), the following information:

(1) The name, address, registration number, and authorized business activity of the registrant discontinuing the business (registrant-transferor).

(2) The name, address, registration number, and authorized business activity of the person acquiring the business (registrant-transferee).

(3) Whether the business activities will be continued at the location registered by the person discontinuing the business or moved to another location (if the latter, the address of the new location should be listed).

(4) Whether the registrant-transferor has a quota to manufacture or procure any controlled dangerous substances listed in Schedule I or II (if so, the basic class or classes of the substance should be indicated).

(5) The date on which the transfer of controlled dangerous substances will occur.

(c) Unless the registrant-transferor is informed by the OBN, before the date on which the transfer was stated to occur, that the transfer may not occur, the registrant-transferor may discontinue the business or moved to another location (if the latter, the address of the new location should be listed).

(2) The name, address, registration number, and authorized business activity of the registrant discontinuing the business (registrant-transferor).

(3) Whether the business activities will be continued at the location registered by the person discontinuing the business or moved to another location (if the latter, the address of the new location should be listed).

(4) Whether the registrant-transferor has a quota to manufacture or procure any controlled dangerous substances listed in Schedule I or II (if so, the basic class or classes of the substance should be indicated).

(5) The date on which the transfer of controlled dangerous substances will occur.

(d) OBN registrations are non-transferable. The transferee must have a unique, active OBN registration prior to the transfer occurring. The transferor cannot transfer the OBN registration with the controlled dangerous substances and cannot transfer controlled dangerous substances to anyone lacking an active OBN registration.

[OAR Docket #21-489; filed 6-15-21]
Permanent Final Adoptions

TITLE 485. OKLAHOMA BOARD OF NURSING
CHAPTER 1. ADMINISTRATION
[OAR Docket #21-443]

RULEMAKING ACTION:
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RULES:
485:1-1-4 [REVOKED]

AUTHORITY:
Oklahoma Board of Nursing; 59 O.S. §§ 567.2(A)(3)

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
November 17, 2020

COMMENT PERIOD:
December 15, 2020 to January 15, 2021

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LEGISLATIVE APPROVAL:
Approved June 11, 2021 by HJR 1046

FINAL ADOPTION:
June 11, 2021

EFFECTIVE:
August 26, 2021

SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
Title 485. Chapter 1 proposed changes delete duplicative language specific to business meetings. The deleted language duplicates language included in the Oklahoma Open Meeting Act, 25 O.S. § 301-314.

Proposed revisions include:
Revocation of 485:1-1-4 as it is duplicative language of the Open Meetings Act 25 O.S. §301-314.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTIONS 250.3(S) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

485:1-1-4. Business meetings [REVOKED]

(a) Special meetings. Special meetings may be called by the President or Secretary, with five (5) days notice to each member of the Board. [59 O.S. Section 567.1(E)]

(b) Emergency meetings. Emergency meetings may be called by the President without required notice for situations of imminent peril to the public health, safety, welfare or other compelling extraordinary circumstances.

(c) Agenda. A copy of the agenda shall be sent to each member at least five (5) days prior to the meeting. Any member wishing to have a special topic placed on the agenda shall notify the President at least fifteen (15) days prior to the meeting. Items of an emergency nature shall be considered at any meeting without prior notice.

(d) Record of meeting. The Secretary shall cause to be kept a record of all meetings which shall include a recording of votes by each member in attendance and such records shall be retained as a permanent record of the transaction of the Board.

(e) Parliamentary authority. The rules contained in the current edition of Robert's Rules of Order Newly Revised shall govern the meetings in all instances to which they are applicable. The President shall have a vote on all matters coming before the Board.

(f) Notice of meetings. Notice of all meetings shall be in writing and delivered to Board members ten (10) days prior to meeting.

[OAR Docket #21-443; filed 6-14-21]

TITLE 485. OKLAHOMA BOARD OF NURSING
CHAPTER 10. LICENSURE OF PRACTICAL AND REGISTERED NURSES
[OAR Docket #21-444]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 3. Regulations for Approved Nursing Education Programs
485:10-3-2 [AMENDED]
485:10-3-5 [AMENDED]
485:10-3-6 [AMENDED]

Subchapter 5. Minimum Standards for Approved Nursing Education Programs
485:10-5-2 [AMENDED]
485:10-5-4.1 [AMENDED]
485:10-5-5.2 [AMENDED]

Subchapter 6. Minimum Standards for Approved Advanced Practice Registered Nursing (APRN) Education Programs (Effective January 1, 2016)
485:10-6-4. [AMENDED]

Subchapter 7. Requirements for Registration and Licensure as a Registered Nurse and Licensed Practical Nurse
485:10-7-1 [AMENDED]
485:10-7-2 [AMENDED]
485:10-7-3 [AMENDED]
485:10-7-4 [AMENDED]
485:10-7-5 [AMENDED]
485:10-7-8 [AMENDED]
485:10-7-9 [AMENDED]

Subchapter 9. Requirements for Registration and Licensure as a Licensed Practical Nurse [REVOKED]
485:10-9-1 through 485:10-9-10 [REVOKED]

Subchapter 10. Advanced Unlicensed Assistant
485:10-10-2 [AMENDED]
485:10-10-3 [AMENDED]
485:10-10-5 [AMENDED]
485:10-10-7 [AMENDED]
485:10-10-8 [AMENDED]
485:10-10-8.2 [AMENDED]

Subchapter 13. Requirements for Employment
485:10-13-1 [AMENDED]
485:10-13-2 [REVOKED]
485:10-13-3 [REVOKED]

Subchapter 15. Requirements for Practice as an Advanced Practice Registered Nurse
485:10-15-5 [AMENDED]

Oklahoma Register (Volume 38, Number 23) 1418 August 16, 2021
485:10-3-2. Establishment of new nursing education programs

(a) Step I. Initial application. An institution wishing to establish a new nursing education program shall:

(1) An institution wishing to establish a new nursing education program shall advise Advise the Board of its intent in writing, and shall seek Board consultation in the initial planning.

(2) The institution shall submit Submit the Step I Initial Application to the Board office at least eight weeks prior to a regularly-scheduled Board meeting, which provides the following information for the Board's consideration:

(A) mission and organization of the educational institution;

(B) accreditation status of the educational institution;

(C) type of nursing program to be established;

(D) relationship of nursing program to the educational institution;

(E) documentation of the rationale for the establishment of the nursing program in Oklahoma;

(F) tentative time-table for program development and implementation;

(G) source of potential qualified Nurse Administrator and faculty, with projected times of employment;

(H) tentative budget plans including evidence of financial resources adequate for developing, implementing, and continuing the nursing program;

(I) source of anticipated student population;

(J) description of support staff for the proposed program;

(K) description of physical facilities;

(L) description of available clinical facilities with letters from clinical resources supporting development of a new program in nursing.

(3) The application shall be signed by the controlling institution's administrative official with evidence that the institution is authorized to offer educational programs in Oklahoma. Regional accreditation is recommended for institutions offering programs in nursing education.

(4) The Board shall advise Be advised by the Board in writing of its decision to:

(A) approve proceeding with development of the program-Step II; or

(B) defer approval pending a visit to the institution and/or receipt of further information; or

(C) deny approval specifying reasons for denial.

(5) The application shall be limited to fifteen (15), single-sided pages, with at least one inch margin, no less than 1.5 line spacing and no less than an 11 point font size.

(b) Step II. Application for Provisional Approval. An institution applying for provisional approval through a Step II application shall:

(1) The institution shall employ Employ a qualified Nurse Administrator ensuring adequate time is provided to develop Step II. A DRAFT of the Step II application for the Board staff to review is provided not less than 14 days before the consultative visit. A consultative visit will be conducted by Board staff at least one month prior to submission of the Step II application. The institution...
shall provide a DRAFT of the Step II application for the Board to review not less than 14 days before the consultative visit. A report of the findings from this visit will be submitted to the Board with the Step II application.  
(2) The Nurse Administrator shall prepare and submit the following materials following the Guidelines for Provisional Approval for the Board's consideration:  
(A) philosophy, program and course objectives;  
(B) curriculum plan;  
(C) policy statements;  
(D) survey of clinical facilities, with evidence that a sufficient amount and variety of clinical experience is available to support an additional nursing education program in the service area;  
(E) faculty qualifications, criteria and job descriptions;  
(F) budget plan projected for a three (3) year period;  
(G) learning resources; and  
(H) institutional and program organizational plans.  
(3) Submit at least four months prior to the anticipated admission of students and at least eight weeks prior to a regularly-scheduled Board meeting, the Nurse Administrator shall submit the "Application for Provisional Approval" for Board review.  
(4) Nursing education and institutional representatives may designate, if desired, representatives to be present during the Board meeting. The Board will advise the institution in writing of its decision to:  
(A) grant Provisional Approval, authorizing the institution to proceed with implementation of the nursing education program and admission of students; or  
(B) defer Provisional Approval and program implementation pending further development; or  
(C) deny Provisional Approval.  
(5) The program cannot admit students until Provisional Approval is granted.  
(6) Faculty qualification form for the Nurse Administrator must be submitted to the Board.  
(7) Qualified faculty must be employed at least thirty days prior to the admission of students.  
(8) Progress reports shall be made by the Nurse Administrator as requested by the Board while on Provisional Approval.  
(9) The application shall be limited to fifty (50), single-sided pages, with at least a one inch margin, no less than 1.5 line spacing and no less than an 11 point font size.  

(A) A Faculty Qualification Record shall be submitted for the Nurse Administrator, and shall include educational preparation and employment experience.  
(B) The Faculty Qualification Record for the Nurse Administrator must be submitted to the Board office by the Nurse Administrator on a form provided by the Board within thirty days of day of appointment, a change in title or status of position, and any time that an advanced degree is attained. The Faculty Qualification Record may be submitted electronically to a designated email address.  
(2) Enrollment and annual reports. Enrollment and annual reports shall be submitted in formats requested by the Board.  
(3) Special reports. Special reports to the Board shall include but are not limited to:  
(A) notification in writing of administrative changes relating to and affecting the program within thirty days of change, to include a change in Nurse Administrator;  
(B) requests in writing to obtain approval prior to implementation for:  
(i) major curriculum changes that alter the length of the program, substantially change the objectives, or reflect a significant philosophical or conceptual shift. Board staff may approve minor changes including but not limited to such matters as reorganizing existing course offerings, transferring existing objectives or content from one course to another or to alterations in the leveling of course objectives.  
(ii) extended, distance learning, or off-campus offerings, when any nursing course is offered;  
(iii) a significant change in instructional format;  
(iv) a pilot or experimental program.  
(4) Pass Rate Reports. Pass Rate Reports are required when the first-time NCLEX writer pass rate falls ten (10) percentage points or more below the national average and at least ten candidates wrote the examination (based on a calendar year.)  
(5) Completion Rate Reports. A completion rate report is required when the program completion rate average is less than 70% for the most recent three (3) annual report years. Program completion rate shall be calculated as 200% of the program length as defined by selective admission to the nursing program's first nursing course. Admission is defined as the grade of the first nursing course that is transcripted with a letter grade of A, B, C, D, or F, which are used to calculate the grade point average. Individual exceptions to the calculation of completion rate include death, military, and peace corp.  
(6) All reports shall be limited to ten (10), single-sided pages, with at least a one inch margin, no less than 1.5 line spacing and no less than an 11 point font size.
485:10-3.6. **Nursing education program visits**

(a) **Survey visit.** Each nursing education program being surveyed shall:

(1) Each nursing education program shall be surveyed:

(A) prior to receiving Full Approval;
(B) within three (3) years after receiving initial Full Approval; and
(C) at least every five (5) years thereafter unless the program has current accreditation by a national nursing accrediting agency recognized by the United States Department of Education.
(D) Special and focused survey visits may be directed by the Board.

(2) Thirty (30) days before the survey visit, submit the applicable fee shall be received in the Board office thirty (30) days before the survey visit and submit the program's self-evaluation report shall be submitted electronically to the Board office.

(3) A draft of the survey visit report will be sent electronically to the nursing education program for additions and/or corrections. Requested additions and/or corrections shall be received electronically in the Board office within two (2) weeks of the date the draft report was received by the nursing education program.

(4) The final report of the survey visit including commendations, recommendations and the decision of the Board shall be provided to the institution.

(b) **Programs with current accreditation by a national nursing accrediting agency recognized by the United States Department of Education.** Nursing education programs with full approval status will be periodically evaluated for continuing approval by the Board.

(1) The nurse administrator of the program shall submit a copy of the notification of accreditation status to the Board within two weeks of receipt, accompanied by the program's accreditation report, supporting documentation, follow-up and/or interim reports.

(2) The Board shall regularly review and analyze program performance reports submitted by the nursing education program including, but not limited to:

(A) Any program challenges or improvements identified by ongoing program improvement review;
(B) Annual reports;
(C) Follow-up or interim reports to national nursing accrediting bodies;
(D) Student retention, attrition, and on-time program completion rates;
(E) Adequate type and number of faculty;
(F) Faculty retention;
(G) Adequate laboratory and clinical learning experiences;
(H) Trended data on NCLEX pass rates and completion rates;
(I) Performance improvement initiatives related to program outcomes; and
(J) Program complaints/grievance review and resolution.

(3) Additional reports or survey visits may be directed by the Board, if the program is not in compliance with the minimum standards for nursing education programs or other sources of evidence regarding achievement of program outcomes.

(c) **Consultation visit.** Consultation visits are available to the nursing education programs upon written request giving the purpose for the visit and are mandatory as indicated in 485:10-3.2. (b)(1).

### SUBCHAPTER 5. MINIMUM STANDARDS FOR APPROVED NURSING EDUCATION PROGRAMS

485:10-5.2. **Administration and organization**

(a) The nursing education program shall:

(1) be an integral part of an educational institution authorized by the state to confer credentials in nursing. An accredited nursing education program shall be an integral part of a governing academic institution that is accredited by an accrediting agency that is recognized by the U.S. Department of Education; if the nursing education program is accredited. The nursing education program shall

(2) provide evidence of current accreditation by a national nursing accrediting agency recognized by the United States Department of Education or be approved by the Board as stated in OAC 485:10-3.1.

(b) The nursing education program shall have comparable status with other programs in the institution and relationships shall be clearly delineated.

(c) The nursing education program shall be organized with the lines of authority, responsibility, and channels of communication clearly defined.

(d) Organization of the nursing education program shall be organized to assure faculty involvement in determining nursing program policies and procedures and faculty responsibility for planning, implementing, and evaluating the curriculum.

(e) Nursing education programs have policies and procedures shall be written in form, congruent with those of the controlling institution, and shall be which are reviewed periodically.

(f) The have a mission and philosophy of the nursing education program shall be consistent with the controlling institution's mission and philosophy and with the law governing the practice of nursing.

485:10-5.4.1. **Clinical learning experiences**

To ensure adequate clinical learning experiences, nursing education programs shall:

(a) Provide an adequate amount and variety of clinical learning experiences, planned by the faculty, to prepare students for practice at the appropriate educational level shall be planned by the faculty and to meet program outcomes.
(b2) Clinical Utilize clinical facilities utilized shall provide providing a safe environment for students' learning experiences and shall provide the type of experiences needed to meet the objectives of the rotation. Clinical facilities are acceptable to the Board for students' clinical learning and are approved by accreditation, evaluation or licensing bodies as appropriate.

(e3) Written criteria for the selection of clinical facilities shall be utilized by the faculty, and the faculty shall evaluate with evaluation of the quality of the learning experiences provided by the facility on a regular basis.

(d4) Written Develop, maintain, and annually review, mutually, agreements with cooperating agencies, shall be mutually developed and maintained, annually reviewed, shall specify the written clinical agreements specifying respective responsibilities, including provisions for continuing use by currently enrolled students, and include provisions for termination of agreement.

(e) Clinical facilities shall be acceptable to the Board for students' clinical learning and shall be approved by accreditation, evaluation or licensing bodies as appropriate.

(f5) The Maintain a maximum ratio of faculty to students in clinical areas involving direct care of patients or clients shall be definable in light of safety, learning objectives, students' level, patient acuity and program outcomes.

(g6) Clinical Utilize consistently with Board policy, clinical preceptors may be used for supervision of students in community health, leadership/management, independent study, elective courses, home health and selected hospitals and long-term care facility experiences consistent with Board policy. Consistent with Board policy, preceptors, when utilized, are academically qualified, oriented, mentored and monitored, and have clearly documented roles and responsibilities.

(h7) Clinical Provide evidence that clinical skills laboratory experiences, which may include simulated patient care experiences, shall be developed, implemented, and evaluated by the faculty to facilitate student preparation for clinical learning experiences.

(i8) Nursing Substitute, if desire to utilize Simulated Patient Care Experiences (SPCE), up to 30% SPCE for clinical hours for each clinical course for nursing education programs on full approval status with 300 total program clinical hours; may substitute up to 30% of Simulated Patient Care Experiences (SPCE) for clinical hours for each clinical course. Programs not on full approval status must obtain Board approval to substitute SPCE for clinical course hours.

(b2) Qualifications Written qualifications, rights, and responsibilities of faculty members shall be available in writing.

(e3) Faculty Written faculty policies shall be available in writing, shall include those used in evaluating performance, specify the teaching load for the faculty and Nurse Administrator, and be in keeping with aligned to accepted educational standards, including those used in evaluating performance and specifying the teaching load for the faculty and Nurse Administrator.

(d4) Sufficient time shall be provided for faculty to accomplish those activities related to the teaching-learning process.

(5) Organize and maintain a faculty organization with written policies and procedures to guide its activities including the following:

(A) hold regular meetings for all members to participate in planning, developing, implementing, and evaluating the nursing program;

(B) establish committees as necessary to carry out the functions of the program;

(C) provide for student participation; and

(D) maintain minutes of all meetings documenting actions and decisions of the faculty.

(eb) All nurse faculty shall:

(1) hold a valid unencumbered license to practice as a Registered Nurse in the State of Oklahoma;

(2) present evidence of a minimum of two (2) years full-time equivalent practice as a Registered Nurse in a clinical setting preceding the first date of first employment as a nursing faculty member, PROVIDED: any person employed in the faculty position on September 1, 2016, is deemed to meet this requirement; and

(3) engage in teaching, scholarship, service and/or practice in keeping with the mission, goals, and expected faculty outcomes.

(gf) All programs leading to licensure as a Registered Nurse in this state shall establish comparable educational qualifications for the nursing faculty as required for other teaching faculty in the governing organization. The minimum requirements shall be as follows:

(1) a master's or higher degree in nursing; or

(2) a baccalaureate degree in nursing plus evidence of continued progress toward a master's or higher degree in nursing with completion of a minimum of six (6) semester hours per calendar year; and

(3) at least one-half of the full-time faculty having a master's or higher degree in nursing; and

(4) part-time clinical instructors, regardless of title used, having a minimum of a baccalaureate degree in nursing.

(gd) All programs leading to licensure as a Practical Nurse in this state shall establish requirements for nursing faculty as follows:

(1) minimum of an associate degree or diploma in nursing in this state, and effective January 1, 2017, has evidence of continued progress toward a baccalaureate or higher degree in nursing with completion of a minimum of
six (6) semester hours per calendar year, PROVIDED: any person employed in the position of faculty of a practical nursing education program on December 31, 2016, is deemed to meet this requirement; and

(2) teacher certification, as established by the State Department of Education, when employed in schools conducted by public comprehensive high school systems.

(h) There shall be a faculty organization with written policies and procedures to guide its activities and shall:

(1) hold regular meetings for all members to participate in planning, developing, implementing, and evaluating the nursing program;
(2) establish committees as necessary to carry out the functions of the program;
(3) provide for student participation; and
(4) maintain minutes of all meetings documenting actions and decisions of the faculty.

SUBCHAPTER 6. MINIMUM STANDARDS FOR APPROVED ADVANCED PRACTICE REGISTERED NURSING (APRN) EDUCATION PROGRAMS (EFFECTIVE JANUARY 1, 2016)

485:10-6-4. Reports to the Board

Board-approved APRN education programs shall submit the following reports:

(a1) A Board-approved APRN education program shall submit written notification to the Board of changes in accreditation status, nurse administrator for the program, or institutional ownership within 30 days of the change.

(b) Upon notification of loss of accreditation status, the program will be removed from the list of Board-approved APRN education programs. The program will be notified that those graduating since loss of accreditation are not eligible for licensure as Advanced Practice Registered Nurses in the state of Oklahoma.

(c2) Additions. Written notification of additions to or changes in the APRN education program that change the advanced practice role, population focus, or degree requirements submitted for approval of the Board prior to implementation.

(d3) The APRN education program shall submit reports to the Board as scheduled in the format requested by the Board, providing documentation on program status and performance as scheduled and in the format requested by the Board.

SUBCHAPTER 7. REQUIREMENTS FOR REGISTRATION AND LICENSURE AS A REGISTERED NURSE AND LICENSED PRACTICAL NURSE

485:10-7-1. Licensure by examination

(a) Qualifications Registered Nurse. An applicant for licensure by examination as a Registered Nurse must meet the following qualifications:

(1) Submits an application containing such information as the Board may prescribe;
(2) Be a minimum of eighteen (18) years of age on or before the date the license is issued;
(3) Cause submission of an official transcript showing completion of the basic professional curricula of a state Board-approved registered nursing education program conducted in a member board jurisdiction that meets the requirements of 485:10-5-6(d), and showing the diploma or degree and the date conferred. The transcript must be obtained from an entity approved and recognized by the U.S. Department of Education as a primary source for providing education transcripts.

(b) Qualifications Licensed Practical Nurse. An applicant for licensure by examination as a Licensed Practical Nurse must meet the following qualifications:

(1) Be a minimum of eighteen (18) years of age on or before the date the license is issued;
(2) Submits an application containing such information as the Board may prescribe;
(3) Cause submission of an official transcript from an entity approved and recognized by the U.S. Department of Education as a primary source for providing education transcripts, showing completion of the basic curricula of a state Board-approved practical nursing education program conducted in a member board jurisdiction that meets the requirements of 485:10-5-6(d), and showing the diploma or degree and the date conferred; or
(4) Has completed equivalent courses through one of the following methods:

(A) in a state approved program of nursing with a minimum overall grade point average of 2.0, and a grade of a "C" or higher in all nursing courses. Evidence is obtained from an entity approved and recognized by the U.S. Department of Education as a primary source for providing education transcripts, verifying successful completion of a minimum of one academic year of instruction in a registered nursing education program, including classroom instruction and clinical practice in nursing care of the adult, nursing care of children, and maternal-infant nursing. Course content in anatomy and physiology, growth and development, mental health, pharmacology and nutrition also have been successfully completed. Courses in external degree programs or completed by challenge examination are not acceptable for PN equivalency; or

(B) has completed a registered nursing education program in a foreign country and meets the requirements of 485:10-7-2(e).

(C) Successful completion of a Board-approved role transition learning packet related to legal and ethical aspects of practical nursing.
(e) **Applications.** Applications for licensure by examination must be completed and filed with the Board prior to the examination. If the application is not completed within one (1) year, the applicant will submit a new application and new fee will be required.

(ed) **Admission to the examination.** The candidate applicant must register with the authorized testing service and submit the required fee. An authorization to test will be issued by the testing service allowing the candidate applicant to schedule the examination.

(de) **Fee for examination.**

(1) The fee for writing or rewriting the licensing examination adopted by the Board for Registered Nurse or Licensed Practical Nurse licensure shall be established by the Board in accordance with statutory guidelines and shall accompany the application.

(2) The fee for rewriting the licensing examination adopted by the Board for Registered Nurse licensure shall be the same as the fee established for the first time writing.

(3) The fee for the examination is not refundable.

(ef) **Policies for the examination.**

(1) Applicants must pass the National Council Licensure Examination (NCLEX) appropriate for Registered Nurses (NCLEX-RN) level of licensure.

(2) Applicants who fail the NCLEX-RN may be eligible to repeat the examination upon filing an application and fee, and upon meeting Board requirements.

(3) To be eligible to write or rewrite the NCLEX-RN, the applicant must submit a completed application, transcript, and fee to the Board and a completed registration form and fee to the authorized testing service within two years of completion of the nursing education program. If more than two years has elapsed, the applicant must complete additional education as follows:

   (A) Successfully complete a Board-approved refresher course in accordance with the Board’s policy;

   or

   (B) Successfully complete nursing didactic coursework and faculty-supervised clinical experience in a board-approved nursing education program at the appropriate educational level, to include at least 80 hours in classroom and skills laboratory review and at least 80 hours participating in patient care activities in the clinical setting.

(4) After completion of the required additional education, the applicant will have two years from the completion date of the additional education to take and pass the NCLEX-RN.

(5) If more than two (2) years has elapsed since the applicant successfully passed the NCLEX-RN and did not obtain licensure as a Registered Nurse, the applicant must complete additional education as follows:

   (A) Successfully complete a Board-approved refresher course in accordance with the Board’s policy;

   or

   (B) Successfully complete nursing didactic coursework and faculty-supervised clinical experience in a Board-approved nursing education program at the appropriate educational level, to include at least 80 hours in classroom and skills laboratory review and at least 80 hours participating in patient care activities in the clinical setting.

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485:10-7-2. **Licensure by endorsement**

(a) **Qualifications Registered Nurse.** An applicant for licensure by endorsement as a Registered Nurse shall:

(1) Submit an application containing such information as the Board may prescribe;

(2) Be a minimum of eighteen (18) years of age on or before the date the license is issued;

(3) An applicant for licensure by endorsement as a Registered Nurse must meet the requirements of the Oklahoma Nursing Practice Act. An evaluation of educational requirements may be completed to ensure the applicant meets educational standards.

(4) An applicant licensed in another state or U.S. territory since January 1, 1952, must have successfully written the licensing examination adopted by the Board with a passing score as established by the Board. A license to practice nursing in Oklahoma will not be issued until this requirement is met.

(5) An applicant must submit evidence of either:

   (A) successful completion of the National Council Licensure Examination for Registered Nurses since July 1, 1982;

   or

   (B) passing the State Board Test Pool Examination for Registered Nurse licensure prior to July 1, 1982.

(6) In addition to meeting other requirements for endorsement established by the Board in these Rules, each applicant for endorsement must demonstrate evidence of continued qualifications for practice through completion of one or more of the following requirements within the last five (5) years prior to receipt of the completed application in the Board office:

   (A) Submission of an official transcript or certificate of completion verifying completion of a nurse refresher course with content consistent with Board policy;

   (B) Successfully pass the National Council Licensure Examination for Registered Nurses;

   (C) Cause submission of an official transcript, provided by an entity approved and recognized by the U.S. Department of Education as a primary source for providing education transcripts, verifying successful completion of at least six (6) academic semester credit hours of nursing courses which include classroom and clinical instruction;

   (D) Present evidence of licensure as a registered nurse in another state, territory or country with employment in a position that requires nursing licensure with verification of at least 520 work hours during the past five (5) years;
(E) Submit evidence of completing at least twenty-four (24) contact hours of continuing education applicable to nursing practice;
(F) Submit current certification in a nursing specialty area.

(7) Applicants for endorsement who took the National Council Licensure Examination for Registered Nurses for Provision of evidence of one of the following if initial licensure was obtained within the last two years must:
(A) Provide evidence of completion of the nursing education program within two years of initial application for licensure by examination; or
(B) Provide evidence of at least six months work experience as a registered nurse in the state, U.S. territory, or country of licensure; or
(C) Successfully complete a Board-approved refresher course in accordance with the Board's policy; or
(D) Successfully complete a Board-approved refresher course in accordance with the Board's policy.

(b) Qualifications Licensed Practical Nurse. An applicant for licensure by endorsement as a Licensed Practical Nurse shall:
(1) Submit an application containing such information as the Board may prescribe;
(2) Be a minimum of eighteen (18) years of age on or before the date the license is issued;
(3) Meet the requirements of the Oklahoma Nursing Practice Act. An evaluation of educational requirements may be completed to ensure the applicant meets educational standards;
(4) If licensed in another state or U.S. territory since June 30, 1954, have successfully written the licensing examination adopted by the Board. A license to practice practical nursing in Oklahoma will not be issued until this requirement is met;
(5) In addition to meeting other requirements for endorsement established by the Board in these Rules, demonstrate evidence of continued qualifications for practice through completion of one or more of the following requirements within the last five (5) years prior to receipt of the completed application in the Board office:
(A) Submission of an official transcript or certificate of completion verifying completion of a nurse refresher course with content consistent with Board policy;
(B) Successfully pass the National Council Licensure Examination for Practical Nurses;
(C) Cause submission of an official transcript, provided by an entity approved and recognized by the U.S. Department of Education as a primary source for providing education transcripts, verifying successful completion of at least six (6) academic semester credit hours or 105 contact hours of nursing courses in a state-approved practical or registered nursing education program, which includes classroom and clinical instruction;
(D) Present evidence of licensure as a practical nurse in another state, territory or country with employment in a position that requires practical nursing licensure with verification of at least 520 work hours during the past five (5) years;
(E) Submit evidence of completing at least twenty-four (24) contact hours of continuing education applicable to nursing practice;
(F) Submit current certification in a nursing specialty area.

(6) Provide evidence of one of the following if the National Council Licensure Examination for Practical Nurses for initial licensure was obtained within the last two years:
(A) Completion of the nursing education program within two years of initial application for licensure by examination; or
(B) At least six months work experience as a Licensed Practical Nurse in the state, U.S. territory, or country of licensure; or
(C) Successful completion of a Board-approved refresher course in accordance with the Board's policy; or
(D) Successful completion of nursing didactic coursework and faculty-supervised clinical experience in a board-approved nursing education program at the appropriate educational level, to include at least 80 hours in classroom and skills laboratory review and at least 80 hours participating in patient care activities in the clinical setting.

(c) Applications.
(1) Applications must be completed and filed with the Board.
(2) Endorsement may be accepted from the original state or U.S. territory of licensure by examination.
(3) If the applicant has written the licensing examination adopted by the Board in a state other than the state or U.S. territory of original licensure, an endorsement will be requested from that state, also.
(4) If the application is not completed within one (1) year after receipt of fee, the application must be refiled.

(ed) Fee for licensure by endorsement.
(1) The fee shall accompany the application.
(2) The fee is not refundable.
(3) If the application is not completed within one (1) year, a new application and new fee will be required for licensure.

de Qualifications for applicants educated in foreign countries or in a U.S. territory. An applicant educated in a foreign country must meet the current educational requirements for licensure in Oklahoma. An applicant educated in a U.S. territory not recognized as a full member of National Council of State Boards of Nursing (NCSBN) must meet the requirements for applicants educated in foreign countries. An applicant educated in a U.S. territory that is a full member of
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NCSBN but in a nursing education program not included on the NCSBN state-approved programs of nursing list at the time of the applicant's graduation from the program must meet the requirements for applicants educated in foreign countries.

(1) The registered nurse applicant must present evidence of:
   (A) graduation from a government-approved post-secondary nursing education program, as verified
       by the Commission of Graduates of Foreign Nursing Schools (CGFNS);
   (B) completion of formal courses including theory and clinical experience in nursing care of the adult,
       maternal-infant nursing, psychiatric-mental health nursing as evidenced by:
       (i) a translated transcript with certified proof of translation received directly from the nursing
           education program in the original country of licensure, or
       (ii) a certified copy of original transcript obtained directly from the Commission of Graduates
           of Foreign Nursing Schools (CGFNS);
   (C) licensure or registration as required in the country of graduation as evidenced by official verification
       received directly from the Commission of Graduates of Foreign Nursing Schools;
   (D) competence in oral and written English as evidenced by receipt of scores directly from the approved
       testing service or from CGFNS verifying successful completion of:
       (i) Test of English for International Communication (TOEIC), to include the Listening and
           Reading Test, and the Speaking and Writing Test of the Educational Testing Service, or
       (ii) International English Language Testing System (IELTS), or
       (iii) Test of English as a Foreign Language Internet-based test (TOEFL iBT) of the Educational
           Testing Service, or
       (iv) Michigan English Language Assessment Battery Test (MELAB) (MFT).
   (E) An evaluation of educational credentials as evidenced by:
       (i) CGFNS Certificate Status or Visa Screen Certificate; or
       (ii) CGFNS Credentials Evaluation Service Professional Report;
       (iii) Reports received from CGFNS must have been completed within the five (5) years immediately
           preceding the date of application for licensure by endorsement. The five-year requirement is
           waived if the applicant holds a license in another state.
   (F) Evidence of either:
       (i) successful completion of the National Council Licensure Examination for Registered Nurses since
           July 1, 1982; or
       (ii) passing the State Board Test Pool Examination for Registered Nurse licensure prior to July
           1, 1982.

(2) The practical nurse applicant must present evidence of:
   (A) competence in oral and written English as evidenced by receipt of scores directly from the testing
       service or from CGFNS verifying successful completion of:
       (i) Test of English for International Communication (TOEIC), to include the Listening and
           Reading Test, and the Speaking and Writing Test of the Educational Testing Service; or
       (ii) International English Language Testing System (IELTS); or
       (iii) Test of English as a Foreign Language Internet-based test (TOEFL iBT) of the Educational
           Testing Service; or
       (iv) Michigan English Test (MET).
   (B) graduation from a government-approved post-secondary practical nursing education program
       or equivalent courses in a government-approved post-secondary nursing education program, as verified
       from the Commission of Graduates of Foreign Nursing Schools (CGFNS);
   (C) licensure or registration as required in the country of graduation as evidenced by official verification
       completed within the last twelve (12) months immediately preceding the date of application for licensure
       by endorsement received directly from the Commission of Graduates of Foreign Nursing Schools;
   (D) completion of formal courses including theory and clinical experience in nursing care of the adult,
       nursing care of children, and maternal-infant nursing in a government-approved school of nursing as
       evidenced by:
       (i) a translated transcript received directly from the nursing education program in the original
           country of licensure with certified proof of translation; or
       (ii) a certified copy of the transcript received directly from the Commission on Graduates of
           Foreign Nursing Schools (CGFNS);
   (E) An evaluation of educational credentials as evidenced by:
       (i) Commission on Graduates of Foreign Nursing Schools (CGFNS) Credentials Evaluation
           Service Professional Report, or
       (ii) Commission on Graduates of Foreign Nursing Schools (CGFNS) Certificate or Visa
           Screen Certificate status;
       (iii) Reports received from CGFNS must have been completed within the five (5) years immediately
           preceding the date of application for licensure by endorsement. The five-year requirement is
           waived if the applicant holds a license in another state.
Successful completion of the licensing examination adopted by the Oklahoma Board of Nursing.

The requirement for verification by CGFNS is waived for applicants currently licensed in another state when the state validates that the credential review report was prepared by an independent credentials review agency.

The requirements for evidence of competence in spoken and written English are waived for applicants who are:

- Graduates of nursing education programs taught in English in Australia, Canada (except Quebec), Ireland, New Zealand, the United Kingdom, Trinidad, Tobago, Jamaica, Barbados, South Africa, and the United States.
- Licensed in another US State or Territory and have successfully completed the licensure examination approved by the Board.

Applicants must submit a completed application and the required fee.

Temporary license for endorsement applicants.

A temporary license may be issued to the applicant on proof of:

- Current unrestricted licensure in another state, territory or country with no history of arrest or disciplinary action requiring further review;
- Evidence of having successfully passed the licensure examination adopted by the Oklahoma Board of Nursing;
- Evidence of meeting educational qualifications through completion of a state board-approved nursing education program meeting the educational standards established by the Board, or an evaluation of educational credentials and nursing licensure or registration as required in country of origin for the foreign-educated nurse as evidenced by:
  - Commission on Graduates of Foreign Nursing Schools (CGFNS) Credentials Evaluation Service Professional Report with verification of equivalent educational credentials and unrestricted licensure in country of origin, or
  - Commission on Graduates of Foreign Nursing Schools (CGFNS) Certificate status or Visa Screen Certificate, accompanied by a verification of graduation from a government approved nursing education program, the translated transcript, and verification of unrestricted nursing licensure or registration as required in country of graduation;
- Payment of the fee for licensure by endorsement and temporary license;
- Foreign educated. Proof by foreign educated applicants must provide evidence of competence in: oral and written English by meeting the requirements of 485:10-7-2(4)(e)(1)(D) and 485:10-7-2(4)(e)(2)(A), unless 485:10-7-2(4)(c)(4)(a) applies;
- Demonstrating evidence of continued qualifications for practice through meeting the requirements of 485:10-7-2(a)(6) or (7) for registered nurse applicants and 485:10-7-2(b)(5) or (6) for practical nurse applicants; and
- Submission of fingerprint images with the fee established by the Oklahoma State Bureau of Investigation and/or vendor for the purpose of permitting a state and national criminal history records search to be completed.

The temporary license may not be issued for a period longer than ninety (90) days.

The temporary license may be extended, but such period shall be no longer than one (1) year for any applicant.

Licensure of active duty military or the spouse of an active military individual. Applications must be completed and filed with the Board.

1. Submit with the endorsement application a copy of the United States Uniformed Services Identification and Privilege Card and a copy of the Permanent Change of Station orders for the active military individual;
2. The requested Oklahoma license and/or temporary license shall be issued within thirty (30) days for their currently held valid license from another state or territory provided the license from the other state or territory is found to be in good standing and reasonably equivalent to the requirements of this state; and
3. The fee for licensure, including temporary license, of active duty military or the spouse of an active duty military individual is waived with the license expiration date extended through the first renewal cycle.

485:10-7-3. Renewal of [RN] [LPN] license

(a) All Registered Nurse and Licensed Practical Nurse licenses issued may be renewed in accordance with the schedule published by the Board.
(b) The applicant must submit an application containing such information as the Board may prescribe.
(c) The application for renewal of license must be completed and accompanied by the established fee before a new license is issued.
(d) The fee for renewal of license shall be established by the Board in accordance with statutory guidelines.
(e) In addition to meeting other requirements for renewal established by the Board in these Rules, effective January 1, 2014, each licensee shall demonstrate evidence of continuing qualifications for practice through completion of one or more of the following requirements within the past two years prior to the expiration date of the license:

1. Verify employment in a position that requires a registered nurse license at the highest level of licensure with verification of at least 520 work hours; or
2. Verify the completion of at least twenty-four (24) contact hours of continuing education applicable to nursing practice; or
3. Verify current certification in a nursing specialty area; or
4. Verify completion of a Board-approved refresher course; or
(5) Verify completion of at least six (6) academic semester credit hours of nursing coursework at the licensee’s current level of licensure or higher.

(6e) If audited, the licensee shall present documentation supporting the continuing qualifications.

485:10-7-4. Reinstatement of license
(a) The registered Nurse or Practical Nurse license is lapsed if not renewed by expiration date thereof.
(b) The applicant must submit an application containing such information as the Board may prescribe.
(c) A completed application for reinstatement must be submitted to the Board office with the required fee. If the application is not completed within one (1) year, a new application and new fee will be required.
(d) The fee for reinstatement of license shall be established by the Board.
(e) An application for reinstatement for a license that has been suspended or surrendered must be in compliance with all terms and conditions of any Order entered with regard to the suspension or surrender and shall be considered by the Board.
(f) An application for reinstatement for a license that has been revoked by the Board shall be considered by the Board.
(g) An application for reinstatement for a license not previously revoked, suspended or surrendered may be granted on such terms and conditions as the Board may require.
(h) In addition to meeting other reinstatement requirements established by the Board in these Rules, if the Oklahoma nursing license has not been in an active status less than five years, each applicant shall demonstrate evidence of continuing qualifications for practice through completion of one or more of the following requirements within the last five (5) years prior to receipt of the completed application in the Board office:
(1) Verify employment in a position that requires a registered nurse licensing at the highest level of licensure with verification of at least 520 work hours; or
(2) Verify the completion of at least twenty-four (24) contact hours of continuing education applicable to nursing practice; or
(3) Verify current certification in a nursing specialty area; or
(4) Verify completion of a Board-approved refresher course; or
(5) Verify completion of at least six (6) academic semester credit hours of nursing coursework at the licensee’s current level of licensure or higher.
(h) In addition to meeting other reinstatement requirements established by the Board in these Rules, if the Oklahoma nursing license has not been in an active licensure status for a period of five (5) years or more, the applicant for reinstatement must demonstrate continued qualifications for practice through completion of one or more of the following requirements within the last five (5) years prior to receipt of the completed application in the Board office:
(1) Submission of an official transcript or certificate of completion verifying completion of a nurse refresher course with content consistent with Board policy;
(2) Successfully pass the National Council Licensure Examination for Registered Nurse at the appropriate level of license;
(3) Submission of an official transcript verifying successful completion of at least six (6) academic semester credit hours of nursing courses which include classroom and clinical instruction; and/or
(4) Present evidence of licensure as a Registered Nurse in another state, territory or country with employment in a position that requires a nursing license at the highest level of licensure with verification of at least 520 work hours during the past five (5) years preceding receipt of the application for reinstatement in the Board office.

485:10-7-5. Inactive status
Any Registered Nurse or Licensed Practical Nurse licensee who desires to retire from the practice of nursing shall:
(a1) Any registered Nurse or Licensed Practical Nurse licensee who desires to retire from the practice of nursing shall submit a written request to be placed on the Inactive List.
(b2) The date of transfer to the inactive status will be the date of approval by the Board. The Board may delegate approval of the licensee's request to be placed on inactive status to the Board Staff.
(c3) A licensee shall remain on the Inactive List unless otherwise indicated without the payment of the renewal fee.
(d4) The return to active practice fee shall be due when the licensee desires to return to active practice. The applicant must submit an application containing such information as the Board may prescribe.
(e5) An application for return to active status for a license that has been placed on Inactive Status by Order of the Board shall be considered by the Board.
(f6) In addition to meeting other requirements to return to active status as established by the Board in these Rules, if the nursing license has been on the Inactive List for a period of five (5) years or more, the licensee must demonstrate continued qualifications for practice through completion of one or more of the following requirements within the last five (5) years prior to receipt of the completed application in the Board office:
(1A) Submission of an official transcript or certificate of completion verifying completion of a nursing refresher course with content consistent with Board policy;
(2B) Successfully pass the National Council Licensure Examination for Registered Nurse at the appropriate level of license;
(3C) Submission of an official transcript verifying successful completion of at least six (6) academic semester credit hours of nursing courses which include classroom and clinical instruction; and/or
(4D) Present evidence of licensure as a nurse in another state, territory or country with employment in a position that requires a nursing license at the highest level of licensure with verification of at least 520 work hours during the past five (5) years preceding...
receipt of the request for return to active status in the Board office.

(17) In addition to meeting other reinstatement requirements established by the Board in these Rules, if the Oklahoma nursing license has been inactive less than five years, each applicant shall demonstrate evidence of continuing qualifications for practice through completion of one or more of the following requirements within the last five (5) years prior to receipt of the completed application in the Board office:

(1A) Verify employment in a position that requires a registered nurse/nursing license at the highest level of licensure with verification of at least 520 work hours; or

(2B) Verify the completion of at least twenty-four (24) contact hours of continuing education applicable to nursing practice; or

(3C) Verify current certification in a nursing specialty area; or

(4D) Verify completion of a Board-approved refresher course; or

(5E) Verify completion of at least six (6) academic semester credit hours of nursing coursework at the licensee's current level of licensure or higher.

485:10-7-8. Endorsement of a Registered Nurse or Licensed Practical Nurse to another state
(a) A Registered Nurse or Licensed Practical Nurse wishing to be licensed in another state may have a certified statement of Oklahoma licensure issued to the Board of Nursing in such state upon request and payment of a fee to Nurses as established by the Board.
(b) If a transcript is provided from the files of a closed nursing education program, a fee as established by the Board will be charged.

485:10-7-9. Change of name and address
Each Registered Nurse or Licensed Practical Nurse licensee requesting a change of name and address shall:

(a1) Each Registered Nurse licensee must provide certified evidence (a copy of marriage license or court action) regarding any change of name within 30 days of the change.

(b2) Evidence of change of name shall be accompanied by a fee as established by the Board to accompany the change of name request.

(c3) Notice of change of address must be submitted in writing by each licensee within 30 days of the change.

SUBCHAPTER 9. REQUIREMENTS FOR REGISTRATION AND LICENSURE AS A LICENSED PRACTICAL NURSE [REVOKED]

485:10-9-1. Licensure by examination [REVOKED]
(a) Qualifications. An applicant for licensure by examination as a Licensed Practical Nurse must meet the following qualifications:

(1) Be a minimum of eighteen (18) years of age on or before the date the license is issued;

(2) Submit an application containing such information as the Board may prescribe;

(3) Cause submission of an official transcript from an entity approved and recognized by the U.S. Department of Education as a primary source for providing education transcripts, showing completion of the basic curricula of a state Board-approved practical nursing education program conducted in a member Board jurisdiction that meets the requirements of 485:10-5-6(d), and showing the diploma or degree and the date conferred; or

(4) Has completed equivalent courses through one of the following methods:

(A) in a state approved program of nursing with a minimum overall grade point average of 2.0, and a grade of a "C" or higher in all nursing courses. Evidence must be provided by an entity approved and recognized by the U.S. Department of Education as a primary source for providing education transcripts, verifying successful completion of a minimum of one academic year of instruction in a registered nursing education program, including classroom instruction and clinical practice in nursing care of the adult, nursing care of children, and maternal-infant nursing. Course content in anatomy and physiology, growth and development, mental health, pharmacology and nutrition also must have been successfully completed. Courses in external degree programs or completed by challenge examination are not acceptable for PN equivalency; or

(B) has completed a registered nursing education program in a foreign country and meets the requirements of 485:10-7-2(d).

(5) Board-approved role transition learning packet related to legal and ethical aspects of practical nursing must be successfully completed by all PN equivalency applicants prior to approval to write the examination for licensure.

(b) Applications. Applications for licensure by examination must be completed and filed with the Board prior to the examination. If the application is not completed within one (1) year, a new application and new fee will be required.

(c) Admission to the examination. The candidate must register with the authorized testing service and submit required fees. An authorization to test will be electronically mailed to the candidate by the testing service allowing them to schedule the exam.

(d) Fee for examination.

(1) The fee for writing the licensure examination adopted by the Board for practical nurse licensure shall be established by the Board in accordance with statutory guidelines and shall accompany the application.
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(2) The fee for rewriting the licensing examination adopted by the Board for practical nurse licensure shall be the same as the fee established for the first-time writing.
(3) The fee for the examination (first time and rewrite) is not refundable.

(e) Policies for the examination.
(1) Applicants must pass the National Council Licensure Examination for Practical Nurses (NCLEX-PN).
(2) Applicants who fail the NCLEX-PN may be eligible to repeat the examination upon filing an application and fee meeting Board requirements.
(3) To be eligible to write or rewrite the NCLEX-PN, the applicant must submit a completed application, transcript, and fee to the Board and a completed registration form and fee to the authorized testing service within two years of completion of the nursing education program or the equivalent coursework and/or related experience. If more than two years have elapsed, the applicant must complete additional education as follows:
   (A) Successfully complete a Board-approved refresher course in accordance with the Board’s policy;
   or
   (B) Successfully complete nursing didactic coursework and faculty-supervised clinical experience in a board-approved nursing education program at the appropriate educational level, to include at least 80 hours in classroom and skills laboratory review and at least 80 hours participating in patient care activities in the clinical setting.
(4) After completion of the required additional education, the applicant will have two years from the completion of the additional education to take and pass the NCLEX-PN.
(5) If more than two (2) years has elapsed since the applicant successfully passed the NCLEX-PN and did not obtain licensure as a Licensed Practical Nurse, the applicant must complete additional education as follows:
   (A) Successfully complete a Board-approved refresher course in accordance with the Board’s policy;
   or
   (B) Successfully complete nursing didactic coursework and faculty-supervised clinical experience in a Board-approved nursing education program at the appropriate educational level, to include at least 80 hours in classroom and skills laboratory review and at least 80 hours participating in patient care activities in the clinical setting.

485:10-9-2. Licensure by endorsement [REVOKED]

(a) Qualifications.
(1) The applicant must submit an application containing such information as the Board may prescribe;
(2) Be a minimum of eighteen (18) years of age on or before the date the license is issued;
(3) An applicant for licensure by endorsement as a Licensed Practical Nurse shall meet the requirements of the Oklahoma Nursing Practice Act. An evaluation of educational requirements may be completed to ensure the applicant meets educational standards.
(4) An applicant licensed in another state or U.S. territory since June 30, 1954, must have passed the licensing examination adopted by the Board. A license to practice practical nursing in Oklahoma will not be issued until this requirement is met.
(5) In addition to meeting other requirements for endorsement established by the Board in these rules, each applicant for endorsement must demonstrate evidence of continued qualifications for practice through completion of one or more of the following requirements within the last five (5) years prior to receipt of the completed application in the Board office:
   (A) Submission of an official transcript or certificate of completion verifying completion of a nurse refresher course with content consistent with Board policy;
   (B) Successfully pass the National Council Licensure Examination for Practical Nurses;
   (C) Cause submission of an official transcript, provided by an entity approved and recognized by the U.S. Department of Education as a primary source for providing education transcripts, verifying successful completion of at least six (6) academic semester credit hours or 105 contact hours of nursing courses in a state-approved practical or registered nursing education program, which includes classroom and clinical instruction;
   (D) Present evidence of licensure as a practical nurse in another state, territory or country with employment in a position that requires practical nursing licensure with verification of at least 520 work hours during the past five (5) years;
   (E) Submit evidence of completing at least twenty-four (24) contact hours of continuing education applicable to nursing practice;
   (F) Submit current certification in a nursing specialty area.
(6) Applicants for endorsement who took the National Council Licensure Examination for Practical Nurses for initial licensure within the last two years must:
   (A) Provide evidence of completion of the nursing education program within two years of initial application for licensure by examination; or
   (B) Provide evidence of at least six months work experience as a Licensed Practical Nurse in the state, U.S. territory, or country of licensure; or
   (C) Successfully complete a Board-approved refresher course in accordance with the Board’s policy;
   or
   (D) Successfully complete nursing didactic coursework and faculty-supervised clinical experience in a board-approved nursing education program at the appropriate educational level, to include at least 80 hours in classroom and skills laboratory review and at
least 80 hours participating in patient care activities in the clinical setting.

(b) Applications.

(1) Applications must be completed and filed with the Board.

(2) Endorsement may be accepted from the original state of licensure by examination.

(3) If the applicant has written the licensing examination adopted by the Board in a state other than the state of U.S. territory of original licensure, an endorsement will be requested from that state, also.

(4) If the application is not completed within one (1) year after receipt of fee, the application must be refiled.

(c) Fee for licensure by endorsement.

(1) The fee shall accompany the application.

(2) The fee is not refundable.

(3) If the application is not completed within one (1) year, a new application and new fee will be required for licensure.

(d) Qualifications for applicants educated in foreign countries or in a U.S. territory.

An applicant educated in a foreign country must meet the current educational requirements for licensure in Oklahoma. An applicant educated in a U.S. territory not recognized as a full member of National Council of State Boards of Nursing (NCSBN) must meet the requirements for applicants educated in foreign countries. An applicant educated in a U.S. territory that is a full member of NCSBN but in a nursing education program not included on the NCSBN state-approved programs of nursing list at the time of the applicant's graduation from the program must meet the requirements for applicants educated in foreign countries.

(1) The applicant must present evidence of:

(A) Competence in oral and written English as evidenced by receipt of scores directly from the testing service or from CGENS verifying successful completion of:

(i) Test of English for International Communication (TOEIC), to include the Listening and Reading Test, and the Speaking and Writing Test of the Educational Testing Service; or

(ii) International English Language Testing System (IELTS); or

(iii) Test of English as a Foreign Language Internet-based test (TOEFL iBT) of the Educational Testing Service; or

(iv) Michigan English Language Assessment Battery (MELAB).

(B) Graduation from a government-approved post-secondary practical nursing education program or equivalent courses in a government-approved post-secondary nursing education program, as verified from the Commission of Graduates of Foreign Nursing Schools (CGFNS);

(C) Licensure or registration as required in country of graduation as evidenced by official verification completed within the last twelve (12) months immediately preceding the date of application for licensure by endorsement received directly from the Commission of Graduates of Foreign Nursing Schools;

(D) Completion of formal courses including theory and clinical experience in nursing care of the adult, nursing care of children, and maternal-infant nursing in a government-approved school of nursing as evidenced by:

(i) A translated transcript received directly from the nursing education program in the original country of licensure with certified proof of translation;

(ii) A certified copy of the transcript received directly from the Commission on Graduates of Foreign Nursing Schools (CGFNS).

(E) An evaluation of educational credentials as evidenced by:

(i) Commission on Graduates of Foreign Nursing Schools (CGFNS) Credentials Evaluation Service Professional Report, or

(ii) Commission on Graduates of Foreign Nursing Schools (CGFNS) Certificate or Visa Screen Certificate status;

(iii) Reports received from CGFNS must have been completed within the five (5) years immediately preceding the date of application for licensure by endorsement. The five-year requirement is waived if the applicant holds a license in another state.

(2) The requirement for verification by CGFNS is waived for applicants currently licensed in another state when the state validates that the credential review report was prepared by an independent credentials review agency.

(3) The applicant must successfully complete the licensing examination adopted by the Oklahoma Board of Nursing.

(4) The requirements for competence in spoken and written English are waived for applicants who are:

(A) Graduates of nursing education programs taught in English in Australia, Canada (except Quebec), Ireland, New Zealand, the United Kingdom, Trinidad, Tobago, Jamaica, Barbados, South Africa, and the United States, or

(B) Licensed in another U.S. state or territory and have successfully completed the licensure examination approved by the Board.

(5) Applicants must submit a completed application with the required application and examination fees.

(e) Temporary license for endorsement applicants.

(1) A temporary license may be issued to the applicant on proof of:

(A) Current unrestricted licensure in another state, territory or country with no history of arrest or disciplinary action requiring further review;

(B) Evidence of having successfully passed the licensure examination adopted by the Oklahoma Board of Nursing;

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(a) All licenses issued may be renewed in accordance with a schedule published by the Board.
(b) The applicant must submit an application containing such information as the Board may prescribe.
(c) The application for renewal of license must be completed and accompanied by the established fee before a new license is issued.
(d) The fee for renewal of license shall be established by the Board in accordance with statutory guidelines.
(e) In addition to meeting other requirements for renewal established by the Board in these Rules, effective January 1, 2014, each licensee shall demonstrate evidence of continuing qualifications for practice through completion of one or more of the following requirements within the past two years prior to the expiration date of the license:
   (1) Verify employment in a position that requires a practical nurse license with verification of at least 520 work hours; or
   (2) Verify the completion of at least twenty-four (24) contact hours of continuing education applicable to nursing practice; or
   (3) Verify current certification in a nursing specialty area; or
   (4) Verify completion of a Board-approved refresher course; or
   (5) Verify completion of at least six (6) academic semester credit hours of nursing coursework at the licensee's current level of licensure or higher.
(f) If audited, the licensee shall present documentation supporting the continuing qualifications.

485:10-9-4. Reinstatement of license [REVOKED]
(a) The Licensed Practical Nurse license is lapsed if not renewed by expiration date thereof.
(b) The applicant must submit an application containing such information as the Board may prescribe.
(c) A completed application for reinstatement must be submitted to the Board office with the required fee. If the application is not completed within one (1) year, a new application and new fee will be required.
(d) The fee for reinstatement of license shall be established by the Board.
(e) An application for reinstatement for a license that has been suspended or surrendered must be in compliance with all terms and conditions of any Order entered with regard to the suspension or surrender and shall be considered by the Board.
(f) An application for reinstatement of a license that has been revoked by the Board shall be considered by the Board.
(g) An application for reinstatement for a license not previously revoked, suspended or surrendered may be granted on such terms and conditions as the Board may require.
(h) In addition to meeting other reinstatement requirements established by the Board in these Rules, if the Oklahoma nursing license has not been in an active status less than five years, each applicant shall demonstrate evidence of continuing qualifications for practice through completion of one or more of the
following requirements within the last five (5) years prior to receipt of the completed application in the Board office:

(1) Verify employment in a position that requires a practical nurse license with verification of at least 520 work hours; or

(2) Verify the completion of at least twenty-four (24) contact hours of continuing education applicable to nursing practice; or

(3) Verify current certification in a nursing specialty area; or

(4) Verify completion of a Board-approved refresher course; or

(5) Verify completion of at least six (6) academic semester credit hours of nursing coursework at the licensee's current level of licensure or higher.

(i) In addition to meeting other reinstatement requirements established by the Board in these Rules, if the Oklahoma practical nursing license has not been in an active licensure status for a period of five (5) years or more, the applicant for reinstatement must demonstrate continued qualifications for practice through completion of one or more of the following requirements within the last five (5) years prior to receipt of the completed application in the Board office:

(1) Submission of an official transcript or certificate of completion verifying completion of a nurse refresher course with content consistent with Board policy;

(2) Successfully pass the National Council Licensure Examination for Practical Nurses;

(3) Submission of an official transcript verifying successful completion of at least six (6) academic semester credit hours or 105 contact hours of nursing courses in a state-approved practical or registered nursing education program, which includes classroom and clinical instruction; and/or

(4) Present evidence of licensure as a practical nurse in another state, territory or country with employment in a position that requires practical nursing licensure with certification of at least 520 work hours during the past five (5) years preceding receipt of the request for return to active status in the Board office.

(g) In addition to meeting other reinstatement requirements established by the Board in these Rules, if the Oklahoma nursing license has lapsed less than five years, each applicant shall demonstrate evidence of continuing qualifications for practice through completion of one or more of the following requirements within the last five (5) years prior to receipt of the completed application in the Board office:

(1) Verify employment in a position that requires a practical nurse license with verification of at least 520 work hours; or

(2) Verify the completion of at least twenty-four (24) contact hours of continuing education applicable to nursing practice; or

(3) Verify current certification in a nursing specialty area; or

(4) Verify completion of a Board-approved refresher course; or

(5) Verify completion of at least six (6) academic semester credit hours of nursing coursework at the licensee's current level of licensure or higher.

485:10-9.5. Inactive status [REVOKED]

(a) Any licensee who desires to retire from the practice of practical nursing shall submit a written request to be placed on the inactive list.

(b) The date of transfer to the inactive status will be the date of approval by the Board. The Board may delegate approval of the licensee’s request to be placed on inactive status to the Board Staff.

(c) A licensee shall remain on the Inactive List unless otherwise indicated without the payment of the renewal fee.

(d) The return to active fee shall be due when the licensee desires to return to active practice. The applicant must submit an application containing such information as the Board may prescribe.

(e) An application for return to active status for a license that has been placed on Inactive Status by Order of the Board shall be considered by the Board.

485:10-9.8. Endorsement of a Licensed Practical Nurse to another state [REVOKED]

(a) A Licensed Practical Nurse wishing to be licensed in another state may have a certified statement of Oklahoma licensure issued to the Board of Nursing in such state upon receipt of a fee as established by the Board.

(b) If a transcript is provided from the files of a closed school of nursing, a fee as established by the Board will be charged.
Permanent Final Adoptions

485:10-9-9. Change of name and address [REVOKED]
(a) Each Licensed Practical Nurse licensee must provide certified evidence (a copy of marriage license or court action) regarding any change of name within 30 days of the change.
(b) Evidence of change of name shall be accompanied by a fee as established by the Board.
(c) Notice of change of address must be submitted in writing by each licensee within 30 days of the change.

485:10-9-10. Issuance of a multistate license to an existing licensee [REVOKED]
Application for a multistate license by an existing licensee must be completed and filed with the Board. If the application is not completed within six (6) months, a new application and new fee will be required.

SUBCHAPTER 10. ADVANCED UNLICENSED ASSISTANT

485:10-10-2. Certification training program
Advanced Unlicensed Assistant certification training programs shall:
(a) The certification training program shall consist of classroom and clinical instruction in the performance of specific core skills that have been selected and approved by the Board;
(b) Any certified training program submitted to the Board for approval shall meet the following requirements:
   (1) Any health-care facility, educational institution or education provider that meets the Board's criteria for approved programs and is approved by the Board may provide the certification training program.
   (2) Any health-care facility, educational institution or education provider wishing to establish a certification training program for advanced unlicensed assistive personnel shall file the appropriate forms with the Board. The application shall include, but is not limited to:
      (A) program plan following the curriculum approved by the Board;
      (B) clock hours of classroom and supervised clinical instruction;
      (C) description of classroom and skills training facility;
      (D) evidence of adequate learning resources;
      (E) faculty qualification record for each instructor.
   (3) The Board shall advise the institution in writing of its decision to:
      (A) approve proceeding with the program; or
      (B) defer approval pending a site visit and/or receipt of further information; or
      (C) deny approval specifying reasons for denial.
   (4) The application shall be limited to fifteen (15), single-sided pages, with at least one inch margin, no less than 1.5 line spacing and no less than an 11 point font size.
   (5) An approved program shall notify the Board when there are substantive changes in the program that alter the length of the program, reorganize course offerings or change in instructors.

485:10-10-3. Curriculum
The curriculum of the Advanced Unlicensed Assistant curriculum shall:
(a) The curriculum of the certification training program shall prepare the graduate for certification and practice as an Advanced Unlicensed Assistant and shall include:
   (1) core skills, personal responsibilities, communication and interpersonal skills;
   (2) content outlines appropriately sequenced and organized to include purpose of procedure, proper equipment, safety precautions and hazards, step-by-step procedure, appropriate disposal of used equipment and materials, documentation and reporting, and legal and ethical responsibilities; and
   (3) classroom/laboratory instruction and supervised clinical practice.
(b) The length of the training program shall be a minimum of 200 hours with the ratio of classroom instruction and practice appropriate to ensure safe and accurate performance. The program shall include at least 80 hours of classroom/laboratory instruction and at least 40 hours of clinical instruction.

485:10-10-5. Applicants
(a) Persons admitted to the program shall provide validation of the ability to safely and accurately perform personal care skills, measuring and recording vital signs, feeding techniques, non-sterile specimen collection, transfer, positioning and turning techniques, infection control, emergency procedures including CPR and the Heimlich maneuver, and non-invasive and non-sterile treatments unless otherwise prohibited by these rules and regulations.
(b) Persons may be admitted into a program that combines training in these skills with training as an Advanced Unlicensed Assistant, provided that the training hours for the Advanced Unlicensed Assistant component meet the requirement under 485:10-10-3(b)(2).

485:10-10-7. Certification
(a) The Board shall establish and maintain a listing (registry) of persons authorized to function as an Advanced Unlicensed Assistant.
(b) An applicant for certification by examination as an Advanced Unlicensed Assistant must meet the following requirements:
(1) has successfully completed the prescribed curricula in a state-approved education program for Advanced Unlicensed Assistants and holds or is entitled to hold a diploma or certificate therefrom; or
(2) has successfully completed an equivalent course approved by the Board in a formal program of instruction in a health-care facility or an educational institution with classroom/laboratory instruction and supervised clinical experience. Evidence must be provided that verifies ability to safely and accurately perform each core skill included in Board-approved Advanced Unlicensed Assistant course;
(3) is a minimum of eighteen (18) years of age on or before the date the certificate is issued
(4) has successfully passed the written and skills certification examinations.
(c) Application for certification:
(1) Applications for certification, accompanied by the appropriate fee, must be complete and filed with the Board in accordance with the procedure designated by the Board. The application must be complete. The required fee must be filed with the application. If the application is not completed within one (1) year, a new application and new fee will be required.
(2) The candidate must will register with the authorized testing service and submit the required fee.
(3) The applicant must will submit an application containing such information as the Board may prescribe.
(d) Fee for certification:
(1) The fees for certification and writing or rewriting the certification examination adopted by the Board shall accompany the applications and is non-refundable.
(2) The fees for rewriting the certification examination adopted by the Board shall be the same as the fee established for the first time writing.
(3) The fee for the examination is not refundable.

485:10-10-8. Recertification
(a) Certification as an Advanced Unlicensed Assistant (AUA) shall be renewed every two years in accordance with the schedule published by the Board.
(b) The application for recertification must be completed and accompanied by the established fee before a new certificate is issued.
(c) The applicant must will submit an application containing such information as the Board may prescribe. If the application is not completed within one (1) year, a new application and new fee will be required.
(d) The application for recertification must be accompanied by one of the following:
(1) verification of employment as an AUA in an acute care setting for a minimum of 12 months within the previous 24 months; or
(2) verification of successful completion of twelve hours of clinical inservice appropriate to the AUA role within the previous 24 months; or
(3) rewriting the certification examination with a passing score, both the written and core skills portions of the exam, within the 24 months immediately preceding renewal of AUA certification; or
(4) verification of initial certification as an AUA within the 24 months immediately prior to renewal of AUA certification.
(e) The fee for renewal of the certificate shall be established by the Board.

485:10-10-8.2. Inactive status
Any Advanced Unlicensed Assistant (AUA) who desires to retire from the practice of advanced unlicensed assistant practice shall:

(a1) Any Advanced Unlicensed Assistant (AUA) who desires to retire from the practice of advanced unlicensed assistant practice shall submit a written request to be placed on the Inactive List.
(b2) The Board, upon the date of the transfer to inactive status, will be the same as the date of approval by the Board. The Board may delegate approval of the certificate holder’s request to be placed on inactive status to the Board Staff.
(c3) A certificate holder shall remain on the Inactive List unless otherwise indicated without the payment of the renewal fee.
(d4) The return to active status fee shall be due when the certificate holder desires to return to active practice. The applicant must submit an application for return to active status containing such information as the Board may prescribe accompanied by the appropriate fee. If the application is not completed within one (1) year, a new application and new fee will be required.
(e5) A have an application to return to active status for a certificate that has been placed on Inactive Status by Order of the Board shall be considered by the Board.
(f6) In addition to meeting other requirements to return to active status as established by the Board in these Rules, if the certification has been on the Inactive List, the application for reinstatement must be accompanied by one of the following:
(1A) verification of employment as an AUA in an acute care setting for a minimum of 12 months within the previous 24 months; or
(2B) verification of successful completion of twelve hours of clinical inservice appropriate to the AUA role within the previous 24 months; or
(3C) rewriting the certification examination with a passing score, both the written and core skills portions of the exam; or
(4D) verification of initial certification as an AUA within the 24 months immediately prior to reinstatement of AUA certification.

SUBCHAPTER 13. REQUIREMENTS FOR EMPLOYMENT
485:10-13-1. Conditions of employment

Conditions of employment require:
(a) Any person who practices or offers to practice nursing or represents himself or herself as a licensed nurse, excluding federal employment, shall possess a valid Oklahoma license.
(b) Any individual offering to practice advanced practice registered nursing as an CNP, CNS, CMN, CRNA, shall possess a valid Oklahoma license as an Advanced Practice Registered Nurse issued by the Board.
(c) A valid temporary license shall be required in lieu of a full certificate of licensure.
(d) Any person employed as a Nurse Administrator, as defined in these rules, shall possess a valid license to practice nursing in Oklahoma, except as otherwise provided by law.
(e) If the term "doctor" is used by a licensed nurse holding the appropriate educational credentials, such usage must be in accordance with 59 O.S. Supp. 2009, §725.1, et seq.

485:10-13-2. Annual report of employing institutions [REVOKED]

The nursing administrator in each licensed health institution or agency may be requested to file an annual report each year. The report, when requested, shall be filed in a format established by the Board. The report is to indicate the name, certificate number and expiration date of each Licensed Practical Nurse, Registered Nurse and Advanced Practice Registered Nurse employed on the designated date.

485:10-13-3. Continuing education [REVOKED]

Each licensed health institution and agency is advised to provide opportunities for Licensed Practical Nurses, Registered Nurses, and Advanced Practice Registered Nurses to maintain a sound knowledge of current nursing practices and procedures. Such opportunities include orientation, skill training, continuing education, and leadership development.

SUBCHAPTER 15. REQUIREMENTS FOR PRACTICE AS AN ADVANCED PRACTICE REGISTERED NURSE

485:10-15-5. Renewal, reinstatement and inactive status of licensure

(a) Renewal. Advanced Practice Registered Nurse renewal shall:
(1) Renewal shall be concurrent with the two-year licensure renewal for Registered Nurse.
(2) The renewal form shall include a statement that the nurse's national certification is current and that certification will be maintained during the period of licensure renewal.
(3) Each Advanced Practice Registered Nurse shall submit submission of a copy of a current national certification document to the Board with the renewal form, if requested.
(b) Reinstatement.
(1) If an Advanced Practice Registered Nurse fails to renew licensure prior to the expiration date of that license, the advanced practice license shall lapse.
(2) The applicant may request reinstatement of advanced practice licensure by submitting a completed application and the required fee. If the application is not completed within one (1) year, a new application and new fee will be required. If the reinstatement is not approved within two (2) years of the expiration date of licensure, the applicant must meet current requirements for initial advanced practice licensure.
(3) The applicant must submit an application containing such information as the Board may prescribe.
(4) In addition to meeting other requirements for reinstatement established by the Board in these Rules, if the Oklahoma APRN license has not been in an active licensure status for a period of two (2) years or more, the applicant for reinstatement of the APRN license must demonstrate continued qualifications for practice through completion of one or more of the following requirements within the last two (2) years prior to receipt of a completed application in the Board office:
(A) Submission of an official transcript or certificate of completion verifying completion of an APRN nursing refresher course meeting the requirements established by the Board in policy;
(B) Submission of an official transcript verifying successful completion of at least six (6) academic semester credit hours of APRN nursing courses in the same role and population focus as was previously held by the APRN in a graduate-level APRN program, which includes classroom and clinical instruction; and/or
(C) Present evidence of licensure or recognition as an APRN in another state with employment in a position that requires APRN licensure or recognition with verification of at least 520 work hours during the past two (2) years preceding receipt of the application for reinstatement in the Board office.
(D) Submission of evidence of current national certification consistent with educational preparation and by a national certifying body recognized by the Board.

(c) Inactive Status.
(1) An Advanced Practice Registered Nurse may submit a written request to place advanced practice licensure on inactive status.
(2) The date of inactive status will be the date of approval by the Board.
(3) The Board may delegate approval to place advanced practice licensure on inactive status to Board staff.
(4) The applicant may request return-to-active status of advanced practice licensure by submitting a completed...
application containing such information as the Board may prescribe and the required fee. If the application is not completed within one (1) year, a new application and new fee will be required. If the advanced practice license has been on inactive status for two or more years, the applicant must meet current requirements for initial advanced practice licensure.

(5) In addition to meeting other requirements for return to active status established by the Board in these Rules, if the Oklahoma APRN license has not been in an active licensure status for a period of two (2) years or more, the applicant for return to active status of the APRN license must demonstrate continued qualifications for practice through completion of one or more of the following requirements within the last two (2) years prior to receipt of a completed application in the Board office:

(A) Submission of an official transcript or certificate of completion verifying completion of an APRN nursing refresher course meeting the requirements established by the Board in policy;
(B) Submission of an official transcript verifying successful completion of at least six (6) academic semester credit hours of APRN nursing courses in the same role and population focus as was previously held by the APRN in a graduate-level APRN program, which includes classroom and clinical instruction;
(C) Present evidence of licensure or recognition as an APRN in another state with employment in a position that requires APRN licensure or recognition with verification of at least 520 work hours during the past two (2) years preceding receipt of the application for return to active status in the Board office;
(D) Submission of evidence of current national certification consistent with educational preparation and by a national certifying body recognized by the Board.

[OAR Docket #21-444; filed 6-14-21]

TITLE 540. PHYSICIAN MANPOWER TRAINING COMMISSION
CHAPTER 30. OKLAHOMA NURSING STUDENT ASSISTANCE PROGRAM

[OAR Docket #21-495]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
540:30-1-2 [AMENDED]
Subchapter 3. Role of Nursing Scholarship Advisory Committee
540:30-3-1 [AMENDED]
Subchapter 5. Categories of Scholarships
540:30-5-1 [AMENDED]
540:30-5-2 [AMENDED]
Subchapter 7. Eligibility
540:30-7-1 [AMENDED]
540:30-7-2 [AMENDED]
540:30-7-4 [AMENDED]
Subchapter 9. Application Process
540:30-9-1 [AMENDED]

540:30-11-1 [AMENDED]
540:30-11-2 [AMENDED]
540:30-11-3 [AMENDED]
540:30-11-5 [AMENDED]
540:30-11-6 [AMENDED]
Subchapter 15. General Administrative Policies
540:30-15-1 [AMENDED]
Subchapter 17. Service Obligation
540:30-17-2 [AMENDED]

AUTHORITY:
Physician Manpower Training Commission; 70 O.S., § 697.17

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Approved June 11, 2021 by HJR 1046

FINAL ADOPTION:
June 11, 2021

EFFECTIVE:
August 26, 2021

SUPERSEDED EMERGENCY ACTIONS:

INTEGRATIONS BY REFERENCE:

GIST/ANALYSIS:
The Board of Commissioners of the Physician Manpower Training Commission has adopted the proposed changes for the Oklahoma Nursing Student Assistance Program.

The proposed changes would expand to higher nursing degree programs, expand eligible facilities to fulfill obligations and increase the amount of awards for the Oklahoma Nursing Student Assistance Program to be consistent with other PMTC programs and meet the current nursing needs across all of rural Oklahoma. This change has no fiscal impact to the agency.

The proposed changes are in an effort to align PMTC programs providing consistent practices in providing greater assistance in recruiting nurses across rural Oklahoma.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS

540:30-1-2. Scope of program
Scholarship loans are available for study prerequisite to licensure as a Practical Nurse, Registered Nurse, or the awarding of a Master's Degree in Nursing or higher and for the upward mobility of LPN's and AD and Diploma RN's to Baccalaureate in Nursing. The Nurse Education Scholarship
Program is a loan program, with repayment to be made through work service to the sponsor. Loan paybacks would be based on one year of service for each academic year in the program, with a minimum of one year service obligation. For students enrolled in the BSN program, funding is available for only the last two years of study. For students enrolled in the MSN-NP, MSN-EDU, DNP or Ph.D. programs, funding is available for two to five years.

SUBCHAPTER 3. ROLE OF NURSING SCHOLARSHIP ADVISORY COMMITTEE

540:30-3-1. Role of Nursing Scholarship Advisory Committee

(a) A Nursing Scholarship Advisory Committee (NSAC) shall assist and advise the Physician Manpower Training Commission relative to the Nursing Student Assistance Program.

(b) Recipients will be selected by the Physician Manpower Training Commission assisted by recommendations of a twelve member Nursing Scholarship Advisory Committee. The Nursing Scholarship Advisory Committee will be appointed by the Physician Manpower Training Commission and will consist of:

1. a Rural Hospital Nursing Service Administrator, representing the Oklahoma Organization of Nurse Executives,
2. an Urban Hospital Nursing Service Administrator, representing the Oklahoma Organization of Nurse Executives,
3. a representative of the Oklahoma Nursing Home Association,
4. a representative of the Oklahoma Hospital Association,
5. a representative of the Oklahoma League for Nursing,
6. a representative of the Oklahoma State Association of Licensed Practical Nurses,
7. three Educators (a representative of the Oklahoma Directors of Practical Nursing Education; a representative of the Associate Degree Nursing Director's Council, and a representative of the Baccalaureate and Higher Degree Nursing Programs),
8. a lay community representative, and
9. a representative from the Physician Manpower Training Commission.

(c) The role of the Nursing Scholarship Advisory Committee will be delineated by the Physician Manpower Training Commission.

SUBCHAPTER 5. CATEGORIES OF SCHOLARSHIPS

540:30-5-1. Matching Nursing Student Assistance Program

(a) Scholarships granted under the Matching Nursing Student Assistance Program shall stipulate that a sponsor and the Physician Manpower Training Commission provide equal dollar amounts for funding the scholarships. The maximum amounts that can be matched are $750.00 per full-time semester for LPN program, $1,250 per full-time semester for an ADN program, $1,750.00 per full-time semester for the BSN program, and $2,500.00 per full-time semester (up to 4 years) for MSN/DNP/Ph.D. program.

(b) Sponsors of nurse students may be hospitals, nursing homes, home health and hospice agencies, other health care delivery facilities, public agencies, corporations, private organizations, communities, foundations, trusts, or other entities who wish to apply for and, if approved, match an amount equal to fifty percent of the loan authorized by the Commission.

(c) Under the provisions of the Matching Nursing Student Assistance Program, a student may receive a minimum total matching scholarship of $1,000 - ($500/$500), up to a maximum total matching scholarship of $5,000 - ($2,500/$2,500) an equal full scholarship amount from both the sponsor and the Physician Manpower Training Commission. The monies are to be used for payment of tuition, required fees, equipment, uniforms, training materials, books, certification exams, and other educationally related expenses necessary for attendance at nursing school.

(d) An approximate guideline of seventy percent of all monies appropriated for the Physician Manpower Training Commission Nursing Student Assistance Program may be used for funding scholarships approved under the Matching Nursing Student Assistance Program. Approximately seventy percent of all funds designated for the Matching Nursing Student Assistance Program may be expended for nursing scholarships in Oklahoma communities with a population under 20,000 that meets the current definition of rural as determined by PMTC. A mix of 25% urban/75% rural should serve as a proportionate split of funds if possible.

(e) Scholarship recipients may carry out their service obligation by practicing full time as a licensed practical or registered nurse (excluding physician's offices, private duty practice, research or non-patient based facilities, federally funded program or facility, industrial and summer camp nursing) as agreed to by contract or with Commission approval.

(f) Scholarship recipients may carry out their service obligation by teaching in an accredited/approved Oklahoma nursing school (provided other Oklahoma Board of Nursing faculty qualifications are met).

(g) Scholarship recipients who become nurse practitioners may carry out their service obligation by practicing full time as a nurse practitioner at any non-federal Oklahoma hospital, nursing home, state health facility, qualified rural health clinic, or non-federal hospital, private owned, or leased rural physician clinic.

(h) Receipts received from sponsors shall be deposited into and disbursed from a Commission revolving fund created by State Law in the State Treasury.
540:30-5-2. Non-Matching Nursing Student Assistance Program

(a) State funds appropriated to the Nursing Student Assistance Program shall be used to grant scholarships under the Non-Matching Student Assistance Program. The maximum amounts that can be awarded are $750.00 per full-time semester for LPN program, $1,250 per full-time semester for an ADN program, $1,750.00 per full-time semester for the BSN program, and $2,500.00 per full-time semester (up to 4 years) for MSN/DNP/Ph.D. program.
(b) Scholarship recipients may carry out their service obligation by practicing full time as a licensed practical or registered nurse (excluding physician's offices, private duty practice, research or non-patient based facilities, federally funded program, or facility, industrial and summer camp nursing) as agreed to by contract or with Commission approval.
(c) Scholarship recipients may carry out their service obligation by teaching in an accredited/approved Oklahoma nursing school (provided other Oklahoma Board of Nursing faculty qualifications are met).
(d) Scholarship recipients who become nurse practitioners may carry out their service obligation by practicing full time as a nurse practitioner at any non-federal Oklahoma hospital, nursing home, state health facility, qualified rural health clinic, or non-federal hospital, private owned or leased rural physician clinic.
(e) Under the provisions of the Non-Matching Nursing Student Assistance Program, the student can receive a scholarship loan in the amount of $2,500 for a given academic year, these monies to be paid for payment of tuition, required fees, training materials, books, and other educationally related expenses necessary for attendance at nursing school.
(f) In awarding grants for the Non-Matching Nursing Student Assistance Program, seventy percent of the designated monies may be earmarked for scholarship recipients who are deemed likely to return to a rural community to practice nursing.

SUBCHAPTER 7. ELIGIBILITY

540:30-7-1. Domicile

(a) For the purpose of obtaining a scholarship loan in accordance with the provisions of the Nursing Student Assistance Program, a person must be required to have maintained domicile in the State of Oklahoma for at least twelve months immediately prior to a request for residency status and must be a citizen of the United States.
(b) In order to be eligible for classification as a legal resident under this program, an individual must establish physical presence in the State during such twelve month period for the purposes of mere temporary residency incidental to enrollment in an educational program, or for application for a loan under this program.
(c) In some cases, it may be necessary to conduct an inquiry into the question of domiciliary intent. If so, an applicant may be requested to provide an appropriate application for analysis on forms to be made available by the Commission.

(d) A student must be required to qualify for payment of in-state tuition and fees when attending a state supported school.

540:30-7-2. Acceptance in a course of study

(a) An applicant Qualifying applicants will have must have been unconditionally admitted as a student in an Oklahoma accredited/approved program of nursing study. Each applicant must submit certification of acceptance and/or of being a student in good standing, academically and otherwise, by the Dean or Director of the nursing school he or she attends or plans to attend. This must certification is to be submitted as a part of the application process. Enrollment in basic courses prerequisite to and/or leading to a nursing program does not qualify an applicant.
(b) Part time nursing students may be considered on an individual basis as a qualified applicant. Evidence of progression within a nursing program must is to be shown each provided semester.
(c) If already attending school, a student must have been unconditionally promoted is to submit documentation of unconditional promotion to the succeeding class with the exception of a part-time student who must shows evidence of progress.

540:30-7-4. Criteria for selection of recipients

The following criteria shall be used for the selection of recipients of nursing scholarship loans:
(1) Academic capability. Must maintain a 3.0 overall GPA.
(2) Motivation to practice in a critical shortage area as defined by the Commission (with emphasis on rural practice).
(3) Agreement to work in an institution, community or agency matching funding with the Commission (if appropriate).
(4) Financial need - only if the number of applicants exceed the availability of funds.

SUBCHAPTER 9. APPLICATION PROCESS

540:30-9-1. Interview; application

(a) Interview. An interview with a representative of the Commission is required before an application is approved for a matching scholarship recipient.
(b) Application form. An application form is provided with the confirmation of an interview. The application form consists of:
   (1) General information.
   (2) Statement regarding financial needs.
   (3) Statement of professional goals.
(c) Supporting information. The following supporting application information may be required:
   (1) Certification of unconditional acceptance or promotion, whichever is applicable for the application.
Permanent Final Adoptions

(2) A letter certifying unconditional acceptance and/or being a student in good standing by nursing school director.
(3) A letter or transcript showing high school GPA or GED score for LPN students;
(4) A letter or transcript showing ACT score, college and/or high school GPA for ADN, BSN, or MSN students;
(5) Current Federal Income Tax form 1040, 1040A, or 1040EZ or proper certification if it is not necessary to file Federal Income Tax form. Dependent applicants must provide parent's income tax form in addition to their own form.
(d) Date due. The application form and supporting information must be received by the commission by the applicable due date set by the Commission.

SUBCHAPTER 11. LOAN PROVISIONS

540:30-11-1. Repayment of discontinued loans
If a loan recipient for whatever reason becomes ineligible to continue participation in the program and repayment is required, then cash repayment (principal and interest) is due within 90 days of the date of the Commission's written notification of ineligibility to the recipient.

540:30-11-2. Penalty for breach of contract
In the event that a loan recipient breaches the terms of the contract, he/she may be assessed liquidated damages which represent a reasonable estimate of the damage or loss of the State and/or the sponsor (if applicable). Said damages shall be at least 100% of the principal.

540:30-11-3. Security for the loan
(a) Each loan must be secured by a contract signed by the recipient and spouse if applicable.
(b) Each loan must be secured by a contract signed by the recipient and a parent if the recipient is under 23 years of age and an unemancipated minor.
(c) If a recipient shows little or no income, each loan must be secured by a contract signed by the recipient and the person providing support for the recipient.

540:30-11-5. Rate of interest Fees
The rate of interest on a nursing scholarship loan will be 12% per annum. The yearly fee of 5% on the unpaid balance of the principal for each year with a minimum of $50.00 for administrative costs. It will be due July 1 of each year that the loan is being serviced.

540:30-11-6. Suit for collection; attorney's fees and collection costs
If it becomes necessary for the Attorney General, on behalf of the State and Commission, to file suit for collection of a loan for notes, the makers of the note shall be responsible for attorney's fees and other costs or charges necessary for the collection of the balance due on the loan. Any collection under this Section will be deposited in the Revolving Fund. That portion representing a contribution(s) by a sponsor may be returned to the sponsor, placed to the sponsor's credit or retained by the Physician Manpower Training Commission as is appropriate.

SUBCHAPTER 15. GENERAL ADMINISTRATIVE POLICIES

540:30-15-1. Installments to recipients
(a) The Commission will pay the loan proceeds in monthly installments or in a lump sum if the NSAC so recommends.
(b) Where applicable, the installments will be paid upon certification by an Officer of the school of satisfactory performance and transcript verifying GPA requirement and proof of enrollment for the following semester or registration for the NCLEX by the scholarship recipient at the end of each semester.

SUBCHAPTER 17. SERVICE OBLIGATION

540:30-17-2. Licensure examinations
(a) Following the completion of required coursework, licensure examinations must be written and completed as soon as possible after notification of eligibility;
(b) If the recipient fails to pass the first two successive licensure examinations offered following the completion of required coursework, the recipient's note(s) become due and payable.

TITLE 540. PHYSICIAN MANPOWER TRAINING COMMISSION
CHAPTER 35. COMMUNITY MATCH INTERN RESIDENT PROGRAM

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CHAPTER 45. PHYSICIAN ASSISTANT SCHOLARSHIP PROGRAM

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RULEMAKING ACTION: PERMANENT final adoption
RULES: 540:45-1-3 [AMENDED]
AUTHORITY: Physician Manpower Training Commission; 70 O.S., § 697.21 and 625.4.
SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
May 4, 2020
COMMENT PERIOD: April 1, 2020 through May 1, 2020
PUBLIC HEARING:
May 1, 2020
ADOPTION:
June 11, 2021
EFFECTIVE:
August 26, 2021
SUPERSEDED EMERGENCY ACTIONS:
n/a
INCORPORATIONS BY REFERENCE:
n/a
GIST/ANALYSIS:
The Board of Commissioners of the Physician Manpower Training Commission, has adopted the proposed changes to the approved rural obligated practice locations, provided by the Commission, for the Community Match Intern Resident Program.
The changes define the obligated rural practice location for the Community Match Intern Resident Program to be consistent with other PMTC programs and meet the current provider needs across all of rural Oklahoma. This change has no fiscal impact to the agency.
The changes are in an effort to align PMTC programs providing consistent practices in providing assistance in recruiting providers across rural Oklahoma.
CONTACT PERSON:
Janie S. Thompson, Executive Director, (405) 604-0020, janie.thompson@pmtc.ok.gov or for legal questions: Joe Ashbaker, Assistant Attorney General, (405) 522-2974, Joe.Ashbaker@oag.ok.gov.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

540:35-1-3. Power to grant loans
The Physician Manpower Training Commission shall be authorized and empowered to grant loans to qualified individuals who have completed a degree of Doctor of Medicine or Doctor of Osteopathic Medicine, and who have completed an intern/residency program in a primary care specialty (Family Practice, General Practice, Internal Medicine, Pediatrics, OB/GYN, Emergency Medicine, or General Surgery), or other specialty as approved by the Commission on an individual basis. The loans shall be provided through participation with communities considered by the Physician Manpower Training Commission to be medically underserved. Priority shall be given to underserved rural communities with a population of less than 10,000, which qualify under the current rules approved by the Commission and State Legislature rural Oklahoma communities outside the Oklahoma City and Tulsa metropolitan service areas and approved by the Commission. Assistance shall be on a matching basis between state and community (40%) and community (60%-40%). The Physician Manpower Training Commission reserves the right to disapprove an application.

[OAR Docket #21-496; filed 6-15-21]
These changes also provide revision to change restrictive phrases in the rules, and replace the emergency rules approved January 27, 2020.

CONTACT PERSON:
Janie S. Thompson, Executive Director, (405) 604-0020, janie.thompson@pmtc.ok.gov or for legal questions: Joe Ashbaker, Assistant Attorney General, (405) 522-2974, Joe.Ashbaker@oag.ok.gov.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

540:50-1-5. Amount and method of payment
(a) Physicians and physician assistants would have to provide documentation of legitimate educational debt in the amount of $160,000/$200,000/$60,000 or above to receive the maximum amount available. If total debt is less than $160,000/$200,000/$60,000 a contract would be tailored, on a prorated basis, to provide an amount not to exceed legitimate educational debt of the physician or physician assistant. Prior to any disbursement, the Commission will—pay liquidated damages, repayment of the principal may be made in cash with interest at a rate that equals the prime interest rate plus one percent (1%) from the date of disbursement of the funds.

[OAR Docket #21-497; filed 6-15-21]

TITLE 540. PHYSICIAN MANPOWER TRAINING COMMISSION
CHAPTER 50. OKLAHOMA MEDICAL LOAN REPAYMENT PROGRAM

[OAR Docket #21-498]
The supervisor-trainee relationship shall become required hours of continuing education. Board-approved courses will count towards the required hours of continuing education. Evidence for continuing education requirements may be taken live or may be Board-approved courses offered by distance education as defined by the Appraiser Qualifications Board, which keeps the State of Oklahoma in compliance with federal criteria; the other redactions remove outdated language in response to the Governor's Executive Order on rule regulation (EO2020-03).

CONTACT PERSON:
Ashley Scott, Government and Community Affairs Director, 400 NE 50th Street, OKC, OK 73105, (405) 521-6616, Ashley.scott@oid.ok.gov.

600:10-1-7. Continuing education
(a) All Trainee, State Licensed, State Certified General Appraisers shall complete the minimum classroom hours set forth in the Appraiser Qualification promulgated by the Appraiser Qualifications Board of the Appraisal Foundation for the three (3) year period preceding renewal. These hours may be obtained any time during the three-year period which concludes on the expiration date printed on the certificate.
(b) Copies of official transcripts of college records or certificates of course completion will be considered as satisfactory evidence for continuing education requirements.
(c) Up to one half of the required hours of continuing education may be taken live or may be Board-approved courses offered by distance education as defined by the Appraiser Qualification Criteria of the Appraiser Qualifications Board of the Appraisal Foundation.
(d) As a part of the continuing education requirement, all Trainee, State Licensed, State Certified Residential and State Certified General Appraisers must successfully complete the seven (7) hour National USPAP Update Course, or an approved equivalent, every two calendar years, commencing on January 1, 2005.

600:10-1-16. Supervision of trainee appraisers
(a) Trainee Appraisers shall report to the Board, on a form prescribed by the Board, the identity of any supervisory appraiser. Trainee Appraisers may have more than one supervisory appraiser. When a Trainee Appraiser has more than one supervisory appraiser, each shall be reported to the Board as indicated above.
(b) The supervisor-trainee relationship shall become effective on the date of receipt of the original required form with original signatures in the administrative office of the Board.
(c) A supervisory appraiser shall notify the Board in writing immediately when supervision of a Trainee Appraiser has been terminated by the supervisory appraiser or the Trainee Appraiser.
(d) Trainee Appraisers shall maintain an appraisal log on a form prescribed by the Board. Separate appraisal logs shall be maintained for work performed with each supervisory appraiser. This appraisal log shall record the following information:
(1) Client name and date of report,
(2) Address or legal description of the real property appraised,
(3) Description of the work performed by the trainee appraiser and the scope of review and supervision of the supervisory appraiser,
(4) Number of actual hours worked,
(5) Type of property appraised,
(6) Form number or description of report rendered, and
(7) The signature and state certificate number of the supervisory appraiser.
(e) Experience credit for the purpose of upgrading will not be given unless:
(1) a properly completed trainee-supervisory report form is on file in the administrative office of the Board, and
(2) the Trainee Appraiser either signs the certification required by Standards Rule 2-3 of the Uniform Standards of Professional Appraisal Practice, or the supervisory appraiser gives credit to the Trainee Appraiser in the certification and complies with the requirements of Standards Rule 2-2(a)(vii), 2-2(b)(vii), or 2-2(c)(vii) as applicable.
(f) Both supervisory and trainee appraisers shall maintain complete workfiles as required by the Uniform Standards of Professional Appraisal Practice and the Oklahoma Certified Real Estate Appraisers Act.
(g) A supervisory appraiser shall meet the following requirements:
(1) be a State Certified General Appraiser or a State Certified Residential Appraiser on a credential issued by the Board for a period of at least three years;
(2) be in good standing with the Board and not have been subject to any disciplinary action with any jurisdiction within the last three years that affects the supervisory appraiser's legal eligibility to engage in appraisal practice.
(3) accept responsibility for training, guidance, and direct supervision of the Trainee Appraiser by signing the form referenced in (a), above.
(4) must successfully complete a Board-sponsored course for trainees and supervisors; provided however, that supervisors in place as of the effective date of this...
rule must successfully complete this course within one (1) year following the effective date of this rule.
(5) Supervisory appraisers must comply with the COMPETENCY RULE of USPAP for the property type and geographic location where the Trainee Appraiser is being supervised.

(f) A supervisory appraiser shall:
(1) accept responsibility for a Trainee Appraiser’s appraisal reports by signing each report and certifying that the report is in compliance with the Uniform Standards of Professional Appraisal Practice, and
(2) personally inspect each appraised property with the Trainee Appraiser until the supervisory appraiser determines that the Trainee Appraiser is competent, in accordance with the Competency Rule of the Uniform Standards of Professional Appraisal Practice, for the property type.

(g) A supervisory appraiser shall notify the Board immediately when supervision of a Trainee Appraiser has been terminated by the supervisory appraiser or the Trainee Appraiser.

(h) Prior to assuming duties as a supervisory appraiser, an appraiser who has been disciplined by the Board must receive approval from the Board.

(i) A supervisory appraiser may assume responsibility for more than three Trainee Appraisers under the following terms and conditions:
(1) The supervisor must apply for authority to supervise more than three Trainee Appraisers with the Board on forms approved by the Board for this purpose. This approval shall extend to the supervisor or supervisors, the facility and the training plan. Any approval issued hereunder shall specify a maximum number of trainees authorized.
(2) The supervisor must maintain the facility to be used for this purpose, which may not be a residence. The facility must have posted hours, approved by the Board, during which the facility will be open and a qualified supervisor present. During the operating hours, the facility and all records specified herein shall be subject to unannounced compliance inspection by a representative of the Board.
(3) The supervisor must prepare a training plan, based on the Core Curriculum and the Real Property Appraiser Body of Knowledge promulgated by the Appraiser Qualification Board of the Appraisal Foundation, appropriate to the level of licensure to which the trainee aspires and for which the supervisor is qualified. This training plan should, as a minimum, include learning objectives for the experience to be gained, a planned time line for further qualifying and continuing education required to bring the trainee to a fully qualified status, and a checklist for monitoring progress by the trainee toward meeting these objectives.
(4) Records maintained in the training facility must include the training plan, an appraisal log, a workfile for each appraisal assignment, and a progress checklist, each maintained on a contemporaneous basis, for each Trainee Appraiser. In addition, appropriate reference materials should be on hand, which must include the current edition of the USPAP.

(j) Approval of any supervisor or supervisors under this paragraph may be conditioned upon an interview of such supervisors by a representative of the Board.

(TITLE 600. REAL ESTATE APPRAISER BOARD
CHAPTER 30. APPRAISAL MANAGEMENT COMPANY REGISTRATION

RULEMAKING ACTION: PERMANENT final adoption
RULES: 600:30-1-4. Fee Schedule [AMENDED]
AUTHORITY: Real Estate Appraiser Board; 59 O.S., § 858-829
SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY: November 3, 2020
COMMENT PERIOD: December 2, 2020 through January 4, 2021
PUBLIC HEARING: January 8, 2021
ADOPTION: January 29, 2021
SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE: January 29, 2021.
LEGISLATIVE APPROVAL: Approved June 11, 2021 by HJR 1046
FINAL ADOPTION: June 11, 2021
EFFECTIVE: September 1, 2021
SUPERSEDED EMERGENCY ACTIONS: N/A
INCORPORATIONS BY REFERENCE: N/A
GIST/ANALYSIS: The proposed rule amendments would modify the fee schedule for Appraisal Management Companies registering with the Real Estate Appraiser Board. The fees have not been increased since implementation in 2011 and would put the State of Oklahoma in alignment with other states’ fee schedules. The proposed amendments would allow an additional staff person to be hired, to assist with the workload of the Board. Currently there are only three staff people. Employee turnover, vacations and the like puts enormous pressure on the individuals to stay in compliance. Being able to add an additional staff person would improve compliance.
CONTACT PERSON: Ashley Scott, Government and Community Affairs Director, 400 NE 50th Street, OKC, OK 73105, (405) 521-6616, Ashley.scott@oid.ok.gov.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED
FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

605:30-1-6. Fee schedule
(a) It is the finding of the Board that the sum of the fees paid by all AMCs registering or renewing a registration under the Oklahoma Appraisal Management Company Regulation Act that would be sufficient for the administration of the Act requires that an annual fee of one thousand five hundred dollars ($1,500.00) be imposed.
(b) The Department shall charge and collect fees as follows:
1. Certificate of Registration (original and renewal) $1,000.00
2. Certificate of Registration $1,500.00
3. Late Fee $100.00
4. Dishonored Check Fee Costs of collection plus $25.00

(c) In addition, the Department shall charge and collect a National Registry Fee in such amount as may be assessed by the Appraisal Subcommittee for all AMCs holding a Certificate of Registration. Said fees shall be transmitted by the Department to the Appraisal Subcommittee.
(d) Notwithstanding any other provision, a Certificate of Registration shall be suspended instanter should payment of any fees be dishonored by the issuing institution for any reason. In such case, the Director shall take immediate steps to provide notification to the Appraisal Subcommittee for inclusion on the National Registry, and to notify the registrant that the Certificate of Registration has been suspended by certified mail, return receipt requested.

[OAR Docket #21-419: filed 6-14-21]

TITLE 605. OKLAHOMA REAL ESTATE COMMISSION
CHAPTER 10. REQUIREMENTS, STANDARDS AND PROCEEDURES

[OAR Docket #21-470]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 5. Instructor and Entity Requirements and Standards
605:10-5-1 [AMENDED]
605:10-5-1.1 [AMENDED]
605:10-5-2 [AMENDED]
605:10-5-3 [AMENDED]
Subchapter 7. Licensing Procedures and Options
605:10-7-2 [AMENDED]
605:10-7-4 [AMENDED]
605:10-7-5 [AMENDED]
605:10-7-6 [AMENDED]
605:10-7-7 [AMENDED]
605:10-7-8 [AMENDED]
605:10-7-8.2 [REVOKED]
605:10-7-8.4 [AMENDED]
605:10-7-11 [AMENDED]
Subchapter 9. Broker's Operational Procedures
605:10-9-1 [AMENDED]
605:10-9-3 [AMENDED]
Subchapter 11. Associate's Licensing Procedures
605:10-11-1 [AMENDED]
605:10-11-3 [REVOKED]
Subchapter 17. Causes for Investigation; Hearing Process; Prohibited Acts; Discipline
605:10-17-2 [AMENDED]
605:10-17-3 [AMENDED]
605:10-17-4 [AMENDED]

AUTHORITY:
Oklahoma Real Estate Commission; 59 O.S., § 858-208

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
January 25, 2021

PUBLIC HEARING:
March 24, 2021

ADOPTION:
March 24, 2021

SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:
April 1, 2021

LEGISLATIVE APPROVAL:
Approved June 11, 2021 by HJR 1046

FINAL ADOPTION:
June 11, 2021

EFFECTIVE:
November 1, 2021

SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
The amendments to Subchapter 5 remove late fees, requirements that licensees renew their license by the 10th day of the month their license expires, removed complex proration calculation for sales associates and broker associated switching license types to managing broker or broker proprietor, removes arbitrary mandatory waiting times for provisional sales associates who successfully complete post-license education requirements, modifies activate of licensure fee, and provides for electronic license request submissions. The proposed revocation of Section 605:10-7-8.2 removes an unnecessary rule regarding licensing of limited liability companies/associations.

The amendments to Subchapter 9 remove the outdated requirement that paper licenses must be maintained in the place of business, and removes the requirement that an associate must have a paper license physically sent to the office they are affiliated with.

The amendments to Subchapter 11 update language to account for the Commission's change from paper to digital licenses and removes the requirement that brokers must send paper licenses back to the Commission upon the release of an associate. The revocation of Section 605:10-11-3 removes an unnecessary rule regarding entities formed by associates to receive payment of commissions.

The amendments to Subchapter 17 streamline investigations and disciplinary hearings before the Commission and allows for faster complaint resolution while maintain the full Commission's authority and role in approving formal hearings prior to scheduling and maintains Commissioner approval for all final disciplinary actions and orders.

CONTACT PERSON:
Grant Cody, Executive Director, Oklahoma Real Estate Commission, 1915 N. Stiles Ave., Suite #200, Oklahoma City, OK 73105-4915, 405-521-3387, Grant@orec.ok.gov

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF NOVEMBER 1, 2021:

SUBCHAPTER 5. INSTRUCTOR AND ENTITY REQUIREMENTS AND STANDARDS
605:10-5-1. Approval of pre-license course
(a) Course approval. Any person or entity seeking to conduct an approved course of study shall make application and submit documents, statements and forms as may reasonably be required by the Commission. The request shall include the following:

1. Completed course application.
2. Application fee of One Hundred Twenty-five Dollars ($125.00) for each course.
3. An approved course syllabus encompassing the contents enumerated in 605:10-3-1 and divided by instructional periods, the name, author and publisher of the primary textbook, or a statement stating the entity will use the OREC syllabus and other items as may be required by the Commission.

(b) Course offering requirements.
1. An entity not conducting an applicable approved course within any thirty-six (36) month period shall automatically be removed from approved status. In such event, the person and/or entity must re-apply as an original applicant.
2. If a course of study is to be conducted in the name of a corporation, the application shall include the names and addresses of all directors and officers.
3. An approved entity shall immediately report any changes in information in regards to the application previously filed with the Commission.

(c) Denied applications. No portion of the fees enumerated in this section are refundable. If an instructor, entity or course application is not approved, the applicant may appeal the decision by filing a written request for a hearing before the Commission. The hearing procedure shall be that as outlined in 605:10-1-3 titled "Appeal of administrative decisions; procedures."

(d) Advertising course offerings. No person or entity sponsoring or conducting a course of study shall advertise the course as approved prior to the course receiving approval from the Commission. Further, no person or entity sponsoring or conducting a course of study shall advertise that it is endorsed, recommended or accredited by the Commission although such person or entity may indicate that a course of study has been approved by the Commission.

(e) Instructor application and approval requirements. An individual determined by the Commission to possess one or more of the following qualifications may, upon receipt of an application and evidence of education and/or experience, be considered for approval as an approved instructor. Each application for approval must be accompanied by a Twenty-Five Dollar ($25.00) application fee, and documentation required for compliance necessary to verify citizenship, qualified alien status, and eligibility under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. In order to qualify, an individual must possess proof of one of the following:

1. A bachelor's degree with a major in real estate from an accredited college or university.
2. A bachelor's degree from an accredited college or university, and at least two (2) years of applicable active experience within the previous ten (10) years as a real estate broker or sales associate.
3. A real estate broker or sales associate licensed in Oklahoma with a minimum of five (5) years applicable active experience within the previous ten (10) years as a real estate broker or sales associate and proof of high school education or its GED equivalent.
4. An individual determined by the Commission to possess a combination of education and/or applicable active broker or sales associate experience in real estate or real estate related fields which constitutes an equivalent to one or more of the qualifications in paragraphs (1), (2), or (3) of this subsection.

(f) Course content examination. Final approval will be considered after the instructor applicant has paid the appropriate examination fee and successfully completed an applicable examination with a passing score of 80% or more. If an instructor applicant has successfully taken an applicable license examination with a passing score of 80% or more within thirty (30) days of filing an instructor application, the passing score may be utilized to meet the applicable examination requirement in this section.

(g) Instructor renewal requirements.
1. In order to maintain approved status, an instructor must comply with complete one of the following:

(A) Attend a Commission directed Instructor Renewal Course every twenty-four (24) months or successfully complete nationally recognized teacher education modules consisting of at least 3 clock hours of credit as approved by the Commission.
(B) Complete one of the following:

(i) Furnish evidence that the instructor has taught a Commission approved pre-license course, or any other real estate related course(s) the Commission determines to be equivalent, within a required thirty-six (36) month period;
(ii) Successfully pass the applicable sales or broker examination with a score of 80% or more;

(ii) Furnish evidence to the Commission that the instructor has audited an in-class prelicense course, in its entirety, that must be validated by the school instructor or director.

2. Instructors must sign a statement affirming that changes to current law and rules have been reviewed and that the instructor has made applicable amendments to the course material. Any instructor not meeting the requirements of this subsection will section may be required to re-apply as an original instructor applicant.

(h) Guest instructors. Guest instructors may be utilized provided an approved instructor is also present during presentations. Total guest instruction and lectures shall not consume more than thirty percent (30%) of the total course time.

(i) Instructor and entity requirements.
1. Instructor must be present. An approved instructor must be present in the same room during all in class course instruction for students to receive credit toward course completion.
(2) **Retention of records.** An instructor/entity shall maintain enrollment records and roll sheets which include number of hours completed by each student for seven (7) years.

(3) **Course completion certificate.** Each individual successfully completing a course of study approved by the Commission shall be furnished a certificate prescribed or approved by the Commission certifying completion. The Commission shall accept from a college or university a certified transcript or a course completion certificate as prescribed by the Commission.

(4) **Commission authorized to audit and inspect records.** A duly authorized designee of the Commission may audit any offering and/or inspect the records of the entity at any time during its presentation or during reasonable office hours or the entity may be required to provide the records to the Commission.

(5) **Clock hours and breaks.** Not more than one clock hour may be registered within any sixty (60) minute period and no more than ten (10) minutes of each hour shall be utilized for breaks.

(6) **Class size limited.** Instructor ratio to students shall not exceed sixty (60).

(j) **Facility requirements.** The offering entity shall ensure that all classroom facilities have adequate lighting, seating space and technology to meet the needs of the student. The classroom area shall be free of distractions and noise.

(k) **Disciplinary action.** An approved course of study, director, and/or instructor may be withdrawn or disciplined as outlined in 605:10-1-3 titled "Appeal of administrative decisions; procedures."

(l) **Advertising course offerings.** No person or entity sponsoring or conducting a course of study shall advertise the course as approved prior to the course receiving approval from the Commission. Further, no person or entity sponsoring or conducting a course of study shall advertise that it is endorsed, recommended or accredited by the Commission although such person or entity may indicate that a course of study has been approved by the Commission.

(c) **Denied applications.** No portion of the fees enumerated in this Section are refundable. If an instructor, entity or course application is not approved, the applicant may appeal the decision by filing a written request for a hearing before the Commission. The hearing procedure shall be that as outlined in 605:10-1-3 titled "Appeal of administrative decisions; procedures."

(d) **Application fee.** Application fee of One Hundred Twenty-five Dollars ($125.00) for each course.

(e) **Advertising course offerings.** No person or entity sponsoring or conducting a course of study shall advertise the course as approved prior to the course receiving approval from the Commission.

(f) **Course offering requirements.** An individual determined by the Commission to possess one or more of the following qualifications may be considered for approval as an instructor upon receipt of an application and evidence of education and/or experience. Each application must be accompanied by a One Hundred Dollar ($100.00) application fee, and documentation required for compliance necessary to verify citizenship, qualified alien status, and eligibility under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. In order to qualify, an individual must possess proof of one of the following:

1. Possession of a bachelor's degree in a related field.
2. Possession of a valid teaching credential or certificate from Oklahoma or another jurisdiction authorizing the holder to instruct in an applicable field of instruction at the entity.
3. Five (5) years full-time experience out of the previous ten (10) years in a profession, trade, or technical occupation in the applicable field of instruction.
4. An individual determined by the Commission to possess a combination of education and/or experience in a field related to that in which the person is to instruct,
which constitutes an equivalent to one or more of the qualifications in (1), (2) or (3) of subsection (e) of this section.

(f) **Instructor renewal requirements.**

(1) In order to maintain approved status, an instructor must comply with one of the following:

   (A) Attend a Commission directed Instructor Renewal Course, or its equivalent, every twenty-four (24) months. An exception to this rule may be given by the Commission if such instructor is licensed or certified through another regulatory body.

   (B) Instructors approved solely for distance education courses must complete three (3) hours every twelve (12) months of instructor training as accepted by the Commission and:

      (A) Furnish evidence that the instructor has taught a Commission approved post-licensure course, or any other real estate related course(s) the Commission determines to be equivalent, within a required thirty-six (36) month period;

      (B) Successfully pass the applicable sales or broker examination with a score of 80% or more; or

      (C) Furnish evidence to the Commission that the instructor has audited an in-class prelicensure course, in its entirety, that must be validated by the school instructor or director.

(2) Instructors must sign a statement affirming that changes to current law and rules have been reviewed and that the instructor has made applicable amendments to the course material. Any instructor not meeting the requirements of this subsection may be required to re-apply as an original instructor applicant.

(g) **Guest instructors.** Guest instructors may be utilized provided an approved instructor is also present during presentations. Total guest instruction and lectures shall not consume more than thirty percent (30%) of the total course time.

(h) **Instructor and entity requirements.**

(1) **Instructor must be present.** An approved instructor must be present in the same room during all course instruction for students to receive credit toward course completion.

(2) **Retention of records.** An instructor/entity shall maintain enrollment records and roll sheets which include number of hours completed by each student for a period of seven (7) five (5) years.

(3) **Course completion certificate.** Each individual successfully completing a course of study approved by the Commission shall be furnished a certificate prescribed or approved by the Commission certifying completion. The Commission shall accept from a college or university a certified transcript or a course completion certificate as prescribed by the Commission.

(4) **Course notification to Commission.** An entity conducting an approved post-licensure education offering shall, within seven (7) days of the completion thereof, successfully submit to the Commission the list of name(s), license number(s) and other personal identifiers of those licensees who have successfully completed said offering. The information shall be submitted to the Commission by way of electronic format as required by the Commission, along with other information which may reasonably be required.

(5) **Commission authorized to audit and inspect records.** A duly authorized designee of the Commission may audit any offering and/or inspect the records of the entity at any time during its presentation or during reasonable office hours or the entity may be required to provide the records to the Commission.

(6) **Clock hours and breaks.** Not more than one clock hour may be registered within any one sixty (60) minute period and no more than ten (10) minutes of each hour shall be utilized for breaks.

(7) **Class size limited.** Instructor ratio to students shall not exceed sixty (60).

(i) **Facility requirements.** The offering entity shall ensure that all classroom facilities have adequate lighting, seating space and technology to meet the needs of the student. The classroom area shall be free of distractions and noise.

(j) **Disciplinary action.** An approved course of study, director, and/or instructor may be withdrawn or disciplined as outlined in Title 59, O.S., Section 858-208, paragraph 6 either on a complaint filed by an interested person or the Commission's own motion, for the following reasons, but only after a hearing before the Commission and/or a Hearing Examiner appointed by the Commission:

   (1) In the event the real estate license of a director is suspended or revoked, the course of study shall automatically be revoked.

   (2) In the event the real estate license of an instructor is suspended or revoked.

   (3) Failure to comply with any portion of the Code or the rules of this Chapter.

   (4) Falsification of records and/or application(s) filed with the Commission.

   (5) False and/or misleading advertisement.

   (6) Any other improper conduct or activity of the director, instructor, or entity the Commission determines to be unacceptable.

605:10-5-2. **Approval of a continuing education course**

(a) **Approval and expiration of application.** An entity seeking to conduct an approved continuing education course shall make application for the approval or renewal of each course. Such approval or renewal shall expire at the end of the thirty-sixth (36) month including the month of issuance.

(b) **Application form.** Entities seeking approval of a course shall submit an application on a form prescribed by the Commission along with a non-refundable fee of Twenty Five Dollars ($25.00) per course. Each application shall include, but is not limited to, the following information:

   (1) The name(s), address(es), and telephone number(s) of the sponsoring entity, the owner(s), and the coordinator/director responsible for the quality of the course.

   (2) The title(s) of the course or courses.

   (3) The number of hours in each course.
(4) A copy of each course's curriculum, including comprehensive course objectives, a detailed outline of the course subject matter and instructor(s) for each course.

(5) The method the entity will use to evaluate the course offering.

(6) The procedure the entity will use to monitor attendance.

(7) A personal resume indicating name(s) and qualifications of the instructor(s).

(8) Any other relevant information useful in determining that the entity is presenting a course which will meet the definition, purposes, goals and objectives adopted by the Commission.

(9) A statement attesting to the fact that in accepting approval as a continuing education entity, the entity will protect and promote the purposes, goals and objectives of continuing education as stated in the License Code and Rules.

(c) Commission course approval notice. The Commission shall within sixty (60) days after receipt of an application inform the entity as to whether the course has been approved, denied, or whether additional information is needed to determine the acceptability of the course.

(d) Course renewal requirements. Upon expiration of the time period, as stated in sub-paragraph (a) of this rule, an application for renewal of any course by an entity shall also be accompanied by a nonrefundable application fee of Twenty Five Dollars ($25.00) per course for a thirty-six (36) month period. Renewal applications shall be subject to the same requirements as original applications; however, the renewal application shall be submitted prior to expiration of the course(s).

(e) Change of information notice requirement. Whenever there is any change in a course, the entity shall notify the Commission prior to the effective date of the change. Such change shall not be considered approved until written notice is received from the Commission.

(f) Advertising of course offering. An entity advertising a course as being approved for continuing education credit shall state in such advertisement, "Approved by the Commission for (correct number) hours of continuing education credit." No entity sponsoring or conducting a course of study shall advertise the course as approved prior to the course receiving approval from the Commission. Further, no entity sponsoring or conducting a course of study shall advertise that it is endorsed, recommended or accredited by the Commission.

(g) Course requirements and limitations.

1. A course will not be approved by the Commission if its duration is less than one (1) clock hour or its equivalent as determined by the Commission.

2. To meet the statutory requirement, a clock hour shall equal sixty (60) minutes, with no more than ten minutes of each hour utilized for breaks.

3. An entity conducting an approved continuing education course shall, within seven (7) days of the completion thereof, successfully submit to the Commission the list of name(s), license number(s) and other personal identifiers of those licensees who have successfully completed the course. The information shall be submitted to the Commission by way of electronic format as required by the Commission, along with other information which may reasonably be required.

4. Each licensee successfully completing a course shall be furnished a completion certificate, prescribed or approved by the Commission.

5. Each course shall be presented in a manner necessary to method that safely and properly presents the course.

6. An approved instructor must be present in the same room during all in-class course instruction for students to receive credit toward course completion. If an instructor is presenting a Commission approved in-class course offering which is delivered to the licensees by way of electronic means to receiving sites other than where the instructor is presenting, the Commission may require that each receiving entity site have an in-class person monitoring the class in lieu of a Commission approved instructor.

(h) Recruitment disallowed.

1. A coordinator/director or instructor shall not allow the classroom to be used by anyone to advertise and/or recruit new affiliates for any firm. The coordinator/director shall cause the following statement to be posted in the classroom in such a manner as will be readable by all participants: "No recruiting for employment opportunities for any real estate brokerage firm is allowed in this class. Any recruiting on behalf of, or permitted by, the Instructor for any real estate brokerage firm is allowed in this class." (2) An instructor shall not wear any identification relating to a specific name or identity of a real estate firm, a group of companies or franchises while in the class or on the premises.

(i) Instructor application and approval requirements: An individual may, upon receipt of an application and evidence of education and/or experience, be considered for approval as an instructor for a three (3) year period including the month of approval. Each application and subsequent renewal must be accompanied by a nonrefundable Fifty Dollar ($50.00) application fee. In order to qualify, an individual must possess proof of one of the following:

1. Possession of a bachelor's degree in a related field.

2. Possession of a valid teaching credential or certificate from Oklahoma or another jurisdiction authorizing the holder to instruct in an applicable field of instruction.

3. Five (5) years full-time experience out of the previous ten (10) years in a profession, trade, or technical occupation in the applicable field of instruction.

4. An individual determined by the Commission to possess a combination of education and/or experience, in a field related to that in which the person is to instruct, which constitute an equivalent to one or more of the qualifications in (1), (2) or (3) of this subsection.

(j) Denied application; appeal. If the Commission is of the opinion that a proposed continuing education offering does not qualify under the Code and/or Rules of the Commission, the Commission shall refuse to approve the offering and shall give notice of that fact to the party applying for approval within fifteen (15) days after its decision. Upon written request from...
the denied party, filed within thirty (30) days after receipt of the notice of denial, the Commission shall set the matter for hearing to be conducted within sixty (60) days after receipt of the request. The hearing procedure shall be that as outlined in 605:10-1-3, titled "Appeal of administrative decisions; procedures."

(k) Disciplinary action. The Commission may withdraw or discipline as outlined in Title 59, O.S., Section 858-208, paragraph 6 the approval of a coordinator/director, instructor, offering or entity either on a complaint filed by an interested person or on the Commission's own motion, for any of the following reasons, but only after a hearing before the Commission and/or a Hearing Examiner appointed by the Commission:

1. In the event the real estate license of an instructor and/or coordinator/director is revoked or suspended.
2. Failure to submit all documents, statements and forms as may be reasonably required by the Commission.
3. Falsification of records and/or applications filed with the Commission.
4. False and/or misleading advertising.
5. Failure to revise an offering so as to reflect and present current real estate practices, knowledge, and laws.
6. Failure to maintain proper classroom order and decorum.
7. Any conduct which gives the coordinator/director, instructor or entity presenting the offering an unfair advantage over other brokers and/or real estate companies.
8. Failure to comply with any portion of the Code or rules of this Chapter.
9. Any other improper conduct or activity of the director, instructor, or entity the Commission determines to be unacceptable.

(l) Retention of records. An instructor/entity shall maintain enrollment records and roll sheets which include number of hours completed by each student for seven (7) five (5) years.

(m) Commission authorized to audit. A duly authorized designee of the Commission may audit any offering and/or inspect the records of the entity at any time during its presentation or during reasonable office hours or the entity may be required to provide the records to the Commission.

(n) Licensee/instructor course credit.

1. A licensee who is the instructor of an approved offering for continuing education shall be credited with one (1) hour for each hour of actual instruction performed.
2. An instructor may not receive continuing education credit for instructing an offering more than one time during a license term.
3. Records of such instruction shall be reported and maintained in the same manner as prescribed for participants elsewhere in the rules of this Chapter.

(o) Guest instructors. Guest instructors may be utilized provided an approved instructor is also present during presentations. Total guest instruction and lectures shall not consume more than thirty percent (30%) of the total course time.

605:10-5-3. Standards for Commission approved real estate courses

(a) Approved instructor. Each in-class course offering shall be conducted by a Commission approved instructor. Each entity conducting a distance education course offering shall have available a Commission approved instructor. The instructor shall be available during normal business hours as posted by the instructor to answer questions about the course material and provide assistance as necessary.

(b) Student must attend entire in-class instruction or complete all modules required for distance education instruction. In order for an entity to certify a student as passing an approved course the student must either:

1. attend the required number of hours of in-class instruction; or
2. complete all instructional modules required for distance education instruction.

(c) Student must successfully complete a prelicense, postlicense or distance education course offering examination. In order for an entity to certify a student as passing an approved prelicense, postlicense or distance education course, the student must successfully complete an examination covering the contents of the course material.

(d) Student transfers. Except with the prior approval of the Commission, a student transferring from one course to another may not count any portion of the student's attendance or work in the former course toward passing the course. A student who enrolls in an entity which offers a Commission approved course may not transfer credit for a course or courses completed in that series to another entity unless the receiving entity offers the identical series of courses and the receiving entity agrees to accept and examine said student throughout successful completion.

(e) Course examinations. Each approved prelicense provisional sales associate course and postlicense course offering shall conclude with an end-of-course examination consisting of no less than one hundred and fifty (150) questions administered by the approved entity. Each approved prelicense broker course shall conclude with an end-of-course examination consisting of no less than two hundred (200) questions administered by the approved entity. Each approved distance continuing education course offering shall conclude with an end-of-course examination consisting of no less than seven (7) questions for each clock hour. End-of-course examination questions may not be the same as any previously used questions covering the respective course content.

(f) Successful completion. In order for a student to successfully complete a prelicense, postlicense or distance education course, the entity must require that the student complete all class material and/or modules and achieve a passing score of at least eighty percent (80%) seventy-five percent (75%) on the entity's final examination. An entity shall require the student to complete sufficient material or modules to ensure mastery of the course offering, and shall require the student to complete the end-of-course examination. An entity may allow any student who fails to achieve a passing score the opportunity to take another examination without repeating instruction.
(g) **Grading standards.** In order for an entity to certify a student as passing an approved course, the student must meet the minimum grading standards established by this Section and the entity. On graded examinations for which this Section sets specific requirements, the entity's policy shall at least equal those requirements as listed in this Section. Other grading standards shall be in accordance with generally accepted educational standards. An entity shall publish grading standards and give them to a student in a written form at the beginning of the course.

(h) **Commission may impose sanction.** The Commission may impose any sanction permitted by law or Rules of the Commission on the approval of any entity, director and/or instructor which fails to provide proper security for their course evaluation or examination and for failing to comply with standards as set out in this Chapter.

(i) **Each entity must post notice.** Each entity must post or provide a notice that is easily observed by any person desiring to enroll in a prelicense course. The notice must at least include the following language: Oklahoma Statutes, Title 59, Section 858:301.1 "Effective November 1, 2009, state law prohibits the issuance of a real estate license to any person who has been convicted, pled guilty or pled nolo contendere to a felony for a pre-determined number of years based on the classification of said felony." Applicants convicted of felony crimes referenced in Title 59 Section 858-301.1 may be ineligible to obtain an Oklahoma Real Estate License for a predetermined number of years. For clarification, please contact the Commission and/or review the cited section of law as referenced herein. Additionally, if the applicant has delinquent unpaid child support or student loans, the applicant must check with the Real Estate Commission before enrolling in this class. The Commission will allow the applicant to seek preapproval prior to enrolling in a pre-license course.

(j) **Additional distance education course requirements.**

1. Each course shall contain suitable learning objectives.
2. Overview statements must be included for each course providing a quick preview of what is contained in the offering.
3. A complete set of questions and an answer key must be provided to the Commission with each course application. An answer key may not be included in any course materials provided to the student.
4. From the date of enrollment, the course shall have a validity period of six (6) months in which to allow successful completion to be attained.
5. Entities must include information with the course material that clearly informs the student of the completion time frame, passing and examination requirements, and any other relevant information necessary to complete the course.
6. Each course must include a statement that the information presented in the course should not be used as a substitute for competent legal advice.
7. Course offerings must be sufficient in scope and content to justify the hours requested for approval.

(k) **Each entity shall promote the Basic Course of Real Estate as Part I of a two part series and the Provisional Postlicense Course of Real Estate as Part II of that series.** Applicants are to be advised that Part II of the series is not to begin until after license issuance and shall be completed prior to their first license expiration.

(l) **All materials that are distributed to students in any class must be current and up-to-date with the License Code and Rules and state or federal laws.**

**SUBCHAPTER 7. LICENSING PROCEDURES AND OPTIONS**

**605:10-7-2. License terms and fees; renewals; reinstatements**

(a) **License term and fees.** Each original license issued under the Code shall be issued to expire at the end of the thirty-sixth (36) month including the month of issuance. Each original provisional sales associate license issued under the Code shall be issued to expire at the end of the twelfth (12th) month including the month of issuance. Fees are non-refundable and are as follows:

1. For an original broker license and each subsequent license renewal, to include corporations, associations or partnerships, the fee shall be Two Hundred and Eighty Dollars ($280.00).
2. For an inactive original broker license and each subsequent inactive license renewal, with the exception of corporations, associations or partnerships, the fee shall be One Hundred and Sixty Dollars ($160.00). In order to activate a license that was renewed inactive in the same license term, the licensee shall pay One Hundred and Sixty Five Dollars ($165.00). Thereafter, any future request to activate in the same license term shall be in accordance with Rule 605:10-7-4.
3. For an original broker associate license and each subsequent license renewal, the fee shall be Two Hundred and Forty Five Dollars ($245.00).
4. For an inactive original broker associate license and each subsequent inactive license renewal, the fee shall be One Hundred and Fifty Dollars ($150.00). In order to activate a license that was renewed inactive in the same license term, the licensee shall pay One Hundred and Fifty Five Dollars ($155.00). Thereafter, any future request to activate in the same license term shall be in accordance with Rule 605:10-7-4.
5. For an active original sales associate license and each subsequent active license renewal the fee shall be Two Hundred Dollars ($200.00).
6. For an inactive original sales associate license and each subsequent inactive license renewal the fee shall be One Hundred and Twenty Five Dollars ($125.00). In order to activate a sales associate license that was renewed inactive in the same license term, the licensee shall pay One Hundred and Thirty Five Dollars ($135.00). Thereafter, any future request to activate in the same license term shall be in accordance with Rule 605:10-7-4.
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(7) For an original provisional sales associate license that is non-renewable the fee shall be Ninety Five Dollars ($95.00).

(8) For an original branch office license and each subsequent license renewal the fee shall be One Hundred and Seventy Dollars ($170.00).

(9) For each duplicate license or pocket card, where the original is lost or destroyed, and a written request is made, a fee of Seven Dollars and fifty cents ($7.50) shall be charged.

(10) The Fifteen Dollar ($15.00) Education and Recovery Fund fee, shall be added and payable with the license fee for an original license and for each subsequent license renewal. Exceptions to this rule are: 1) a provisional sales associate license fee shall be Five Dollars ($5.00) for their twelve (12) month license term; and, 2) a branch office shall not pay the fee.

(b) Terms cannot be altered. Terms shall not be altered except for purposes of general reassignment of terms which might be necessitated for the purpose of maintaining an equitable staggered license term system.

(c) Expiration date. The actual expiration date of a license shall be midnight of the last day of the month of the designated license term. A person who allows their license to expire shall be considered an applicant and subject to a national criminal history record check, as defined by Section 150.9 of Title 74 of the Oklahoma Statutes.

(d) Late penalty. All renewals shall be filed on or before midnight of the tenth day of the month in which said license is due to expire, except in the event that date falls on a Saturday, Sunday or holiday; in such case, the next Commission working day shall be considered the due date for all renewals except electronic online renewal wherein this exception would not apply. Any such renewal application filed after such date shall be subject to a late penalty fee of Ten Dollars ($10.00).

(e) Actual filing of license renewal. A license shall lapse and terminate if a renewal application and required fees have not been filed with the Commission by midnight of the date on which the license is due to expire, except in the event that date falls on a Saturday, Sunday or holiday; in such a case, the next Commission working day shall be considered the due date. A renewal application and required fees are considered filed with the Commission on the date of the United States postal service postmark or the date personal delivery is made to the Commission office.

(f) Reinstatement of license. Any licensee whose license term has expired shall be considered for reinstatement of same license upon payment of an amount equal to the current examination fee an Eighty Dollar ($80.00) reinstatement fee in addition to the license and late penalty fee(s) for each delinquent license period(s). The following documents and fees must be submitted:

(1) Lapsed less than one year. In the case of a license lapsed less than one year:
   (A) License and late penalty fee.
   (B) Reinstatement fee.
   (C) National criminal history check.
   (D) Documents as required by the Commission.

(2) Lapsed more than one year but less than three years. In the case of a license lapsed more than one year but less than three years:
   (A) License and late penalty fee.
   (B) Reinstatement fee.
   (C) National criminal history check.
   (D) A completed reinstatement application.
   (E) Successful completion of the appropriate licensing examination.
   (F) A statement that the applicant has read a current License Code and Rules booklet.
   (G) Documents as may be required by the Commission.

(3) Lapsed more than three years. If an application is submitted more than three (3) years subsequent to the most recent year of licensure, the applicant shall be regarded as an original applicant.

(l) Reinstatement of a provisional sales associate license wherein post-license education was completed prior to license expiration date. An applicant who successfully completed the post-license education requirement before their first license expiration date and failed to renew their license on or before such date shall be eligible to reinstate the license as a sales associate according to 605:10-7-2 (4)(c)(1) through (3).

(m) Reinstatement of a provisional sales associate license wherein post-license education was not completed prior to license expiration date. An applicant who has not successfully completed the postlicense education requirement prior to the first license expiration date shall not be eligible to reinstate such license and shall apply and qualify as an original applicant.

(n) Reinstatement of revoked license. An applicant may not apply for re-license or reinstatement of license for a minimum of three (3) years from the effective date of license revocation, except for an applicant whose license was automatically revoked pursuant to Sections 858-402 or 858-604 of Title 59, Oklahoma Statutes. Upon the passage of the three (3) year period, the applicant shall be required to comply with the requirements of an original applicant.

(o) Reinstatement of an automatically revoked license. An applicant who has had their license automatically revoked, pursuant to Section 858-402 or 858-604 of Title 59 of the Oklahoma Statutes, shall be required to comply with the requirements of (4)(e) of this section. In addition, reinstatement will not be granted until all outstanding amounts due to the Commission have been paid in full.

(p) Reinstatement of a surrendered or cancelled license. A surrendered or cancelled license applicant may be reinstated provided the applicant has received approval for re-issuance from the Commission. The following forms and fees must be submitted:

(1) Reinstatement with term of license still current. A surrendered or cancelled license applicant whose license term is still current:
   (A) Applicable reinstatement Reinstatement fee equal to the current examination fee.
   (B) Re-issuance fee equal to the transfer of license fee.
(C) Documents as may be required by the Commission.

(D) Criminal history background check.

(2) Reinstatement with term of license expired. A surrendered or cancelled license applicant whose license term has expired shall be required to comply with the requirements of (1)(e) of this section.

(3) Reinstatement of provisional sales associate with term of license expired. A surrendered or cancelled provisional sales associate whose license term has expired shall be required to comply with the following:

(A) If a provisional sales associate completed the post-license requirement on or before the first license expiration date, the applicant shall be eligible to reinstate the license according to 605:10-7-2 (1)(e), (1) through (2).

(B) If a provisional sales associate did not complete the post-license requirement on or before the first license expiration date, the applicant shall be required to apply and qualify as an original applicant.

1(k) Continuing education requirement. Each licensee with the exception of those as listed in Title 59, O.S., Section 858-307.2 (D) seeking renewal of a license must submit evidence that they have completed the continuing education requirements enumerated in Section 858-307.2 of Title 59. An applicant seeking active reinstatement of a lapsed license must submit evidence that all continuing education requirements have been completed for each term in which an active license is requested.

1(m) License fees prorated. If a real estate sales associate qualifies for a license as a real estate broker associate or broker, or if a real estate broker associate qualifies for a license as a real estate broker, the unused license fee shall be credited to the new license fee. The unused license fee credit shall commence with the first full month following the month in which the broker license is to be issued.

1(n) License expires after effective date of national criminal history check.

(1) Any licensee who allows their license to expire for more than one (1) year shall be required to submit to a national criminal history check; however, such individual shall be allowed to proceed with reinstatement of such license pending receipt by the Commission of a completed fingerprint card background check, application Part A, and fee as stated elsewhere in these rules for the background search. If, the Commission does not receive a completed Part A of the application and completed fingerprint card background check, and fee within thirty (30) days from the date of request by the Commission, the license will be placed inactive and a hold placed on the license until receipt by the Commission of the aforementioned items. Thereafter, upon receipt by the Commission, the license may be reactivated so long as appropriate reactivation forms and fees, as stated elsewhere in these rules, have been received by the Commission. However, if the fingerprint card is rejected for the purposes of a national criminal history check, the Commission will provide written notice to the licensee and the licensee must submit a new and unique fingerprint card to the Commission within thirty (30) days of receipt of such notice or the license will be placed on inactive status.

(2) A provisional sales associate who completes the Provisional Post-License Course prior to their first license expiration date but fails to timely renew the license shall be eligible to apply under the requirement under the preceding paragraph. However, after a period of three (3) years from the date of the license expiration such applicant shall no longer be eligible to apply under this section.

1(e) Issuance of license from provisional sales associate to sales associate. A provisional sales associate is required to furnish to the Commission evidence of successful completion of the Provisional Post-License Course of Real Estate, Part II of II education requirement as set forth in Section 858-302 of Title 59, of the Oklahoma Statutes. Upon successful completion of the Provisional Post-License Course of Real Estate, Part II of II education requirement, the provisional sales associate must submit the appropriate document(s) to the Commission prior to the provisional sales associate's license expiration date for issuance of a renewable sales associate license. The Commission shall not issue the provisional sales associate a renewable sales associate license until the end of the provisional sales associate's license term and until the provisional sales associate has submitted evidence of successful completion of the forty-five (45) clock hour postlicense course requirement and submitted all required form(s) and fee(s) as required by the Commission.

1(p) Active sales associate to inactive broker associate, or sales associate and/or broker associate to inactive broker license - no remaining credit to be given. In the event an active sales associate, within six (6) months of obtaining their original license, reinstatement or license renewal qualifies for an inactive broker associate license, the Commission shall not credit the difference in license fees. In the event an active sales associate or broker associate within six (6) months of obtaining their original license, reinstatement or license renewal qualifies for an inactive broker license, the Commission shall not credit the difference in the license fees.

1(q) Licensee on active duty as a member of the Armed Forces of the United States.

(1) In accordance with Title 59, O.S., Section 4100.6 of the Post-Military Service Occupation, Education and Credentialing Act while a license holder is on active duty the license may be renewed without payment of the license and education and recovery fund fee and meeting the continuing education requirement. Such waiver shall be requested in writing to the Commission prior to license expiration along with evidence of the order for active duty. The license issued pursuant to this rule may be continued as long as the licensee is a member of the Armed Forces of the United States on active duty and for a period of at least one (1) year after discharge from active duty. Upon discharge from active duty and a request for license activation, the licensee shall submit to the Commission evidence of successful completion of the continuing education requirement for the current license renewal term.
(2) If a licensee on active duty does not request such a waiver in writing and the license expires, the applicant may, by written request provide the Commission documentation as required in subparagraph (1) of this subsection; however, no later than one (1) year after discharge from active duty.

(3) In the event a license expires during the events as noted herein, the Commission shall waive the criminal history background check and license examination.

(4) Member of the National Guard or reserve component of the armed forces. In accordance with Title 72, Chapter 1, Section 48.2 Extension and Renewal of Professional Licenses, any licensee whose license expires while on active duty as a member of the National Guard or reserve component of the armed forces shall be extended until no later than one (1) year after the member is discharged from active duty status. Upon the Commission receiving a copy of the official orders calling the member or reservist to active duty and official orders discharging the member or reservist from active duty all licensee fee and continuing education shall be waived for this time period as well as the criminal history background check and license examination.

(c) Reinstatement for corporation, association or partnership.
   (1) A corporation, association or partnership that has lapsed for less than three (3) years that wishes to reinstate must submit:
      (A) License fee(s) and late penalty fees.
      (B) Reinstatement fee forms and documents as required by the Commission.
      (C) If the corporation or association has been inactive for more than sixty (60) days, a current "Certificate of Good Standing."
   (2) Any corporation, association or partnership that has lapsed for more than three (3) years must submit an original application to be considered for licensure.

(d) Reinstatement for branch offices.
   (1) A branch office that has lapsed for less than three (3) years that wishes to reissue must submit:
      (A) License fee(s) and late penalty fees.
      (B) Reinstatement fee forms and documents as required by the Commission.
   (2) Any branch office that has lapsed for more than three (3) years must submit an original application as a new branch office.

(1) Specific license fees waived for low-income individuals. In accordance with Title 59, Section 4003, any applicant who can present satisfactory evidence of being a low-income individual shall receive a one-time one-year waiver of the licensure fees as outlined in 605:10-7-2 (a). Such waiver shall be prorated for a multi-year license so the applicant shall only receive a waiver for one year of the applicable license fees. For the purposes of this section, "low-income individual" means an individual who is enrolled in a state or federal public assistance program, or whose household adjusted gross income is below 140% of the federal poverty line or a higher threshold to be set by the executive branch department that oversees business regulation. Satisfactory evidence that the applicant is a low-income individual must be made upon forms provided by the Commission and must be presented upon application for original licensure.

605:10-7-4. Request for activation or re-issuance of license
(a) Requirements. All requests for activation or re-issuance of a license must be accompanied by the appropriate document(s) and fee of Twenty-five Dollars ($25.00) Forty Dollars ($40.00) as required by the Commission. Upon activation of an inactive license wherein the licensee paid the reduced inactive license fee rate, the licensee shall be required to pay the remaining active license fee as outlined in 605:10-7-2.

(b) Multiple change requests on same license. In the event a licensee's request involves more than one change to the license at the same time, and each individual change requires a separate fee elsewhere in the rules of this Chapter, the Commission shall only require that one fee be charged to reissue the license if the request is done in a timely manner.

(c) Continuing education and/or experience required for activation. A licensee requesting activation of a license must have complied with the continuing education requirement as set forth in Section 858-307.2 of Title 59 of the Oklahoma Statutes and rule 605:10-3-6 and, if applicable, the experience requirement as set forth in Section 858-303 of Title 59 of the Oklahoma Statutes and rule 605:10-3-4 and 605:10-3-4.1. Further, upon a licensee's request for activation being completed and processed, the licensee shall then be required to complete the continuing education requirement for the next license term for which the license is to be renewed active or activated.

(d) Active status requested, however, Commission unable to activate for reasons as stated in statutes elsewhere. In the event a licensee requests an active original license, subsequent license renewal, or activation to be issued on active status and for reasons beyond the Commission's control the licensee is unable to obtain an active license at that time, the fees as received by the Commission shall be retained and not refunded. Once the licensee corrects the problem with the appropriate regulatory agency and such agency authorizes the issuance of an active license, the Commission will then, upon receipt of an activation fee and required documentation, issue an active license.

605:10-7-5. Name changes
(a) Name change request. Any change of name of a licensee or licensed firm must be filed in the Commission office within ten (10) days of such change. Filed shall mean the date of the United States postal service postmark or the date personal or electronic delivery is made to the Commission office. The licensee or firm shall submit the license certificate to the Commission office along with the request for such name change. Upon any request for a change of name there shall be paid a fee to the Commission of Twenty-five Dollars ($25.00) for each license to be changed. The Commission may require additional documents as may reasonably be required by the Secretary-Treasurer.
(b) **Group name changes.** Under certain circumstances as determined by the Commission, the Commission may place a cap of Seven Hundred Fifty Dollars ($750.00) on group transactions requesting licenses to be reissued. To qualify, such request must be received complete and require no further correspondence and/or documents except for the issuance of the licenses.

605:10-7-8. **Corporation and Association licensing procedures and requirements of good standing**

(a) **Broker license requirement.** Each corporation and association who performs activities which require a real estate license pursuant to Title 59, O.S., Section 858-102 of the License "Code" shall apply as a real estate broker business entity. Upon approval by the Commission, the corporation or association shall be granted a real estate broker license. In order to obtain a license, the corporation or association shall furnish to the satisfaction of the Commission, but not limited to, the following items:

1. Completed application form(s) and required fee(s).
2. Verification that the corporation or association is authorized to transact business as a corporation business entity in the State of Oklahoma and that the corporation or association is in good standing in the State of Oklahoma.
3. Corporation or association must be in compliance with Title 59, O.S., Section 858-312.1 of the License "Code."
4. Corporation or association must have a managing corporate broker who holds a separate license as a real estate broker.
5. The designation of a managing corporate broker shall be established by sworn statement signed by the President of the corporation or authorized member or manager of the association stating the date and place such action was effected.
6. In the event of the death or disability of the managing corporate broker, or the event of the retirement or cessation of employment for any reason by the managing corporate broker, or the event of the retirement or cessation of employment for any reason by the managing corporate broker, the corporation or association shall be required to appoint a new managing corporate broker and such notice of change must be filed in writing with the Commission if after the occurrence of the event. The notice of change in a managing corporate broker must be accompanied by the appropriate documents as required by the Commission and a Twenty-five Dollar ($25.00) Forty Dollar ($40.00) change of status fee.
7. The corporation is to Corporations and associations must notify the Commission in writing within ten (10) days of the date of a change in corporate officers or association members.

(b) **Corporation and managing corporate Business entity and managing broker responsible for acts.** The managing corporate broker in conjunction with the corporation or association is responsible for all acts of the corporation business entity, including the acts of all associates associated with the corporation entity.

(c) **Corporation Business entity closing requirements or partial ceasing of real estate activities.** When a corporation or association discontinues a portion of real estate activities, the corporation business entity is required to comply with the following:

1. Immediately notify the Commission.
2. Comply with Section 605:10-13-1(n).
(d) **Group change information.** Under certain circumstances as determined by the Commission, the Commission may place a cap of Seven Hundred Fifty Dollars ($750.00) on group transactions requesting Licenses to be issued. To qualify, such request must be received complete and require no further correspondence and/or documents except for the issuance of the licenses.

(c) **Limited liability company.** A limited liability company shall be considered as an association.

605:10-7-8.2. Association licensing procedures and requirements of good standing

**REVOKED**

(a) **Broker license requirement.** Each association who performs activities which require a real estate license pursuant to Title 59, O.S., Section 858-102 of the License "Code" shall apply as a real estate broker. Upon approval by the Commission, the association shall be granted a real estate broker license. In order to obtain a license, the association shall furnish to the satisfaction of the Commission, but not limited to, the following items:

1. Completed application form(s) and required fee(s).
2. Verification that the association is authorized to transact business as an association in the State of Oklahoma and that the association is in good standing in the State of Oklahoma.
3. Association must be in compliance with Title 59, O.S., Section 858-312.1 of the License "Code".
4. Association must have a managing member or manager who holds a separate license as a real estate broker.
5. The designation of a managing broker member or manager shall be established by a sworn statement signed by an authorized member or manager of the association stating the date and place such action was effected.
6. In the event of the death or disability of the managing broker member or manager, or in the event of the retirement or cessation of employment for any reason of the managing broker member or manager, the association shall be required to appoint a new managing broker member or manager and such notice of change must be filed in the Commission office no later than thirty (30) working days of the occurrence of the event. The notice of change in a managing broker member or manager must be accompanied by the appropriate documents as required by the Commission and a Twenty-five Dollar ($25.00) change of status fee.

(b) **Association and managing broker member or manager responsible for acts.** The managing broker member or manager in conjunction with the association is responsible for all acts of the association, including the acts of all associates associated with the association.

(c) **Association closing requirements or partial ceasing of real estate activities.** When an association discontinues a portion of the real estate activities or ceases all real estate activities, the association is required to comply with the following:

1. Immediately notify the Commission.
2. Comply with Section 605:10-13.1 (m).

(d) **Limited liability company.** A limited liability company shall be considered as an association.

605:10-7-8.4. Managing broker, broker proprietor or branch broker's corporation or association

Corporations or Associations formed for the purpose of receiving compensation

Within the meaning of subsection 14 of Section 858-312 of the "Code" payment of a commission by a broker to a managing broker's, broker proprietor's or branch broker's broker or associate's corporation or association does not constitute a payment of a fee (commission) to an unlicensed person provided the corporation or association and the managing broker, broker proprietor or branch broker and/or associate abide by the following requirements:

1. The corporation or association shall not perform any act requiring a real estate license and shall not hold itself out as engaged in such activity.
2. The managing broker, broker proprietor or branch broker licensee requesting registration with the Commission must have an active individual real estate license.
3. The managing broker of the branch broker must provide approval to the Commission a written statement approving of the branch broker's broker or associate's corporation or association.
4. The managing broker, broker proprietor or branch broker licensee requesting registration with the Commission must be the majority stockholder and president of the corporation or majority member of the association.
5. Ownership of a managing broker's, broker proprietor's or branch broker's the broker or associate's corporation or association is limited to spouses and blood relatives.
6. The corporation or association shall not advertise nor receive referral fees or commissions except from the broker.
7. The managing broker, broker proprietor or branch broker licensee requesting registration with the Commission must pay a forty dollar ($40.00) registration fee and file a written statement make the following declarations to the Commission with the Commission including the following:

(A) A statement that the managing broker, broker proprietor or branch broker licensee requesting registration with the Commission is the majority stockholder and president of the corporation or majority member of the association.
(B) Names and relations of all officers/members and/or stockholders.
(C) Verification that the association or corporation is in good standing with the Oklahoma Secretary of State.
(8) An individual broker or associate may only register one corporation or association for the purpose of receiving compensation.

605:10-7-11. Applicant criminal history

(a) This section establishes the criteria utilized by the Commission in determining the effect of criminal history on applicant eligibility for real estate licensure and certification. This section applies to:
(1) All individuals seeking to obtain a real estate license;
(2) All individuals seeking an initial determination of their eligibility to obtain a real estate license.
(b) The Commission shall maintain a list of felony crimes that disqualify an applicant from obtaining a real estate license within ten (10) years of completion of the criminal sentence, including parole and probation. The felony crimes included on the list substantially relate to the practice of real estate and pose a reasonable threat to public safety for the reasons stated below:
(1) Real Estate Licensees have unique access to residential homes and commercial buildings.
(2) Real Estate Licensees have daily contact with the public and individuals in the occupation.
(3) Real Estate Licensees play a vital role in assisting the public with substantial long-term financial obligations.
(c) The Commission's list of disqualifying felony crimes is available on the Commission's website or upon request by contacting the Commission office.
(d) Individuals may request an initial determination from the Commission regarding whether the individual's criminal history disqualifies that individual from obtaining a real estate license. Such request must be in writing and directed to the Oklahoma Real Estate Commission. The individual must submit a copy of their criminal history and any related documents and court records that specify the criminal history of the individual.
A ninety-five dollar ($95.00) fifty dollar ($50.00) fee shall accompany any request for initial determination. The fee shall be collected by the Commission prior to the determination.
(e) Individuals may appeal the Commission's initial determination of disqualification by submitting a request in writing of all deleted or unused trade names.

605:10-9-1. Place of business and broker requirements

(a) Place of business. Each broker shall maintain a specific place of business, and supervise a brokerage practice which is available to the public during reasonable business hours. Each broker shall be available to manage and supervise such brokerage practice and comply with the following:
(1) The broker's license, as well as those of all licensees associated with the broker, must be maintained in the place of business as registered with the Commission and available upon request.
(2) The place of business shall consist of at least one enclosed room or building of stationary construction wherein negotiations and closing of real estate transactions of others may be conducted and carried on with privacy and wherein the broker's books, records and files pertaining to real estate transactions of others are maintained.
(3) Each broker shall register for each place of business a physical business address and office telephone number(s).
(b) Branch offices. If a broker maintains one or more places of business, the additional places of business shall be referred to as a branch office. Each associate's license shall be issued to and available upon request in the office to which the associate is assigned, whether that be the main place of business or branch office.
(c) Office located at residence. The office may be in the residence of the broker.
(d) Associates not permitted to have an office. Associates are not permitted to have a place of business, but must be registered with a place of business maintained and registered in the name of the broker.
(e) Licenses issued to place of business. All licenses will be issued to the street address of the place of business, unless the United States Postal Service refuses to deliver mail when addressed in such manner, electronically to each licensee in the individual License Portal.
(f) Broker may be broker for more than one firm. A broker may be the broker for more than one firm so long as the firms are at the same location.
(g) Broker is responsible for acts of unlicensed assistants. A broker is responsible for all real estate related activities of any unlicensed assistant working within the firm.

605:10-9-3. Trade names

Each licensed broker or entity must register in writing to the Commission all trade names used in connection with real estate activities prior to the trade name being advertised or displayed in any way. Further, each broker is to notify the Commission in writing of all deleted or unused trade names. The registration of each trade name must be accompanied by a ten dollar ($10.00) registration fee.

SUBCHAPTER 9. BROKER'S OPERATIONAL PROCEDURES

SUBCHAPTER 11. ASSOCIATE'S LICENSING PROCEDURES
605:10-11-2. Associate licenses
(a) License issuance and change request. Each associate license shall be issued to the associate's broker, who shall retain custody of the license electronically to each associate through the individual License Portal. Upon an associate leaving the association of the broker, the associate's license shall be returned to the Commission, updated electronically after receiving a release or transfer executed by the broker together with a release executed by the broker. Any change of association from one firm to another, or relocation from one office to another within a firm by an associate must be filed in the Commission office within ten (10) days. The associate's new broker shall be required to provide consent to sponsor the associate with the Commission. An associate requesting an association or office change shall be required to pay a fee of Forty Dollars ($40.00).
(b) Broker refusal to release associate. In the event a broker refuses for any reason to release an associate, the associate shall notify the broker by certified mail in writing of the disassociation and furnish the Commission a sworn statement that the notification has been sent to the broker. Upon receipt by the Commission of the aforementioned statement, the Commission shall release the licensee.
(c) Group change requests. Under certain circumstances as determined by the Commission, the Commission may place a cap of Seven Hundred Fifty Dollars ($750.00) on group transactions requesting licenses to be reissued. To qualify, the request must be received complete and require no further correspondence and/or documents except for the issuance of the licenses.
(d) Associates transfer. When an affiliated associate leaves a broker for whom the associate is acting, the broker shall immediately cease the license of that associate to be forwarded to the Commission along with a release of association form. The broker shall make every attempt to notify the associate of the disassociation.
(e) Active associate may continually act. An active associate transferring from one broker to a new broker may continually act if the change is done in a timely manner and in compliance with the ten (10) day notification requirement and other applicable rules of this Chapter.
(f) Compensation due a disassociated associate. A previous broker may pay compensation due a disassociated associate directly to the associate and not be required to make the payment through the associate's new broker. However, any agreements between the associate and prior broker requiring further activities to be performed in connection with the compensation to be received, can only be performed with consent and acknowledgement of the new broker.
(g) Change of home address. An associate is required to notify the Commission office of his or her current home address. The change shall be filed in the Commission office within ten (10) days of change. No fee is required to change the licensee's records; however a fee of Forty Dollars ($40.00) will be charged if the change requires a new license to be issued.

605:10-11-3. Associate's corporation or association formed for the purpose of receiving compensation [REVOKED]

SUBCHAPTER 17. CAUSES FOR INVESTIGATION; HEARING PROCESS; PROHIBITED ACTS; DISCIPLINE

605:10-17-2. Complaint procedures
(a) Complaint may be filed by public or Commission's own motion. A complaint alleging misconduct on the part of a licensee or any person unlicensed pursuant to the Code who violates provisions of the Code may be filed by any person in writing on a form for such supplied by the Commission, or may be ordered by the Commission on its own motion. The Commission will accept a complaint alleging misconduct on a form not supplied by the Commission if such form is notarized by a notary public.
(b) Complaint notification; licensee response. When a complaint has been filed the licensee or unlicensed person pursuant to the Code shall be immediately notified and shall be required to file an adequate written response within fifteen (15) days of the notice.
(c) **Investigation and/or investigative session.** Subsequent to the fifteen (15) day answer period, a field investigation or preliminary investigative session the Commission may continue to investigate the complaint, may be conducted to ascertain whether or not charges should be lodged and a formal hearing ordered. Such investigation or investigative session shall be under the supervision of the Secretary-Treasurer of the Commission. He or she may designate an attorney who will act as prosecutor for the Commission to examine the any results of the field investigation and/or conduct a preliminary investigative session. The prosecutor so designated may in the name of the Commission subpoena witnesses, take testimony by deposition and compel the production of records and documents bearing upon the complaint.

(d) **Findings reported to Commission.** At the completion of the investigation or investigative session, a written report accompanied by findings, if any, shall may be submitted to the Commission. Following receipt of the report, the Commission shall determine whether or not the apparent evidence warrants lodging formal charges and ordering a formal hearing, and if a formal hearing is ordered all parties shall then be furnished with copies of a a written report accompanied by findings, if any.

605:10-17-3. **Complaint hearings; notice and procedures**

(a) **Summary suspension.** If the Commission finds that public health, safety, or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order, summary suspension of a license may be ordered pending proceedings for revocation or other action within thirty (30) days. The summary suspension shall remain in effect until further order by the Commission.

(b) **Formal hearing ordered; notification.** Except as provided in (a) of this section, the Commission may issue a disciplinary order only after entering into a consent order with respondent(s) or after a hearing of which licensee or unlicensed person pursuant to the Code affected shall be given at least fifteen (15) days written notice, specifying the offenses of which the licensee or unlicensed person pursuant to the Code is charged. Such notice may be served as provided by law for service of notices, or by mailing a copy by certified mail to the last known address. If the licensee is an associate associated with a broker, the Commission in like manner shall notify the broker with whom associated.

(c) **Formal hearing location.** The hearing on such charges shall be set at such time and place as the Commission through its Secretary-Treasurer may prescribe and the notice in (b) of this section shall specify this time and place.

(d) **Formal hearing before Commission; hearing examiner or selected panel.** The Secretary-Treasurer shall schedule each formal disciplinary hearing before a Hearing Examiner, a selected panel of the Commission, or the Commission as a whole. In the case of a proceeding conducted by the Commission as a whole or a panel of the Commission, the Chairman or his/her designee shall preside. Designated counsel shall advise the Chair as to rulings upon the questions of admissibility of evidence, competence of witnesses and any other question of law where such ruling is required or requested.

(e) **Request for postponement.** Once a hearing has been scheduled, the Secretary-Treasurer may for sufficient cause postpone or reschedule a hearing upon proper motion or request having been filed with the Commission office seventy-two (72) hours prior to the hearing.

1. Each postponement request must be in writing and must state the specific reason(s) for the request.
2. The Commission may require official documentation supporting such request.
3. An emergency postponement request shall be considered at the time of the emergency.
4. The granting of a continuance whether general or emergency, shall not be interpreted to deny the Commission the power to impose summary suspension if the Commission finds that public health, safety, or welfare imperatively requires emergency action, and incorporates a finding to that effect in its Order, summary suspension of a license may be ordered pending proceedings for revocation or other action within thirty (30) days.

(f) **Hearings public; witnesses may be excluded.** All hearings shall be public except that upon motion of either party, witnesses may be excluded from the hearing room when such witness is not testifying.

(g) **Court reporter.** A court reporter shall be present to record the proceedings on behalf of the Commission. Any person desiring a copy of the transcript of the proceedings, may purchase such from the reporter.

(h) **Formal hearing procedures.** The designated attorney for the State shall present the State's case. The respondent may present his or her own evidence or may present such through his or her own counsel. If the charges against the respondent resulted from a complaint filed by a party present at the hearing, the complaining party may be a witness for the State. In order that the hearing will not be encumbered by evidence having no bearing on the issues, testimony by all witnesses will be limited to matters relevant to the issues involved. The order of procedure shall be as follows:

1. Recitation of the statement of charges by the person presiding.
2. Opening statement by the State.
3. Opening statement by the respondent.
4. Presentation of the State's case followed by cross-examination and questioning by the Hearing Examiner or hearing panel.
5. Respondent's presentation followed by cross-examination and questioning by the Hearing Examiner or hearing panel.
6. Closing arguments by the State.
7. Closing arguments by the respondent.
8. The Hearing Examiner or hearing panel may ask the parties questions consistent with general trial practices under the Administrative Procedures Act.

(i) **Order; hearing before Commission.** If the case be heard by the Commission as a whole, the Commission shall deliberate and render a decision with confirmation of such
decision in writing in the form of an Order distributed to all parties by mail.

Proposed order consideration; hearing before hearing examiner or panel. In the case of a hearing conducted by a panel of the Commission or by a Hearing Examiner, following the hearing, the Hearing Examiner or attorney sitting as counsel to the panel shall prepare a proposed Order to be considered by members of the Real Estate Commission at a future meeting.

Proposed order notification; written exceptions. Affected parties. All respondents will be furnished copies of the proposed Order and notified as to the date the proposal will be considered by the Commission for adoption. At the same time, notice will also be given to the parties that written exceptions or requests to present oral exceptions or arguments, if any, should be submitted on or before a designated date pursuant to Section 311, of Title 75, Oklahoma Statutes. Upon adoption of the Order by the Commission as a whole, the adopted Order shall be distributed to all parties.

Actual notification pertaining to this Section. For purposes of this Section, notice shall be deemed to have been given at the time that notice is deposited in the United States mail with proper postage thereon and mailed to the last known address of the notified person, or date when such notice is served in person by a person duly authorized as a representative of the Commission.

Violation found. If the Commission shall determine that any licensee or unlicensed person pursuant to the Code is guilty of violation of the "Code," such person may be disciplined in the manner as prescribed in such "Code."

605:10-17-4. Prohibited dealings

Within the meaning of subsection 8 of Section 858-312 of the "Code," untrustworthy, improper, fraudulent or dishonest dealing shall include, but not be limited to, the following:

1. The making of a brokerage service contract without a date of termination.
2. Purchasing of property by a licensee for himself or herself or another entity in which the licensee has an interest as defined in 605:10-15-1 (c), if such property is listed with the broker or the broker's firm, without first making full disclosure thereof and obtaining the approval of the owner, or the failure by the licensee to exert the licensee's best effort in order to later purchase or acquire the property for themself or another entity in which they have an interest as defined in 605:10-15-1 (c).
3. Repeated misrepresentations, even though not fraudulent, which occur as a result of the failure by the licensee to inform himself or herself of pertinent facts concerning property, as to which he or she is performing services.
4. Procuring the signature(s) and dates of such signature(s) to a purchase offer or contract or to any lease or lease proposal which has no definite maximum purchase price or lease rental, or no method of payment, termination date, possession date or property description.
5. The payment of any fees or amounts due the Commission with a check that is dishonored upon presentation to the bank on which the check is drawn.
6. Lending a broker's license to an associate; permitting an associate to operate as a broker; or failure of a broker to properly supervise the activities of an associate. A broker permitting the use of the broker's license to enable an associate licensed with the broker to, in fact, establish and conduct a brokerage business wherein the broker's only interest is the receipt of a fee for the use of the broker's sponsorship.
7. Failure to make known in writing to any purchaser any interest the licensee has in the property they are selling.
8. Failure of the licensee to inform the buyer and seller in writing at the time the offer is presented that the buyer and seller will be expected to pay certain closing costs, brokerage service costs, and approximate amount of said costs.
9. Failure, upon demand in writing, to respond to a complaint in writing, or to disclose any information within licensee's knowledge, or to produce any document, book or record in licensee's possession or under licensee's control that is real estate related and under the jurisdiction of the Real Estate Commission, for inspection to a member of the Commission staff or any other lawful representative of the Commission.
10. Failure to reduce an offer to writing, when a proposed purchaser requests such offer to be submitted.
11. Failure to submit all bona fide offers to an owner when such offers are received prior to the seller accepting an offer in writing.
12. Any conduct in a real estate transaction which demonstrates bad faith or incompetency.
13. Failure to act, in marketing the licensee's own property, with the same good faith as when acting in the capacity of a real estate licensee.
14. An associate who does not possess the license of a broker or branch office broker as defined in the rules, but is intentionally acting in the capacity of a broker or branch office broker.
15. Discouraging a party from obtaining an inspection on a property.
16. Allowing access to, or control of, real property without the owner's authorization.
17. Knowingly providing false or misleading information to the Commission during the course of an investigation.
18. Interfering with an investigation by means of persuading, intimidating or threatening any party or witness, or tampering with or withholding evidence relating to the investigation.
19. Knowingly cooperating with an unlicensed person or entity to perform licensed real estate activities as required by Title 59 O.S. Section 858-301.
20. Failing to disclose any known immediate family relationship to a party to the transaction for which the broker is providing brokerage services.
(21) Failure by a broker to ensure all persons performing real estate licensed activities under the broker are properly licensed.
(22) An associate shall not perform licensed activities outside their broker's supervision.
(23) Failing to maintain documents relating to a trust account or real estate transaction for the time period as required by Rule 605:10-13-1.

[OAR Docket #21-470; filed 6-15-21]

TITLE 612. STATE DEPARTMENT OF REHABILITATION SERVICES
CHAPTER 1. ADMINISTRATIVE OPERATIONS

[OAR Docket #21-424]

RULEMAKING ACTION: PERMANENT final adoption

AUTHORITY: Commission for Rehabilitation Services; 74 O.S. § 166.2
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GIST/ANALYSIS:
Revisions to Chapter 1 consist of compliance with Executive Order 2020-03 which required state agencies to identify costly, ineffective, duplicative, and outdated regulations. Additional revision, name change of Disability Determination Division (DDD) to Disability Determination Services (DDS).

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., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS

612:1-1-3. Philosophy and Balanced Scorecard
(a) Philosophy. The Department of Rehabilitation Services (DRS) provides services to persons with disabilities who may have the ability to pursue employment, education to children who are deaf and/or blind, and those who, due to the severity of their disabilities, may benefit in terms of increased participation in the family or community. DRS also determines eligibility for Social Security Disability Assistance Insurance (SSDI) and Social Supplemental Security Income (SSI) through its Disability Determination Division Services. Services are arranged through resources available in the community, or provided through DRS resources. All services provided must be appropriate, timely, and provided in an economical and efficient manner within the framework of federal and state laws, the State Plan, and the administrative rules and procedures issued by the Department of Rehabilitation Services.

(b) Balanced Scorecard. For the Department of Rehabilitation Services, this philosophy for the Department of Rehabilitation Services rests upon a value-based decision plan developed through the consensus of all DRS personnel. This plan guides the development of all administration of the Department of Rehabilitation Services. The mission of DRS is to provide opportunities for individuals with disabilities to achieve productivity, independence, and an enriched quality of life. This mission will be carried forward through goals and objectives based upon established values. These will be achieved through a strategic planning process consistent with the Rehabilitation Act.

SUBCHAPTER 5. PROGRAM DIVISIONS WITHIN THE DEPARTMENT

612:1-5-2. Division of Vocational Rehabilitation (DVR)
The Division of Vocational Rehabilitation provides vocational rehabilitation services designed to result in an employment outcome for persons with disabilities. Priority is given to those with the most severe significant disabilities. All unit heads, and the Vocational Rehabilitation Field Coordinators report directly to the Division Administrator. Local office staff report to DVR Program Managers, who report to Field Coordinators. DVR has field staff assigned to meet the needs in every county of the state, although staff may not be office have an office in each county. Local office staff report to DVR Program Managers, who report to Field Coordinators at the State Office.
Permanent Final Adoptions

612:1-7-1. Relationships with elected state officials [REVOKED]
(a) **Governor.** Under authority of Title 74, Section 166.1 etc. seq. of Oklahoma State Statutes, a three-member Commission for Rehabilitation Services governs the Department of Rehabilitation Services. One member of the Commission is appointed by the Governor for a three-year term. An annual report of the Department's activities is presented to the Governor. The Governor reviews budget requests and legislative proposals submitted by the Department, among other activities related to the work of the Department.
(b) **Attorney-General.** The Attorney-General approves bonds provided for in the Oklahoma Social Security Act. He or she renders opinions concerning provisions and effect of laws or acts, when requested by the Commission for Rehabilitation Services, its Chairperson, or the Director of Rehabilitation Services. The Attorney General also prosecutes for or defends the State in civil or criminal actions.
(c) **State Treasurer.** The State Treasurer is designated and makes the official custodian of all monies, funds, rentals, penalties, costs, proceeds of sale of property, deeds, fines, forfeitures, and public charges of every kind that may be received by any State Officer, State Board, or Commission. All state agency warrants are issued and paid by the Treasurer. Vouchers issued by the Department for special purposes are drawn by the Department on Special Accounts in the State Treasury and are also paid by the Treasurer.
(d) **State Auditor and Inspector.** State officers, state agencies, and all county governments are audited at least annually by the State Auditor and Inspector. In addition, whenever called upon by the Governor, the Auditor shall specially examine the books and accounts of any Officer of the State. In addition to his general responsibility to the State as a whole, the Auditor has the specific responsibility of annually auditing the Department's expenditure of State funds in those programs administered by the Department which are funded solely by State funds.
(e) **Supreme Court.** The Supreme Court is the final arbiter of most questions of state law.
(f) **Secretary of State.** Oaths of members of the Commission for Rehabilitation Services and their bonds are deposited with the Secretary of State, in accordance with provisions of Oklahoma Statutes. Rules of general applicability and future effect are adopted, amended, or revoked in accordance with the Administrative Procedures Act.

612:1-7-2. Relationships with appointed state officials [REVOKED]
(a) **Division of Capital Assets Management.** The Director of the Division of Capital Assets Management is responsible for the award of State contracts for supplies, materials, and equipment. The Division of Capital Assets Management is also the contracting body for leases covering State real property and is responsible for disposing of any real or personal property of the State which an agency determines is surplus to its needs.
(b) **Oklahoma Employment Security Commission.** The Oklahoma Employment Security Commission is charged with the responsibility of promoting employment security by increasing opportunities for job placement, through its operation of public employment offices and by paying compensation to eligible workers who become unemployed. In addition, the Employment Security Commission assists the Department in the verification of employment for applicants and recipients of Department services.
(c) **Merit System of Personnel Administration.** The Merit Act of 1959 established the Merit System of Personnel Administration and created and defined the structure and duties of the first administrative body of that system. Later, the Oklahoma Personnel Act abolished the State Personnel Board and created and transferred the powers, duties, and responsibilities to the Office of Personnel Management and the Ethics Commission and Merit Protection Commission.
(1) **Office of Human Capital Management (HCM).** The Office of Human Capital Management is responsible for: the development of an efficient and effective system of personnel administration that meets the management needs of the various state agencies; maintaining and revising a classified system of employment which protects state employees from arbitrary dismissal or unfair treatment; maintaining an equitable system for the classified service; helping recruit and select qualified people; conducting a management training program; and assuring equal employment opportunity.
(2) **Ethics Commission and Merit Protection Commission.** The Ethics Commission and Merit Protection Commission is responsible for assuring that the rights of employees and agencies under the Merit System of Personnel Administration are not abridged.
(d) **The Director of Office of Management and Enterprise Services.** The Director of Office of Management and Enterprise Services maintains in his office records showing the debts and credits of each separate fund or appropriation for each State agency. He or she also pre-audits the claims of the Department's general administrative funds and any special construction funds. An annual budget estimate is prepared by the Department and filed with the Director of the Office of Management and Enterprise Services, who serves as the senior budget officer of the State.
(e) **State Fire Marshal.** The State Fire Marshal is involved in reviewing fire protection and safety features of facilities operated and funded by the Department.
(f) **Secretary of the State Election Board.** Among other duties, the Secretary of the State Election Board is to promote and encourage voter registration and voter participation in elections. The State Department of Rehabilitation Services will cooperate with the Secretary of the State Election Board in compliance with the National Voter Registration Act of 1993.

[OAR Docket #21-424; filed 6-14-21]
TITLE 612. STATE DEPARTMENT OF REHABILITATION SERVICES
CHAPTER 3. MANAGEMENT SERVICES DIVISION

[OAR Docket #21-425]

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PERMANENT final adoption

RULES:
Subchapter 5. Process Improvement [REVOKED]
612:3-5-1. Purpose [REVOKED]

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N/A

GIST/ANALYSIS:
Revised Part 1. General Provisions. This Part was relocated to Chapter 1 Administrative Operations, Subchapter 18 Process Improvement.

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., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 5. PROCESS IMPROVEMENT [REVOKED]

PART 1. GENERAL PROVISIONS [REVOKED]

612:3-5-1. Purpose [REVOKED]
The purpose of this Chapter is to set forth the policies and procedures governing the operations of the Process Improvement Unit and its subsections, Program Standards, Case Review, and Policy, of the Department of Rehabilitation Services. The policies in this Chapter are promulgated under the authority of the Commission for Rehabilitation Services as established in 74 O.S., Section 166.1 et seq and the Administrative Procedures Act, 75 O.S., Sections 250 et seq.

[OAR Docket #21-425; filed 6-14-21]

TITLE 612. STATE DEPARTMENT OF REHABILITATION SERVICES
CHAPTER 10. VOCATIONAL REHABILITATION AND SERVICES FOR THE BLIND AND VISUALLY IMPAIRED

[OAR Docket #21-426]

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RULES:
612:10-1-1. Legal Authority [AMENDED]
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Part 13. Supportive Services
612:10-7-130. Maintenance [AMENDED]
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612:10-7-162. Textbooks, supplies, training tools and equipment [AMENDED]
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Part 19. Special Services for Individuals who are Blind, Deaf, or have other Significant Disabilities
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612:10-7-242. Pre-Employment Transition Services [AMENDED]
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Subchapter 13. Special Services for the Deaf and Hard of Hearing
Part 3. Certification of Interpreters
612:10-13-20. Certification maintenance [AMENDED]

AUTHORITY:
Commission for Rehabilitation Services; 74 O.S. § 166.2

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GIST/ANALYSIS:
Revisions to Chapter 10 consist of compliance with Executive Order 2020-03 which required state agencies to identify costly, ineffective, duplicative, and outdated regulations. Additional language revisions to match Workforce Innovation and Opportunity Act (WIOA).

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS

612:10-1-1.1. Legal Authority
The administrative rules presented in this Chapter are based upon the Rehabilitation Act [29 USC 701 et seq.], and were promulgated by the Commission for Rehabilitation Services under the authority of 74 O.S., Section 166.1, et seq. and reauthorized under the Workforce Innovation and Opportunity Act (WIOA) (P.L. 113-128), signed into law on July 22, 2014. To the extent that any of these administrative rules are inconsistent with federal laws or accompanying regulations, the federal laws or regulations shall govern and supersede the applicable administrative rule.

612:10-1-2. Definitions
The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:
"Act" means the Rehabilitation Act [29 USC 701 et seq.].
"ADL" Activities of Daily Living often refer to the routine activities carried out for personal hygiene and health (including bathing, dressing, feeding) and for operation of a household.
"Applicant" means an individual who has completed and signed an agency application form or has otherwise requested vocational rehabilitation services; who has provided information necessary to initiate an assessment to determine eligibility and priority for services; and who is available to complete the assessment process.
"Appropriate modes of communication" means specialized aids and supports that enable an individual with a disability to comprehend and respond to information that is being communicated. Appropriate modes of communication include, but are not limited to, the use of interpreters, open and closed captioned videos, specialized telecommunications services and audio recordings, Brailled and large print materials, materials in electronic formats, augmentative communication devices, graphic presentations, and simple language materials.
"Assessment for determining eligibility and vocational rehabilitation needs", means, as appropriate in each case a review of existing data to determine if an individual is eligible for vocational rehabilitation services; and to assign priority for an order of selection described in 34 CFR 361.36 in the States that use an order of selection; and to the extent necessary, the provision of appropriate assessment activities to obtain necessary additional data to make the eligibility determination and assignment.
"Assistive technology" means technology designed to be utilized in an assistive technology device or service.
"Assistive technology device" means any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.
"Assistive technology service" means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device.
"Authorized Representative" means a client's or applicant's parent, guardian, advocate (i.e., Client Assistance Program) or other person designated by the client or applicant as the individual authorized to deal with the Department on behalf of the client or applicant, consistent with provisions of the Act. Authorized representative does not include an employee of the Department of Rehabilitation Services, another state agency, or vendor of the Department unless the person is actually the parent, guardian, or is serving in the capacity of guardian (for example, court appointed).
"Best correction" refers to the use of standard eyeglasses or contact lenses and does not include the use of biologic telescopic systems or specialized lenses which cannot be worn by the individual on a sustained basis.

"Blind" means persons who are blind within the meaning of the State Law relating to Vocational Rehabilitation. Legal blindness means a visual acuity of 20/200 or less in the better eye with best correction, or a visual field of 20 degrees or less.

"Client/Consumer" means an individual found eligible and receiving services under the Act.

"Clubhouse model" means a psychosocial and vocational approach to work adjustment for people with mental illness. The work ordered day is a core element of the clubhouse, which focuses on strengths, talents and abilities. Work in the clubhouse helps members develop appropriate social skills and gain self-worth, purpose and confidence. The clubhouse enables members to return to the workforce and achieve employment outcomes.

"Community rehabilitation program" (CRP) means a program that directly provides or facilitates the provision of vocational rehabilitation services to individuals with disabilities, and provides singly or in combination, services for an individual with a disability to enable the individual to maximize opportunities for employment, including career advancement.

"Comparable services and benefits" means services that are provided or paid for in whole or in part by other Federal, state or local public agencies, health insurance or employee benefits, and are available to the individual at the time needed to ensure the progress of the individual toward achieving the employment outcome in the individual’s individualized plan for employment in accordance with 34 CFR 361.53, and commensurate to the services that the individual would otherwise receive from the designated State vocational rehabilitation agency. For the purposes of this definition, comparable services and benefits do not include awards and scholarships based on merit but the progress of the individual toward achieving his/her identified employment outcome.

"Compensatory training" means training required before the client can enter a formal training program or employment, such as pre-vocational or personal adjustment training.

"Competitive integrated employment" means full or part-time work that is compensated at or above minimum wage, offers an individual with a disability benefits and opportunities for advancement comparable to those offered to employees in similar positions, and is performed in a setting where the individual with a disability interacts with persons without disabilities to the same extent that employees who are not individuals with disabilities and who are in comparable positions interact with these persons. Specific criteria defining competitive integrated employment are detailed in 34 CFR 361.5(c)(9).

"Consumer Independence Support Services" (CISS) are defined as providing independent living assessment, intensive counseling, community integration, and housing modifications to further assist consumers—individuals with severe disabilities in achieving independence.

"Continuity of Services" means once an individual is selected for services in accordance with policy/administrative rules, regardless of the priority category from which the individual was selected, the individual will receive the necessary purchased services, including post-employment services.

"Counselor" means the qualified vocational rehabilitation professional, who is an employee of the designated state unit, and who has primary responsibility for the management of an individual's rehabilitation services record of service/case record, including determination of eligibility, service planning and management, counseling and guidance, and determination of successful or unsuccessful rehabilitation. Counselor is equivalent to such terms as VR/ SBVI Specialist and VR/SBVI Coordinator.

"Customized employment" means competitive integrated employment, for an individual with a significant disability, that is based on an individualized determination of the unique strengths, needs and interests of the individual; designed to meet the specific abilities of the individual and the business needs of the employer; and carried out using flexible strategies such as those detailed in 34 CFR 361.5(c)(11).

"Department" unless otherwise indicated in the text, means the Department of Rehabilitation Services as constituted in 74 O.S., Section 166.1 et seq.

"DRS" means the Department of Rehabilitation Services.

"DVR" means the Division of Vocational Rehabilitation.

"DSBVI" means the Division of Services for the Blind and Visually Impaired.

"Electronic Case Management System" means a "system of records" which is a group of any records under the control of any agency from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual.

"Eligibility" or "Eligible" means:

(A) when used in relation to an individual's qualification for Vocational Rehabilitation services, a determination that the individual has a physical or mental impairment which for such individual constitutes or results in a substantial impediment to employment; can benefit in terms of an employment outcome from rehabilitation services; and requires vocational rehabilitation services to prepare for, secure, retain, advance in or regain employment;

(B) when used in relation to an individual's qualification for Supported Employment services, a determination that the individual is eligible for Vocational Rehabilitation services; is an individual with the most significant disabilities (priority group one); and

(i) for whom competitive employment has not traditionally occurred; or

(ii) for whom competitive employment has been interrupted or intermittent as a result of a significant disability; and

(iii) who, because of the nature and severity of their disability, need intensive supported employment services, and extended services after the transition from intensive supported employment services, in order to perform such work;

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(C) when used in relation to an individual’s qualification for Rehabilitation Teaching services, a finding that an individual is legally and/or functionally blind, has a rapidly progressive eye condition, or has a visual impairment that with or without secondary disabilities results in functional visual limitations; the individual has identifiable deficiencies in independent living due to disabilities and it is expected services will improve the individual's independence in the home and community.

"Eligible individual" means an applicant for vocational rehabilitation services who meets the eligibility requirements of 34 CFR 361.42(a).

"Employment and Retention" (E&R) means short-term job coach support for individuals with severe disabilities who require assistance preparing for, obtaining, and maintaining employment.

"Employment outcome" means, with respect to an eligible individual, entering, advancing in, or retaining full-time or part-time competitive integrated employment as defined in 34 CFR §361.5(c)(9) (including customized employment, self-employment, telecommuting, or business ownership), or supported employment as defined in 34 CFR §361.5(c)(53), that is consistent with an individual's unique strengths, resources, concerns, priorities, concerns, abilities, capabilities, interests, and informed choice. (Note: As specified in federal rule, a designated State unit may continue services to individuals with uncompensated employment goals on their approved individualized plans for employment prior to the effective date of the final federal regulations until June 30, 2017, unless a longer period of time is required based on the needs of the individual with the disability, as documented in the individual's service record.)

"Extended employment" means work in a non-integrated or sheltered setting for a public or private nonprofit agency or organization that provides compensation in accordance with the Fair Labor Standards Act and any needed support services to an individual with a disability to enable the individual to continue to train or otherwise prepare for competitive integrated employment.

"Extended period of time" means, with respect to duration of vocational rehabilitation services that are expected to extend at least 6 months from eligibility.

"Extended services" means ongoing support services provided to individuals with the most significant disabilities, including youth with the most significant disabilities, after the time-limited vocational rehabilitation services have been completed and job stabilization has been achieved. They consist of specific services, including natural supports, needed to maintain the supported employment placement. Extended services are paid from funding sources other than DRS and are specifically identified in the IPE, except that DRS may provide and pay for extended services for youth with the most significant disabilities for a period not to exceed 4 years or extend beyond the date when the youth reaches age 25.

"Extreme medical risk" means a risk of substantially increasing functional impairment or risk of death if medical services including mental health services, are not provided expeditiously.

"Family member" means for purposes of receiving vocational rehabilitation services in accordance with 34 CFR 361.48(b)(9), an individual who either is a relative or guardian of an applicant or eligible individual; or lives in the same household as an applicant or eligible individual; who 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.

"Functional capacities" means a client's assets, strengths, and resources which maintain or increase the individual's ability to work. Functional capacities include mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills.

"Functional limitations" means physical or mental conditions, emergent from a disability, which impair, interfere with, or impede one or more of an individual's functional capacities.

"Higher education" means universities, colleges, community/junior colleges, vocational schools, technical institutes, or hospital schools of nursing.

"Highly challenged" describes a client receiving supported employment services who, due to the nature of the disability, requires a greater level of support from the job coach to achieve and maintain employment.

"IEP" means Individualized Education Program as required by the Individuals with Disabilities Education Act.

"Independent Living (IL) Core Services" is defined as information and referral services; independent living skills training; peer counseling; individual and systems advocacy; and services that facilitate the transition of individuals with significant disabilities from institutions to community-based residences, assist individuals at risk of entering institutions to remain living in the community, and assist the transition to postsecondary life for youth with significant disabilities who were eligible for special education and are no longer in school.

"Independent Living Services" as defined in the Rehabilitation Act, 29 USC Section 705 (17) and (18), include IL core services and counseling, housing procurement and modifications, personal assistance, mobility training, habilitation technology, life skills training, interpreters, readers, transportation, community integration, supported living, physical rehabilitation, aids and devices, social and recreational opportunities, and other services that are necessary and not inconsistent with the Act's provisions related to independent living.

"Individual with a disability" means an individual who has a physical or mental impairment whose impairment constitutes or results in a substantial impediment to employment; and who can benefit in terms of an employment outcome from the provision of vocational rehabilitation services having one or more physical or mental conditions which materially limits, contributes to limiting, or, if not corrected, will probably result in limiting an individual's employment activities or vocational functioning.
"Individual with a severe disability" means with respect to eligibility for the state's Optional Program for Hiring Applicants with Disabilities, an individual who has a physical or mental impairment which seriously limits one or more functional capacities (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of an employment outcome.

"Individual with a significant disability" means an individual with a disability:
(A) who has a severe physical or mental impairment that seriously limits one or more functional capacities (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of an employment outcome;
(B) whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time; and
(C) who has one or more physical or mental disabilities resulting from amputation, arthritis, autism, blindness, burn injury, cancer, cerebral palsy, cystic fibrosis, deafness, head injury, heart disease, hemiplegia, hemophilia, respiratory or pulmonary dysfunction, mental illness, intellectual disability, multiple sclerosis, muscular dystrophy, musculoskeletal disorder, neurological disorders (including stroke and epilepsy), paraplegia, quadriplegia, other spinal cord conditions, sickle cell anemia, specific learning disability, end-stage renal disease or other disability or combination of disabilities determined on the basis of an assessment for determining eligibility and vocational rehabilitation needs to cause comparable substantial functional limitation.

"Individual with the most significant disability" means an individual with a significant disability who meets the designated State unit's criteria for an individual with a most significant disability. These criteria must be consistent with the requirements in 34 CFR 361.36(d)(1) and (2):
(A) who has a severe physical or mental impairment that seriously limits three or more functional capacities in terms of an employment outcome;
(B) whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time; and
(C) who has one or more physical or mental disabilities resulting from amputation, arthritis, autism, blindness, burn injury, cancer, cerebral palsy, cystic fibrosis, deafness, head injury, heart disease, hemiplegia, hemophilia, respiratory or pulmonary dysfunction, mental illness, intellectual disability, multiple sclerosis, muscular dystrophy, musculoskeletal disorder, neurological disorders (including stroke and epilepsy), paraplegia, quadriplegia, other spinal cord conditions, sickle cell anemia, specific learning disability, end-stage renal disease or other disability or combination of disabilities determined on the basis of an assessment for determining eligibility and vocational rehabilitation needs to cause comparable substantial functional limitation.

"Individual's representative" means any representative chosen by an applicant or eligible individual, as appropriate, including a parent, guardian, other family member, or advocate, unless a representative has been appointed by a court to represent the individual, in which case the court-appointed representative is the individual's representative.

"Integrated setting" means:
(A) With respect to the provision of services, a setting typically found in the community in which applicants or eligible individuals interact with non-disabled individuals other than non-disabled individuals who are providing services to those applicants or eligible individuals.
(B) With respect to an employment outcome, a setting typically found in the community where the employee with a disability interacts, for the purpose of performing the duties of the position, with other employees within the particular work unit and the entire work site, and, as appropriate to the work performed, other persons (e.g., customers and vendors) who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that employees who are not individuals with disabilities and who are in comparable positions interact with these persons in which applicants or eligible individuals interact with non-disabled individuals, other than non-disabled individuals who are providing services to those applicants or eligible individuals, to the same extent that non-disabled individuals in comparable positions interact with other persons.

"Intercurrent (acute) conditions" means an illness or injury occurring during the actual course of an individual's rehabilitation which, if not cared for, will complicate or delay achievement of the client's employment outcome as identified in the client's IPE.

"IPE" means the Individualized Plan for Employment.

"Job Club" is a structured learning experience for a client to build skills in self-assessment, resume development, job search and research strategies, and interview techniques to assist the person to enter a career of their choice.

"Job Coach/Employment Training Specialist" means a qualified individual providing support services to eligible individuals in supported employment and employment and retention programs. Services directly support the eligible individual's work activity including marketing and job development, applied behavioral analysis, job and work site assessment, training, and worker assessment, job matching procedures, and teaching job skills.

"Long-term treatment" means medical or psychological treatment that is expected to last more than three months.

"Maintenance" is a service provided to assist with the out of ordinary or extra expense to the individual resulting from and needed to support the individual's participation in diagnostic, evaluative, or other substantial services in the IPE.

Activities of Daily Living (ADL) expenses are not eligible for maintenance payments means monetary support provided to
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...an individual for expenses, such as food, shelter, and clothing, that are in excess of the normal expenses of the individual and that are necessitated by the individual's participation in an assessment for determining eligibility and vocational rehabilitation needs or the individual's receipt of vocational rehabilitation services under an individualized plan for employment.

"Milestones" means a payment system that reimburses a vendor based on incentives and outcomes. The vendor is paid when the client completes pre-defined checkpoints on the way to a desired employment goal.

"Multiple services" means the counseling and guidance provided as a routine part of case management plus two or more VR services. Comparable benefits and/or services can count toward meeting the definition of multiple services. Services routinely provided as a package do not count as multiple services for the purpose of determining the presence of a significant disability, even if two or more services are included in the package.

"Natural supports" means any assistance, relationships or interactions that allow a person to maintain employment in ways that correspond to the typical work routines and social interactions of other employees. Natural supports may be developed through relationships with people or put into place by the adaptation of the work environment itself, depending on the support needs of the person and the environment.

"Occupational license" means any license, permit, or other written authority required by a state, city or other governmental unit to be obtained in order to enter an occupation.

"OMES-DCAM" means Office of Management & Enterprise Services-Division of Capital Assets Management, which sets thresholds for State Purchasing guidelines.

"Ongoing support services" means services specified in the IPE according to individual need, which support and maintain an individual with the most significant disabilities in supported employment. Sponsored ongoing support services are provided from the time of placement until the individual is stabilized on the job. Ongoing support services are provided by one or more extended services providers, or by natural supports, following transition throughout the individual's term of employment.

"Other Qualified Rehabilitation Personnel" means qualified rehabilitation personnel who, in addition to rehabilitation counselors, are necessary to facilitate the accomplishment of the employment outcomes and objectives of an individual (Section 100(a)(3)(E) of the Act.) Other qualified rehabilitation personnel include, but are not limited to, rehabilitation teachers of the blind who are certified at the national level.

"Package of services" means several services which are usually provided together for the same purpose. The services in a package are usually, but not always, from the same category of services (see definition of multiple services, this section). Examples include, but are not limited to: surgery, anesthesia, and hospitalization; or personal computer, software, and peripheral equipment.

"Personal assistance services" means a range of services including, among other things, training in managing, supervising, and directing personal assistance services, provided by one or more persons, that are designed to assist an individual with a disability to perform daily living activities or off the job that the individual would typically perform without assistance if the individual did not have a disability. The services are also designed to increase the individual's control in life and ability to perform everyday activities on or off the job; necessary to the achievement of an employment outcome; and provided only while the individual is receiving other vocational rehabilitation services.

"Physical and mental restoration services" means services which are necessary to correct or substantially modify a physical or mental condition which is stable or slowly progressive, within a reasonable period of time, corrective surgery or therapeutic treatment that is likely, within a reasonable period of time, to correct or modify substantially a stable or slowly progressive physical or mental impairment that constitutes a substantial impediment to employment.

"Physical or mental disability impairment" means a physical or mental condition which, if not corrected, materially limits, contributes to limiting or will result in limiting an individual's activities or functioning, any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculo-skeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine; or any mental or psychological disorder such as intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Post-employment services" means one or more of the services identified in 34 CFR 361.48(b) that are provided subsequent to the achievement of an employment outcome and that are necessary for an individual to maintain, regain, or advance in employment, consistent with the individual's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice.

"Pre-employment transition services" means the required activities and authorized activities specified in 34 CFR 361.48(a)(2) and (3).

"Prior approval" refers to the receipt of approval from the granting authority prior to issuing the authorization for the purchase of goods and services.

"Record of Service" means any item, collection, or grouping of information about an individual that is maintained by an agency, including, but not limited to, the individual's education, financial transactions, medical history, and criminal or employment history and that contains his name, or the identifying number, symbol, or other identifying particular assigned to the individual.

"Rehabilitation Act" means the Rehabilitation Act [29 USC 701 et seq.].

"Rehabilitation engineering" means the systematic application of engineering sciences to design, develop, adapt, test, evaluate, apply, and distribute technological solutions to...
problems confronted by individuals with disabilities in functional areas, such as mobility, communications, hearing, vision, and cognition, and in activities associated with employment, independent living, education, and integration into the community.

"Rehabilitation technology" means the systematic application of technologies, engineering methodologies, or scientific principles to meet the needs of, and address the barriers confronted by, individuals with disabilities in areas that include education, rehabilitation, employment, transportation, independent living, and recreation. The term includes rehabilitation engineering, assistive technology devices, and assistive technology services.

"Related factors" means those factors which are not directly attributable to the impediment to employment, but which have impact on the potential for successful rehabilitation. They frequently become evident only from an assessment of the person's social, vocational, educational, and environmental circumstances.

"SBVI" means the Division of Services for the Blind and Visually Impaired, depending upon the context.

"Section 504 Plan" is a plan designed as a protection for students with disabilities who may not be considered eligible for special education under IDEA in compliance with Section 504 of the Rehabilitation Act of 1973 as amended.

"Small business enterprises" means a small business operated by blind or other individuals with severe disabilities under the management and supervision of the state DRS. Such businesses include only those selling, manufacturing, processing, servicing, agricultural, and other activities which are suitable and practical for the effective utilization of the skills and aptitudes of individuals who are blind or individuals who have severe disabilities. Small business enterprises provide substantial gainful employment or self-employment commensurate with the time devoted by the operators to the business, the cost of establishing the business and other factors of an economic nature.

"Sole local agency" means a unit or combination of units of general local government or one or more Indian tribes that has the sole responsibility under an agreement with, and the supervision of, the State agency to conduct a local or tribal vocational rehabilitation program, in accordance with the vocational rehabilitation services portion of the Unified or Combined State Plan.

"Stabilization" means the period of time when job coach support is reduced to the long-term maintenance level while the individual retains employment, and personal satisfaction with the job, as well as employer satisfaction with the person's job performance. Stabilization must include appropriate individualized supports, including a minimum of two employee contacts and one employer contact per month.

"Student with a disability" means, in general, an individual with a disability in a secondary, postsecondary, or other recognized education program who meets the requirements set forth in 34 CFR 361.5(c)(51)

"Substantial impediment to employment" means that a physical or mental disability (in the light of attendant-related medical, psychological, vocational, educational, communication, and other related (cultural, social or environmental) factors) hinders that individual from preparing for, entering into, engaging in, advancing in, or retaining employment consistent with the individual's abilities and capabilities occupational performance, by preventing his/her obtaining, retaining, or preparing for a gainful occupation consistent with his/her capacities and abilities.

"Supported employment" (SE) means competitive integrated employment, including customized employment, or employment in an integrated work settings in which an individual with a most significant disability, including a youth with a most significant disability, is working on a short-term basis toward competitive integrated employment that is individualized, and customized, consistent with the unique strengths, abilities, interests, and informed choice of the individual, including with ongoing support services for individuals with the most significant disabilities who meet the requirements set forth in 34 CFR 361.5(c) (53) and temporary, on a short-term basis toward competitive work, consistent with the strength, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals, for individuals with the most significant disabilities who meet the eligibility criteria for supported employment as defined in 34 CFR 361.5(c)(53). For purposes of this definition, "short-term basis" shall mean six months or up to 12 months in limited circumstances as described in 34 CFR.

"Supported employment services" means ongoing support services, including customized employment, and other appropriate services needed to support and maintain an individual with a most significant disability, including a youth with a most significant disability, in supported employment that are:

(A) Organized and made available, singly or in combination, in such a way as to assist an eligible individual to achieve competitive integrated employment;

(B) Based on a determination of the needs of an eligible individual, as specified in an individualized plan for employment;

(C) Provided by the designated State unit for a period of time not to exceed 24 months, unless under special circumstances the eligible individual and the rehabilitation counselor jointly agree to extend the time to achieve the employment outcome identified in the individualized plan for employment; and

(D) Following transition, as postemployment services that are unavailable from an extended services provided and that are necessary to maintain or regain the job placement or advance in employment.

"Transition services" means, for a student or a youth with a disability, a coordinated set of activities designed within an outcome-oriented process that promotes movement from school to post-school activities, including postsecondary education, vocational training, competitive integrated employment, supported employment, continuing and adult education, adult services, independent living, or community participation. Transition services (1) are based upon the individual student's
or youth's needs, preferences and interests; (2) include instruction, community experiences, the development of employment and other post-school adult living objectives, and, if appropriate, acquisition of daily living skills and functional vocational evaluation; (3) promote or facilitate the achievement of the employment outcome identified in the student's or youth's individualized plan for employment; and (4) include outreach to and engagement of the parents, or, as appropriate, the representative of such a student or youth with a disability.

"Transportation" is a service provided to assist with the costs of travel, including instruction in the use of public transportation vehicles and systems, which result from and are needed to support the individual's participation in diagnostic, evaluative, or other substantial and necessary VR services means travel and related expenses that are necessary to enable an applicant or eligible individual to participate in a vocational rehabilitation services, including expenses for training in the use of public transportation vehicles and systems.

"Vocational rehabilitation services", if provided to an individual, means those services listed in 34 CFR 361.48; and if provided for the benefit of groups of individuals, means those services listed in 34 CFR 361.49.

"VR" means the Division of Vocational Rehabilitation, or the more general term vocational rehabilitation services, depending upon the context.

"Youth with a disability" means an individual with a disability who is not younger than 14 years of age; or older than 24 years of age. Youth with disabilities means more than one youth with a disability.

612:10-1-3. Basic philosophy of rehabilitation programs

(a) Purpose. The purpose of programs and services provided by the Division of Vocational Rehabilitation (DVR) and the Division of Services for the Blind and Visually Impaired (DSBVI) is to empower individuals with disabilities to maximize employment, economic self-sufficiency, independence, and inclusion and integration into society by operating statewide comprehensive, coordinated, effective, efficient, and accountable through comprehensive programs of vocational rehabilitation programs, each of which is an integral part of a statewide workforce development system. Vocational rehabilitation programs are designed to assess, plan, develop and provide vocational rehabilitation services for individuals with disabilities, consistent with their unique strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice, so that they may prepare for and engage in competitive integrated employment and achieve economic self-sufficiency.gainful employment (34 CFR 361.1-01).

(b) Basic philosophy. DVR and DSBVI vocational rehabilitation programs are carried out in accordance with the principles stated in Section 440101 (a) of the Rehabilitation Act as amended by the Workforce Innovation and Opportunity Act (WIOA) (P.L. 113-128), signed into law on July 22, 2014 seeks to empower individuals with disabilities including:

(1) Individuals with disabilities, including individuals with the most significant disabilities, are generally presumed to be capable of engaging in gainful employment and the provision of individualized vocational rehabilitation services can improve their ability to become gainfully employed.

(2) Individuals with disabilities must be provided the opportunities to obtain gainful competitive integrated employment performed on a full-time or part-time basis in integrated settings.

(3) Individuals with disabilities must have the opportunity to be active and full partners in their vocational rehabilitation process.

(4) Qualified vocational rehabilitation counselors and other qualified and specialized rehabilitation personnel are necessary to facilitate the accomplishment of the employment outcomes and objectives of an individual.

612:10-1-3.1. Procedural exceptions

Procedures set forth in this Chapter are not intended to reflect every situation that might confront DVR or DSBVI staff or to replace the staff's use of good judgment. In individual cases an exception from basic procedures may be requested. Authority to approve certain deviations from standard procedures rests as appropriate, with either the DVR or DSBVI Division Administrator Division Administrator. Authority to approve certain procedural exceptions has beemay be delegated to program manager the Program Managers and Area Field Coordinators field coordinators. Only those procedural exceptions stated in a rule may be applied to that rule.
served with a subpoena for the release of client information, staff should notify the general counsel immediately. In a legal proceeding, client information can only be released without the client's consent in response to a court order. A subpoena by itself is not sufficient to authorize disclosure of client information.

(b) **Written release required.** Release of personal information must be by written consent of the individual or authorized individual's representative. If requested in writing by an applicant or eligible individual, DRS will make all requested information in that individual's record of services available to the individual in a timely manner except as provided in subsection (c). The Department's Authorization for Release of Information form may be used when the client requests that personal information be released by DRS to a third party and may also be used to request confidential information from other sources. Other release forms are acceptable, as long as they provide the required information. Written authorization for release of information must include:

1. The nature of the information to be released;
2. Designation of the parties to whom the information is to be released;
3. The specific purpose for which the released information may be used;
4. Designation of the agency or person authorized to disclose the information; and
5. Dates of initiation and termination of consent.

(c) **Release of information to the individual.** The individual, or the individual's representative, will be given access to the relevant case record, or provided copies of requested information upon providing a written authorization for release of information, except as in (1) through (3) of this Subsection.

1. Psychological, psychiatric, mental health and substance abuse treatment records and information from psychological, psychiatric, mental health and substance abuse treatment practitioners may only be obtained provided the requirements of Section 1-109 of Title 43A of the Oklahoma Statues are met. Under these circumstances, refer the individual, or the individual's representative, to the treating health professional.
2. When a DRS professional staff person believes medical or other information not covered in (1) of this Subsection may be harmful to the individual, the information may not be released directly to the individual but must be provided to the individual through a third party chosen by the individual, which may include, among others, an advocate, a family member, or a qualified medical or mental health professional, unless a representative has been appointed by a court to represent the individual, in which case the information must be released to the court-appointed representative.
3. Information obtained from another organization or agency may be released only through that agency, or under the conditions established by the outside agency, organization or providers. For example, information from the Veteran's Administration and Social Security Administration may not be released. Refer the individual requesting such information to the source from which the information was obtained.
4. An explanation of State policies and procedures affecting personal information will be provided to each individual in that individual's native language or through the appropriate mode of communication.

(d) **Request for information correction.** An individual who believes that information in the individual's case record is inaccurate or misleading may request that the information be amended. Even if the information is not amended, the request for amendment must be documented in the case record.

(e) **Release of information to other programs or authorities.** Paragraphs (1) through (4) of this Subsection provide the rules governing release of personal information to other programs or authorities.

1. Upon receiving the informed written consent of the individual, or the individual's representative, information may be released to another agency or organization. Only that information that would be released to the involved individual, or the individual's representative will be released, and only to the extent that the other program or organization demonstrates that the information requested is necessary for its program.
2. Personal information will be released if required by Federal law or regulations.
3. Personal information will be released in response to investigations in connection with law enforcement, fraud, or abuse, unless expressly prohibited by Federal or State laws or regulations, and in response to an order issued by a judge, magistrate, or other authorized judicial officer.
4. Personal information may be released in order to protect the individual or others if the individual poses a threat to his or her safety or to the safety of others.

(f) **Release of information for audit, evaluation or research.** Personal information may be released to an organization, agency, or individual engaged in audit, evaluation, or research, only:

1. For the purposes directly connected with the administration of the DVR or DSBVI program;
2. For purposes which would significantly improve the quality of life for persons with disabilities; and
3. If the organization, agency or individual assures:
   A. The information will be used only for the purpose it is being provided;
   B. The information will be released only to persons officially connected with the audit, evaluation or research;
   C. The information will not be released to the individual;
   D. The information will be managed in a manner to safeguard confidentiality; and
   E. The final product will not reveal any personal identifying information without the informed written consent of the involved individual or the individual's representative. [34CFR361.38]

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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 and pre-employment transition services for students with disabilities regardless of whether the student has applied or been determined eligible for vocational rehabilitation services, 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 DSBV1 staff, in accordance with (g) and (h) of this section, approves the claim, then forwards it to the DRS 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.

(1) All authorizations are to be issued prior to or simultaneously with the provision of the services.

(2) Verbal authorizations may be made when needed to ensure effective delivery of services. Verbal authorization must be followed immediately by the actual authorization.

(3) 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.

(b) Since the Department is a state-federal agency, it does not pay sales, excise, or transportation taxes. A prior vendor contract is required before authorizations can be made to any post-secondary school.

(1) By state law, a vendor contract cannot be issued for more than 12 months. If this written purchase agreement should lapse, vendor’s claims will be denied by the Department.

(A) Training facility agreements. Training services are purchased from a specific vendor when a written agreement has been approved. Training facility are any type of facility that provides training such as colleges, real estate school, private trade schools, private vocational schools and career techs. A post-secondary school (private or public) must have a prior written vendor contract with DRS before services can be authorized to that vendor, unless the school is participating in a direct payment program.

(B) Out-of-state vendor contracts. Are required to have a prior written vendor contract with DRS before services can be authorized to that vendor. The client will be provided an opportunity to attend the training facility of choice provided the facility has a written agreement with the Department.

(2) When a vendor has this prior written purchasing agreement with the Department, and required approvals have been obtained, authorization may be issued for vocational rehabilitation services directly to that vendor.

(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 DSBV1 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. Other nonmedical vendors will not require a prior written purchasing agreement unless stated otherwise in the DRS administrative rule manual section(s) for that service.

(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. All other vocational rehabilitation services will be purchased pursuant to the administrative rules in (j) and (m) 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 individual 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 DSBV1 staff, in accordance with (j) and (m) of this section, approves the claim, then forwards it to the DRS Finance Services Division.
(1) When a vendor does not abide by the authorization or written purchasing agreement or bills and accepts payment 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.

(2) The vendor will not be used for further rehabilitation services until agreement to discontinue the objectionable practice is reached.

c) The Department retains right and title to any tools, equipment, durable medical equipment, or other goods costing $500 or more purchased with DVR and DSBV1 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 approved. Since the Department is a state-federal agency, it does not pay sales, excise, or transportation taxes.

(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 using the items as planned.

(1) 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. 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.

(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: The individual is liable for services he/she arranged which were not planned and initiated under the auspices of DRS.

(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 the amount of the DCAM 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 the DCAM authority order limit, the rehabilitation professional will follow rules in (1) through (7) of this subsection. The Department retains right and title to any tools, equipment, durable medical equipment, or other goods costing $500 or more purchased with DVR and DSBV1 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 approved.

(1) The rehabilitation professional will obtain specialist recommendations for purchase requirements and approvals in accordance with agency policy. 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) 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. 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) 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 21 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. 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 using the items as planned.

(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 $5,000.00 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. 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 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 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 case load will be requested to determine the appropriate action to take. 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.

(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. Purchasing vocational rehabilitation 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.

(k) When a prior written purchasing agreement for vocational rehabilitation goods or services, other than direct client payments, is not required, and the service or package of services to be obtained will cost the amount of the OMES-DCAM 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 vocational rehabilitation services, other than direct client payments, is not required, and the service or package of services will cost more than the OMES-DCAM order limit, the rehabilitation professional will follow administrative 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 administrative rules.
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 $5,000.00 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. 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 Finance 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 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.

(1) Program Managers will review record of services 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 records of services 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 administrative rules, a fiscal audit of the entire caseload will be requested to determine the appropriate action to take. Prior to the initiation of the Individualized Plan for Employment (IPE), the counselor must determine if:

(a) a vendor agreement is needed;
(b) there is an established rate or fee schedule; and
(c) client’s participation in cost of services is required.

(m) 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.

612:10-1-8. Vendor contracts [REVOKED]

(a) Nonmedical vendor contracts. A post-secondary school (private or public) must have a prior written purchasing agreement with DRS before services can be authorized to that vendor, unless the school is participating in a direct payment program. Other nonmedical services to be purchased from a vendor will not require a prior written purchasing agreement unless stated otherwise in the DRS manual section(s) for that service, or in accordance with 612:10-1-7. Services requiring a prior written agreement cannot be authorized until a prior written agreement has been completed. Prior to the initiation of the Individualized Plan for Employment (IPE), the counselor must determine if:

1. a vendor agreement is needed;
2. there is an established rate or fee schedule; and
3. client’s participation in cost of services is required.

(b) Training facility agreements. Training services are purchased from a specific vendor when an active agreement has been approved by the Department of Central Services and placed on file in the Office of Management and Enterprise Services.

(c) Out-of-state vendor agreements. By state law, an agreement cannot be issued for more than 12 months. If an agreement should lapse, vendor’s claims for client’s training will be denied by the Department under state law. The client will be provided an opportunity to attend the training facility of choice provided the facility has an active agreement with the Department.

(d) Medical vendor agreements. Medical services or supplies may be purchased only from medical vendors having active purchasing agreements with the Department.

SUBCHAPTER 3. CLIENT PARTICIPATION IN COST OF SERVICES

612:10-3-2. Consideration of comparable services and benefits

(a) Determination of availability. Prior to providing an accommodation or auxiliary aid or service or any VR services, vocational rehabilitation services, except those services listed under 34 CFR 361.53 (b), to an eligible individual or to members of the individual’s family, except those services specified in Paragraph (1), the VR or SBVI counselor must determine whether comparable services and benefits, as defined in 34 CFR 361.5 (c) (8) are available to the individual unless such a determination would interrupt or delay services according to 34 CFR 361.53 (a-c), under any other program unless any of the conditions in Paragraph (2) apply to the individual.

(b) The VR services listed in (A) through (F) are to be provided without first determining the availability of comparable services and benefits. However, comparable services and benefits may be used for these VR services if the comparable services and benefits are readily available at the time the VR services are needed. VR services exempt from a required search for comparable services and benefits are:

(A) information and referral services to eligible individuals not in an open priority group under the order of selection;

(B) assessment for determining eligibility and vocational rehabilitation needs by qualified personnel, including, if appropriate, an assessment by personnel skilled in rehabilitation technology;
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(C) counseling and guidance, including information and support services to assist an individual in exercising informed choice;
(D) referral and other services to secure needed services from other agencies through cooperative agreements;
(E) job-related services, including job search and placement assistance, job retention services, follow-up services, and follow-along services; and
(F) rehabilitation technology, including telecommunications, sensory, and other technological aids and devices.

(2) Determining whether comparable benefits and services are available will not be required prior to providing any VR services if that determination would interrupt or delay:
(A) the progress of the individual toward achieving the employment outcome identified in the IPE;
(B) an immediate job placement; or
(C) the provision of such services to any individual at extreme medical risk.

(b) Exempt services. The vocational rehabilitation services described in 34 CFR 361.48 (b) are exempt from a determination of the availability of comparable services and benefits under paragraph (a) of this section as identified in 34 CFR 361.53 (b) (1-6). Counselors will advise clients of available benefits, help in completing the application for such benefits when needed, and refer clients to the appropriate contact person. Each client is required to apply for such benefits. DVR and DSBVI will not participate in the cost of services for any client who fails to apply for and accept available comparable benefits.

(4) Whether or not the client must participate in the cost of VR services has absolutely no effect upon the required search for, or use of, available comparable benefits. Available comparable benefits cannot be used in place of client resources when the client is required to participate in the cost of VR services.

(5) A student loan is not a comparable benefit. Failure to apply for a student loan which must be repaid will not be cause to withhold participation by DVR or DSBVI. Clients who have defaulted on a student loan will not be assisted with post-secondary training until the client has cleared the default or has made arrangement with the lender on the terms of payment.

(6) Clients will be informed of and are expected to provide the counselor a copy of the award letter(s) or other written notice of comparable benefits received from other sources.

(d) Awards and scholarships based upon merit will not be counted as comparable benefits.

(e) A student loan is not a comparable benefit. Failure to apply for a student loan which must be repaid will not be cause to withhold participation by DVR or DSBVI. Clients who have defaulted on a student loan will not be assisted with post-secondary training until the client has cleared the default or has made arrangement with the lender on the terms of payment. Documentation of the arrangement made must be in the case record before post-secondary training services are provided when it is known a client has defaulted on a loan. The counselor will inform such clients of organizations which can help resolve debt problems, such as credit counseling services and legal aid.

(f) Clients are expected to provide the counselor a copy of the award letter(s) or other written notice of comparable benefits received from other sources, and it is expected the comparable services and benefits available to the client will be used to defray all or part of the cost of the individual’s IPE.

(g) The client’s IPE will be reviewed and amended by the client and VR counselor whenever comparable services or benefits that were not accounted for in the original plan become available to the client.

(h) Interagency coordination. Cooperative agreements between DRS and other service providers may affect how comparable services and benefits available from such service providers will be applied in an IPE. Cooperative agreements entered into by DRS with other service providers will include:

The vocational rehabilitation services portion of the Unified or Combined State Plan must assure that the Governor, in consultation with DRS and other appropriate agencies, will ensure that an interagency agreement or other mechanism for interagency coordination takes effect between DRS and any appropriate public entity, including the State entity responsible for administering the State Medicaid program, a public institution of higher education, and a component of the statewide workforce development system, to ensure the provision of vocational rehabilitation services, and if appropriate, accommodations or auxiliary aids and services, (other
than those services listed in paragraph (b) of this section) that are included in the individualized plan for employment of an eligible individual, including the provision of those vocational rehabilitation services (including, if appropriate, accommodations or auxiliary aids and services) during the pendency of any interagency, dispute in accordance with the provisions of paragraph (d) (3) (iii) of 34 CFR 361.53 (d) (1-3).

(1) provisions for determining and stating the financial responsibility of each agency in providing services;
(2) conditions, terms, and procedures for DVR to be reimbursed by other agencies for providing covered services;
(3) procedures for resolving interagency disputes under the agreement; and
(4) coordination of agency procedures for timely VR services delivery.

(e) Responsibilities under other law. If a public entity other than DRS is obligated under Federal law (such as the Americans with Disability Act, Section 504 of the Act, or section 188 of the Workforce Innovation and Opportunity Act) or State law, or assigned responsibility under State administrative rules or an interagency agreement established under this section, to provide or pay for any services considered to be vocational rehabilitation services (e.g., interpreter services under 34 CFR 361.48 (i)), and, if appropriate, accommodations or auxiliary aids and services other than those services listed in paragraph (b) of this section, the public entity must fulfill that obligation or responsibility according to the terms in 34 CFR 361.53 (e) (1-2).

612:10-3-3. Client participation in services cost and financial status determination Participation of individuals in cost of services based on financial need

(a) DRS has chosen to consider the financial need of eligible individuals or individuals who are receiving services through the trial work experiences under 34 CFR 361.42 (e) for purposes of determining the extent of their participation in the costs of vocational rehabilitation services, other than those services identified in paragraph (c) in this section according to the criteria set forth in 34 CFR 361.54 (b) (1-2).

(ab) DVR and DSBVI requires requires the client to participate in the cost of some vocational rehabilitation services if the client and/or client's family income exceeds the established basic living requirement for the applicable family size. Any client whose available family income exceeds the applicable basic living requirements is required to apply the monthly surplus to the costs of services during each 30 day period services are provided who has been determined eligible for Social Security benefits under Title II or XVI of the Social Security Act is exempt from client participation in service costs.

(b) Before an individual can be provided services other than those listed in DRS policy, the counselor must evaluate the client's financial situation to determine if the client must participate in the cost of services, and if so, the amount of such participation. Any client whose available family income exceeds the applicable basic living requirements is required to apply the monthly surplus to the costs of services during each 30 day period services are provided. DVR and DSBVI funds will not be used to purchase services based on client's financial status when there is any refusal on client's behalf to participate in the cost of services. However, the client can be provided services not based on financial status. Any client who does not have a surplus is not required to participate in the cost of services. Financial status does not exempt the client from required use of comparable benefits. If a payment is required of the client, it will be made to the vendor.

(c) The counselor will re-evaluate the client's financial situation at least annually and any time there is a change in the financial situation of the client or family. The amount of client participation in cost is based upon the most recent determination of client's financial status at the time the IPE or amendment is written, and is stated in the IPE or amendment. A basic living requirement has been established for different size family groups. A family member is an individual who is a relative or guardian of an applicant or eligible individual. Basis living requirements are based on 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 need 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 and single;
(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 (7) of this section or;
(6) The counselor verifies the client has the financial resources to demonstrate self-sufficiency and the client declares no family contributions are available.

(7) An eligible individual whose disability has resulted in the need to live with family or friend, and as appropriate the individual's spouse and dependent children, will be considered as a separate household regardless of living arrangements.

(A) Verification of family membership should be based upon whatever available information most accurately documents family membership according to the definition given in this administrative rule.

(B) Examples of acceptable verification include the latest Federal income tax return, payroll information, insurance policies, client report, and/or counselor observation.

(d) The client's financial status must be verified when an IPE includes services which require client participation in cost of services. Information used to verify the client's financial status includes such documents as income tax returns, bank statements, pay stubs, canceled checks, payment receipts, and/or payroll documents. It is the client's responsibility to provide
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the documents needed for verification of financial status information for the family. If the client refuses to provide the requested verification, DVR and DSBV1 resources will not be used to defray the cost of services which require client participation in cost of services. The client can be provided services not based on financial needs, the following services do not require a determination of financial need status:

1. services provided to assess eligibility and priority for services (services which would require the individual's participation in cost under an IPE will also require the individual's participation in cost during an evaluation of the individual's ability to benefit from VR services);
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, including other components of the statewide workforce development system;
4. on-the-job training, work experience, internships and apprenticeships;
5. personal or vocational adjustment training;
6. personal assistance services;
7. job-related services including job search and placement assistance, job retention services, follow-up services and follow-along services; under 34 CFR 361.48 (b) (12);
8. compensatory training;
9. Supported employment, employment and retention; or
10. any auxiliary aid or service (e.g., interpreter services, reader services) that an individual with a disability require under Section 504 of the Act or the American with Disabilities Act (42 U.S.C. 12101, et seq.) or regulations implementing those laws, in order for the individual to participate in the VR program.

e. Any client who does not have a surplus is not required to participate in the cost of services. Financial need does not exempt the client from required use of comparable benefits. If a payment is required of the client, it will be made to the vendor.

The counselor will re-evaluate the client's financial situation at least annually and any time there is a change in the financial situation of the client or family. The amount of client participation in cost is based upon the most recent determination of client's financial needs at the time the IPE or amendment. If applicable, the extent of the individual's participation in paying for the cost of services is identified on the IPE service (e.g. Family monthly income surplus will be exhausted prior to agency financial contribution).

g. The client's financial needs must be verified when an IPE includes service which require client participation in costs of services.

(h) Determination of income and liabilities will be verified and documented by the counselor in the record of service when services in the IPE and amendments require client participation in cost. If the individual refuses to provide the requested information, DRS resources will not be used to purchase services which require client participation in cost of the services.

(A) Income generated from salaried wages will be calculated by gross earnings minus federal taxes, state taxes and social security deductions.

(B) Income generated from business or profession will be calculated by adjusted gross minus additional federal and state taxes divided by 12 to determine a monthly amount.

(C) Income received from unearned sources, such as pensions, public assistance, interest, dividends, royalties, trust fund, or money payments of any kind will be counted. Educational grants, stipends, or loans will not be included in the calculation. If a yearly income is available, it will be divided by 12 to calculate a monthly amount.

(2) Liabilities. When the client is making payments on any areas of liability listed below, payments will be itemized. If payments are not being made on a debt, an expense cannot be shown for this item.

(A) Medical. Out-of-pocket medical payments not covered by insurance, including medication and supplies, can be used as a medical expense. Monthly premiums for health insurance can be included.

(B) Disability related expenses. Disability related expenses beyond the basic living requirements may be considered, if not funded by DRS.

(C) Other. Court order commitments, including child support, can be counted as a liability.

(D) Education expenses. Costs for any family member incurred only for tuition, books, and fees toward post-secondary educational expenses, not included in the IPE or paid by grants, scholarships, fee waivers, etc., can be counted as a liability. Only the amount of the payments can be counted as a liability.

(i) Case recording requirements. A statement regarding the re-evaluation of financial needs must be included in the record of service. The financial review may be included in the IPE review if they occur at the same time.

612:10-3.4. Services exempt from client participation in service costs [REVOKED]

(a) DVR and DVS clients who have income and assets above the basic living requirements will be required to apply surplus resources to the cost of rehabilitation services except for the following services which do not require a determination of financial status:

1. services provided to assess eligibility and rehabilitation needs (services which would require the individual's participation in cost under an IPE will also require the individual's participation in cost during an evaluation of the individual's ability to benefit from VR services);

2. counseling, guidance, referral, and other services provided directly by DVR and DVS staff;

3. on-the-job training, work experiences, internships and apprenticeships;

4. personal or work adjustment training;

5. reader services;

6. interpreter services;
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612:10-3-5. Basic living requirements [REVOKED]
(a) A basic living requirement has been established for different size family groups. A family member is an individual who is a relative or guardian of an applicant or eligible individual. Basic living requirements are based on 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) of the Social Security Act;
   (2) At least 21 years of age and single;
   (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 rule. Examples of acceptable verification include the latest Federal income tax return, payroll information, insurance policies, client report, and/or counselor observation.
   (c) An eligible individual whose disability has resulted in the need to live with family or friends, and as appropriate the individual's spouse and dependent children, will be considered as a separate household regardless of living arrangements.

612:10-3-6. Income and Liabilities [REVOKED]
Determination of income and liabilities will be verified and documented by the counselor in the case recording when services in the IPE and amendments require client participation in cost. If the individual refuses to provide the requested information, DRS resources will not be used to purchase services which require client participation in cost of the services.

612:10-7-2. Field 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 qualified vocational rehabilitation counselor is responsible for the determination of an individual's eligibility to receive services from DVR or DBVI. 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

SUBCHAPTER 7. VOCATIONAL REHABILITATION AND SERVICES FOR THE BLIND AND VISUALLY IMPAIRED

PART 1. SCOPE OF VOCATIONAL REHABILITATION AND SERVICES FOR THE BLIND AND VISUALLY IMPAIRED

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a decision. 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 qualified vocational rehabilitation counselor's primary vocational rehabilitation service is counseling and guidance with job placement. 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 DSBVI case.

(d) The qualified vocational 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 administrative rules. 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) client 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 needs test prior to the provision of any service (other than exempt services listed in 612:10-3-3612:10-3-4) to determine if the client will be required to participate in the cost of services. Verification of financial needs is not required if all services on the IPE are "exempt services" or if the agency will not be contributing to the sponsorship of "non-exempt" services (s) on the IPE.

(g) The counselor will inform each individual of his or her rights and responsibilities as an applicant or client of DVR and DSBVI. Cross reference 612:10-7-3.

(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.

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 (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.
(2) Be on time and keep appointments with DVR/DSBVI staff, doctors and others. Call in advance or as soon as possible, if you cannot come to an appointment.
(3) Follow the advice of doctors and other medical professionals to include compliance with all prescribed medications.
(4) Participate with your DVR/DSBVI qualified vocational rehabilitation counselor in developing the Individualized Plan for Employment, (IPE) including participating in assessments needed to determine your needs and strengths.
(5) Provide enrollment documents to your 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.
(6) Attend education or training classes on a regular basis and make at least maintain passing grades, if your IPE includes these services.

(A) Payment of training services based on client's financial need will not be provided if the client's grades fall below 1.8 overall GPA.
(B) Training services may be paid for a client having an overall GPA between 1.8 and 1.9 for the first semester that grades fall below 2.0 overall GPA. Subsequent enrollments can only be paid if the student's overall GPA shows progress.

(7) Review your IPE with your qualified vocational rehabilitation counselor at least once a year and participate in making revisions to the plan when needed.
(8) Maintain satisfactory progress toward completing the IPE.
(9) 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.
(10) Keep the appropriate professional informed of changes in the individual's address, financial status, need, or other program-related changes.

(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.

(12) Work with the counselor to obtain or keep suitable competitive integrated gainful employment or appropriate independent living outcomes as services are being completed.

PART 3. CASE PROCESSING REQUIREMENTS

612:10-7-21.1. Processing incoming referrals

(a) Processing incoming referrals. All referrals to DVR and DSBVI will be contacted by the VR counselor and appropriate action taken within 30 days, after 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 referrals who are deaf or non-English speaking. In situations where the individual cannot be personally contacted, correspondence will be mailed to the individual for informational purposes.

(b) Referrals to rehabilitation teachers. All individuals who are legally blind, whether being served by a DVR counselor or a DSBVI counselor, will be referred to a rehabilitation teacher. Rehabilitation teachers may also receive counselor referrals and provide services for individuals who are not legally blind but have functional limitations due to vision loss and have potential to benefit from rehabilitation teaching services.

612:10-7-21.2. Information and referral system

(a) DVR and DSBVI staff will ensure that individuals with disabilities, including eligible individuals who do not meet order of selection criteria when the agency is operating under an order of selection, are provided accurate vocational rehabilitation information and guidance, using appropriate modes of communication. This information and guidance will be used to assist the individual in preparing for, securing, retaining, or regaining employment.

(b) Staff will ensure that individuals with disabilities are appropriately referred to Federal and State programs, including other components of the workforce investment system. An appropriate referral shall:

(1) be to the Federal or State program(s) best suited to address the specific employment needs of the individual; and

(2) include, for each involved program, provision to the individual of:

(A) a notice of the referral from DVR or DSBVI to the agency responsible for the program;

(3) provide the information identifying a specific point of contact within the agency responsible for the program; and

(C) information and advice regarding the most suitable services to assist the individual.

612:10-7-22.1. Application Processing referrals and applications

(a) Application for services. Referrals. An individual is considered to have submitted an application when the individual or the individual's authorized representative, as appropriate, DR S must establish and implement standards for the prompt and equitable handling of referrals of individuals for vocational rehabilitation services, including referrals of individuals made through the one-stop service delivery systems under section 121 of the Workforce Innovation and Opportunity Act. The standards must include timelines for making good faith efforts to inform these individuals of application requirements and to gather information necessary to initiate an assessment for determining eligibility and priority for services.

(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.);

Processing incoming referrals. All referrals to DVR and DSBVI will be contacted by the VR counselor and appropriate action taken within 30 days, after 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 referrals who are deaf or non-English speaking. In situations where the individual cannot be personally contacted, correspondence will be mailed to the individual for informational purposes.

(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; Referrals to rehabilitation teachers. All individuals who are legally blind, whether being served by a DSBVI counselor, will be referred to a rehabilitation teacher. Rehabilitation teachers may also receive counselor referrals and provide services for individuals who are not legally blind but have functional limitations due to vision loss and have potential to benefit from rehabilitation teaching services.

(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. Application. The minimum information necessary to initiate an assessment to determine eligibility and priority for services consists of: Once an individual has submitted an application for vocational rehabilitation services, including applications made through common intake procedures in one-stop centers under section 121 of the Workforce Innovation and Opportunity Act (WIOA), an eligibility determination must be made within 60 days, unless exceptional and unforeseen circumstances beyond the control of the designated State unit preclude making an eligibility determination.
within 60 days and counselor and the individual agree to a specific extension of time; or meets the other criteria under 34 CFR 361.41 (b) (1) (i-ii).

1. Individual's name. In those instances of exceptional and unforeseen circumstance beyond the control of DRS, where the eligibility determination is unable to be completed within the time frame identified in (b) of this section. The QVRC, utilizing the electronic case management system, will complete the Extension of Eligibility form documenting the date the eligibility form was completed, the date of expected eligibility determination; along with documentation of the date of when the client and counselor agreed to the extension; unless a decision was made to conduct a Trial Work Experience.

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) General Health Checklist. Social Security Administration (SSA) Beneficiaries Verification. The general health checklist (GHC) is a survey tool used to determine what diagnostic information will be needed to assess an applicant's eligibility or ineligibility. A general health checklist will be completed for each applicant. The counselor/teacher in consultation with the client will decide if purchasing a medical examination is necessary when the GHC indicates the presence of any condition. This decision will be based upon availability of existing medical records, and the reported degree of limitation to employment caused by the condition. During the initial interview, the VR counselor shall advise applicants for the VR program that individuals who are SSI/SSDI beneficiaries are generally presumed eligible for VR and that verification of the applicant's benefit status is needed. Verification may include a copy of an award letter from SSA, or a Ticket-to-Work as found in 34 CFR 361.42 (a) (3) (i-ii).

(d) 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.

(e) Case recording requirements - Initial interview, Necessary information. Pertinent information from the initial interview and applicant information forms is recorded in a narrative that is placed in the case file. The minimum information necessary to initiate an assessment to determine eligibility and priority for services consists of:

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 handout and approved client handbook.

2. 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.

3. The record must document availability of documentation of the reported disability.

(f) General Health Checklist. The general health checklist (GHC) is a survey tool used to determine what diagnostic information will be needed to assess an applicant's eligibility or ineligibility. A general health checklist will be completed for each applicant. The counselor/teacher in consultation with the client will decide if purchasing a medical examination is necessary when the GHC indicates the presence of any condition. This decision will be based upon availability of existing medical records, and the reported degree of limitation to employment caused by the condition.

(g) Informed Choice. VR and DSBVI staff must assure that applicants or, as appropriate, their representatives are provided information and support services to assist applicants and recipients of services in exercising informed choice throughout the rehabilitation process in accordance with 34 CFR 361.52.

1. Informed choice and the provision of vocational rehabilitation services require that communications with persons with disabilities are effective.

2. DVR staff informs each applicant and recipient of services through appropriate modes of communication about the availability of and opportunities to exercise informed choice. Individuals with cognitive or other disabilities who require assistance in exercising informed choice will be notified that support services are available.

(h) Case recording requirements. Pertinent information from the initial interview and applicant information forms is recorded in a narrative that is placed in the record of service.

1. Documentation of the process of providing informed choice information and use of appropriate modes of communication is included in the record of service.

2. The record must document that the applicant or representative was provided an explanation of their due process rights, their rights and responsibilities as an applicant, and given a copy of the CAP handout and approved client handbook.

3. 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.

612:10-7-24.4. Ineligibility procedures

(a) If the VR Counselor determines that an applicant is not eligible for VR services, or that an eligible individual receiving services under an IPE is no longer eligible for VR services:

1. The individual, or individual's authorized representative, will be given an opportunity for full consultation before the ineligibility determination is made; and
(2) the individual, or individual’s authorized representative, will be informed in writing, and in appropriate accessible format if needed, of the ineligibility determination, including:

(A) the reasons for the determination;
(B) a description of how to ask for mediation, or an impartial review of the determination; and
(C) a description of the services available from the Client Assistance Program and information on how to contact that program.

(D) refer the individual:

(i) To other programs that are part of the one-stop service delivery system under the Workforce Innovation and Opportunity Act that can address the individual’s training or employment-related needs; or
(ii) To Federal, State, or local programs or service providers, including, as appropriate, independent living programs and extended employment providers, best suited to meet their rehabilitation needs, if the ineligibility determination is based on a finding that the individual has chosen not to pursue, or is incapable of achieving, an employment outcome as defined in 34 CFR 361.5(c)(15).

(b) Any ineligibility determination that is based upon a finding that the individual is incapable of benefiting in terms of an employment outcome will be reviewed within 12 months of the determination and annually thereafter if requested by the individual or the individual's authorized representative. This review need not be conducted in situations in which the individual has refused it, the individual is no longer present in the State, the individual’s whereabouts are unknown, or the individual’s medical condition is rapidly progressive or terminal.

612:10-7-24.5. 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 trial work status. There are two major categories of closure:

(1) Closure due to ineligibility. The designated State unit may not close an applicant's record of services prior to making an eligibility determination unless the applicant declines to participate in, or is unavailable to complete, an assessment for determining eligibility and priority for services, and the State unit has made a reasonable number of attempts to contact the applicant or, if appropriate, the applicant’s representative to encourage the applicant's participation.

(A) Disability too severe (from Trial Work Experience 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) 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-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, including a referral to Federal, State or local programs or service providers, including, as appropriate, independent living programs and extended employment providers, best suited to meet their rehabilitation needs, if the ineligibility determination is based on a finding that the individual has chosen not to pursue, or is incapable of achieving, an employment outcome no matter the reason for closure.

612:10-7-25.1. Order of selection

(a) Ability to serve all eligible individuals; order of selection for services

The Department, in consultation with the Oklahoma Rehabilitation Council, has determined, due to budgetary constraints or other reasonable limitations, that it cannot serve all individuals who are determined eligible for DVR and DSBVI services. The Department consults with the Oklahoma Rehabilitation Council regarding the that DRS either must be able to provide the full range of services listed in section 103 (a) of the Act and 34 CFR 361.48, as appropriate, to all eligible individuals or, in the event that vocational rehabilitation services cannot be provided to all eligible individuals in the State who apply for the services, include in the vocational rehabilitation services portion of the Unified or Combined State Plan the order to be followed in selecting eligible individuals to be provided vocational rehabilitation services.

(1) need to establish an order of selection, including any re-evaluation of the need; The ability of the designated State unit to provide the full range of vocational rehabilitation services to all eligible individuals must be supported.
by a determination that satisfies the requirements of paragraph (b) or (c) of this section and a determination that, on the basis of the designated State unit's projected fiscal and personnel resources and its assessment of the rehabilitation needs of individuals with significant disabilities within the State, it can follow the guidance according to 34 CFR 361.36 (a).

(2) Priority categories of the particular order of selection. Prior to the start of each fiscal quarter, or when circumstances require, the DRS Director will determine in which priority groups new Individualized Plans for Employment will be written and initiated. The Director may restrict the writing and initiation of new Individualized Plans for Employment within a priority group to cases having eligibility dates falling on or before a specified date providing that all individual's in higher priority groups are being served. Considerations in making this determination will include, but not be limited to, the projected outcomes, service goals, expenditures, and resources available for each priority group. Projected costs and resources for each priority group will be based upon costs of current Individualized Plans for Employment, anticipated referrals, availability of financial resources, and adequacy of staffing levels. The Director will implement actions under the order of selection through written notice to DVR and DSBVI staff.

(3) Criteria for determining individuals with the most significant disabilities; and

(4) Administration of the order of selection.

(b) Priority groups. Basis for assurance that services can be provided to all eligible individuals. It is the policy of DRS to provide vocational rehabilitation services to eligible individuals under an order of selection. Under the order of selection, the Department has established three priority groups on the basis of serving first those with the most significant disabilities. Every individual determined to be eligible for DVR and DSBVI services is placed in the appropriate priority group based upon the documentation used to determine eligibility and/or vocational rehabilitation needs. Selection and placement in a priority group is based solely upon the significance of the eligible individual's disability, and is not based upon the type of disability, geographical area in which the individual lives, projected type of vocational outcome, age, sex, race, color, creed, religion, or national origin of the individual. The priority groups are: For the State agency that determined, for the current fiscal year and the preceding fiscal year, that it is able to provide the full range of services, as appropriate, to all eligible individuals, the State unit, during the current fiscal and preceding fiscal year, must have in fact followed the criteria in 34 CFR 361.36 (b) (1-2).

(1) Priority Group 1. Eligible individuals with a most significant disability are individuals with the most significant barriers to employment. A most significant barrier is one that includes a severe physical or mental impairment resulting in serious limitations in three or more functional capacities and which can be expected to require multiple vocational rehabilitation services over an extended period of time.

(2) Priority Group 2. Eligible individuals with a significant disability are individuals with significant barriers to employment. A significant barrier is one that includes a severe physical or mental impairment resulting in serious limitations in at least one, but not more than, two, functional capacities and which can be expected to require multiple vocational rehabilitation services over an extended period of time.

(3) Priority Group 3. Eligible individuals with disabilities not meeting the definition of individual with a significant or most significant barrier to employment.

(c) Implementation. Determining need for establishing and implementing an order of selection. Prior to the start of each fiscal quarter, or when circumstances require, the DRS Director will determine in which priority groups new Individualized Plans for Employment will be written and initiated. The Director may restrict the writing and initiation of new Individualized Plans for Employment within a priority group to cases having eligibility dates falling on or before a specified date providing that all consumers in higher priority groups are being served. Considerations in making this determination will include, but not be limited to, the projected outcomes, service goals, expenditures, and resources available for each priority group. Projected costs and resources for each priority group will be based upon costs of current Individualized Plans for Employment, anticipated referrals, availability of financial resources, and adequacy of staffing levels. The Director will implement actions under the order of selection through written notice to DVR and DSBVI staff. The written notice will specify the implementation date of the action and direct DVR and DSBVI staff on how to handle cases by priority group and application date. DVR and DSBVI staff will inform each eligible individual on their caseloads; the State agency must determine, prior to the beginning of each fiscal year, whether to establish and implement an order of selection.

(1) of the priority groups in the order of selection;

(2) of the individual's assignment to a priority group; and

(3) of the individual's right to appeal that assignment.

(d) Closing and opening priority groups. Need for order of selection. When all or part of a priority group is closed, designated cases within that priority group without a written IPE will be placed on a waiting list after the individual has been determined to be eligible. No IPE will be written for cases on the waiting list. Staff will continue to take applications, diagnose and evaluate all applicants to determine eligibility and vocational rehabilitation needs, find the individual eligible when documentation supports such a decision, then place each eligible individual's case in the appropriate priority group. If an eligible individual is placed in a closed priority group, his or her case will go on the waiting list and no IPE will be written or initiated. The DRS Director will notify DVR and DSBVI staff in writing when all or part of a closed priority group is opened. When this directive includes new applicants who are found eligible, individuals already on the waiting list within that same priority group will be given priority over new applicants. When all or part of closed priority groups are opened, staff will contact individuals on the waiting list to develop and
implement their Individualized Plans for Employment using the priorities in Paragraphs (1) - (3) of this Subsection. The Department, in consultation with the Oklahoma Rehabilitation Council, has determined, due to budgetary constraints or other reasoned limitations, that it cannot serve all individuals who are determined eligible for DVR and DSBVI services. The Department consults with the Oklahoma Rehabilitation Council (ORC) regarding the:

1. contact individuals within the highest open priority group first. Most Significant being the highest of all priority groups; need to establish an order of selection, including any re-evaluation of the need;
2. within each opened priority group, staff will contact individuals on the waiting list in order of application date, earliest application date first, then priority categories of the particular order of selection;
3. staff will contact individuals whose cases will remain on the waiting list to explain how their cases will be handled, criteria for determining individuals with the most significant disabilities; and
4. administration of the order of selection.

(c) Continuity of Services. Establishing an order of selection. Any individual with an IPE that existed prior to the date all or part of that individual's priority group was closed will continue to receive services as planned. Such an IPE may be amended if the changes are necessary for the individual to continue progress toward achieving an appropriate employment outcome, or are otherwise necessary within policy. Persons requiring post employment services will also be provided the necessary services regardless of priority group assignment. Basis for order of selection. An order of selection must be based on a refinement of the three criteria in the definition of individual with a significant disability in section 7.21 (A) of the Act and 34 CFR 361.5 (c) (30).

1. Factors that cannot be used in determining order of selection of eligible individuals. An order of selection may not be based on any other factors, including requirements identified in 34 CFR 361.36 (d) (2) (i-vii).
2. It is the administrative rules of DRS to provide vocational rehabilitation services to eligible individuals under an order of selection. Under the order of selection, the Department has established three priority groups on the basis of serving first those with the most significant disabilities. Every individual determined to be eligible for DVR and DSBVI services is placed in the appropriate priority group based upon the documentation used to determine eligibility and/or vocational rehabilitation needs. Selection and placement in a priority group is based solely upon the significance of the eligible individual's disability, and is not based upon the type of disability, geographical area in which the individual lives, projected type of vocational outcome, age, sex, race, color, creed, religion, or national origin of the individual. The priority groups are:

(A) Priority Group 1. Eligible individuals with a most significant disability are individuals with the most significant barriers to employment. A most significant barrier is one that includes a severe mental or physical impairment resulting in serious limitations in

three or more functional capacities and which can be expected to require multiple vocational rehabilitation services over an extended period of time.
(B) Priority Group 2. Eligible individuals with a significant disability are individuals with significant barriers to employment. A significant barrier is one that includes a severe physical or mental impairment resulting in serious limitations in at least one, but not more than two, functional capacities and which can be expected to require multiple vocational rehabilitation services over an extended period of time.
(C) Priority Group 3. Eligible individuals with disabilities not meeting the definition of individual with a significant or most significant barrier to employment.

(f) Information and referral services. Administrative requirements. Information and referral services will remain available to eligible individuals who are not in an open priority group. These individuals will be given information and guidance, using appropriate modes of communication, to assist such individuals in preparing for, securing, retaining or regaining employment, and will be appropriately referred to Federal and State programs (other than the vocational rehabilitation program) including other components of the statewide workforce investment system in the state. No IPE will be written to provide such services to these individuals. In administering the order of selection, the State agency must implement the order of selection on a statewide basis according to 34 CFR 361.36 (c) (1-3) (i-ii).

1. Notification of Priority Group Placement. Upon placement into a priority category, the client shall receive written notification of his or her priority classification and information regarding the policies and procedures governing availability of vocational rehabilitation services, including notification of placement on a wait list, when applicable and a referral to other programs that are part of the one-stop service delivery system under the WIOA that can address the individual’s training or employment related needs. 34 CFR 361.43 (d) (1-2) the written notification shall include information about Due Process rights and the Client Assistance Program. The electronic case management system will contain a copy of the written notification.

(A) When a client is reclassified into a different priority category, he or she shall be notified, in writing, of the new priority category and provided written information as to how the change will affect the availability of vocational rehabilitation services. The written notification shall include information about Due Process rights and the Client Assistance Program.
(B) An applicant who has been determined eligible for vocational rehabilitation will be placed in Eligibility Status, for completion of a comprehensive assessment to determine employment goal and rehabilitation needs and for development of the Individualized Plan for Employment (IPE). An individual who is placed in an order of selection priority group that
is not currently being served will be placed on a wait-
ing list and held there pending further directives from
the Director concerning opening or closing of priority
groups.
(C) If an applicant is determined to be ineligible, the
counselor will notify the applicant and provide in-
formation on further options in accordance with DRS
administrative rules on ineligibility decisions and 34
CFR 361.57 (b) (2) (ii or iv).

PART 5. CASE STATUS AND CLASSIFICATION
SYSTEM

612:10-7-45. Case statuses and case flowElectronic
Case Management System Progression
(a) The electronic case management system is comprised
of a logical flow from one status to another as an individ-
ual progresses through the vocational rehabilitation
process. This electronic case management system covers
the life cycle of a case from referral and application through
eligibility, plan, employment, closure, and post-employ-
ment services. Statuses are:
(1) Application
(2) Trial Work Experience
(3) Closed ineligible from application status
(4) Eligibility accepted for services, plan develop-
ment phase
(5) IPE developed
(6) Services completed and ready for employment
(7) Employed
(8) Closed, rehabilitated, Successful employment for at
least 90 consecutive days
(9) Closed, not rehabilitated after IPE initiation
(10) Closed, not rehabilitated before IPE initiation
(11) Post employment services
(12) Post employment services completed
(b) No case action is effective until all required approvals
have been obtained in accordance with policy administra-
tive rules. The effective date of any case action, including closures,
is the date the last required approval is obtained in accordance
with policy administrative rules.

612:10-7-52. Provision of ServicesScope of vocational
rehabilitation services for individuals
with disabilities
(a) Overview of service provision. Vocational rehabili-
tation services are provided as specified in the approved IPE.
Services are to be provided using the service delivery methods,
and within the time frames, specified in the IPE. Authorizations
may be issued only for those services for which DRS is spec-
tified as the responsible pay source in the approved IPE. New
service needs must be included in an approved IPE amendment
before they are authorized. All authorizations for payment of
services will be made in accordance with applicable DRS
purchasing policies.
(b) Services for individuals who have applied for or been
determined eligible for vocational rehabilitation services.

As appropriate to the vocational rehabilitation needs of each
individual and consistent with each individual's individualized
plan for employment, the designated State unit must ensure that
the following vocational rehabilitation services are available to
assist the individual with a disability in preparing for, secur-
ing, retaining, advancing in, or regaining an employment out-
come that is consistent with the individual's unique strengths,
resources, priorities, concerns, abilities, capabilities, interests,
and informed choice, as found in 34 CFR 361.48 (b) (1-21)
(c) Scope of vocational rehabilitation services for groups
of individuals with disabilities. DRS may provide for the
following vocational rehabilitation services for the benefit
of groups of individuals with disabilities as listed in 34 CFR
361.49 (a) (1-9).
An individual's written report of employment information and required wage information when it is documented on an authorized DRS form (DRS-C-065) with their dated signature; or

A detailed case note identifying the individual's employment information including the start date, hours per week, and competitive hourly wage that is based on the counselor's conversation with the actual employer. Prior to calling an employer, the individual shall be informed that information provided and gathered is limited to what is necessary to document and verify employment. This provides the individual the opportunity to discuss preferences and options for obtaining required documentation. A signed Release of Information should be in the case file.

If verification as stated above is not forthcoming and all efforts to obtain acceptable verification are documented, then the following is acceptable: a detailed case note identifying the individual's employment information including the start date, hours per week, and competitive hourly wage that include the date employment verification was received with justification for the individual not providing formal documentation.

Contact. When a client is placed in employed status, contact is maintained through the end of the required 90 days and documented until it is determined the employment is satisfactory and the case can be closed. This determination that the employment outcome is satisfactory will be made with the full participation of the client.

Case recording.

(1) Documentation of all contacts with the client during the 90 days to address any employment related issues, including satisfaction with the employment.

(2) Documentation in a case note of the start date of employment, type of employment (i.e. cook, housekeeper, lawyer) employer name address, hourly/weekly wages and benefits.

(3) When applicable, and information is not obtainable from the client, the counselor will document the employment, type of employment (i.e. cook, housekeeper, lawyer) employer name address, hourly/weekly wages and benefits including by what means the employment was discovered and the date of the discovery of employment.

(4) Attempts to obtain verification of employment earnings will be documented in a case note including the reason as to why this verification was not forthcoming.

Closed not rehabilitated, after IPE initiation [REVOKED]

Use of Closed not rehabilitated status. Cases closed in this status have progressed to service status and for some reason the IPE could not be completed. The decision to close the case in this status is made only after the client is given the opportunity to fully participate in the decision and all factors have been considered. Clients who choose to remain in extended employment as a goal, without pursuing competitive employment in an integrated setting through supported employment or other programs, will not be considered as having achieved an employment outcome. A case is closed in this status due to ineligibility only with full participation of the client, client's parent, guardian, or other representative unless the individual has refused to participate, the individual is no longer a resident of Oklahoma, the individual's whereabouts are unknown, or the individual's condition is rapidly progressive or terminal. The rationale for the ineligibility decision is documented in the case record, and in a letter written to the client, including the views of the client or appropriate representative. A copy of the letter is given to the client or appropriate representative with a detailed explanation of the services available from CAP. Procedures for annual review of ineligibility are to be explained to the client or appropriate representative in an understandable form. When appropriate, a referral is made to other agencies.

Case recording requirements. The client, or authorized representative, must be given an opportunity to participate fully in the closure decision. A copy of the closure notification letter will be given to the client. The recording on the case will summarize the services provided, explain why the IPE could not be completed, referral to any other appropriate programs, and contain the client's views of the closure decision, when appropriate.

Closed not rehabilitated, before IPE initiation [REVOKED]

Use of Closed not rehabilitated, before IPE initiation status. Cases closed in this status are those which, although accepted for vocational rehabilitation services, did not progress to the point where services were actually initiated.

Case recording requirements. When a case is closed under these circumstances, the closure is documented in the case record and on a closure notification letter to the client and the client will be given the opportunity to fully participate, and to express his/her views of the decision. A copy of the closure letter will be given to the client, or as appropriate, the client's representative.

Post-Employment services

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. 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. 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. Post-employment services are not to be used in instances of underemployment when extensive retraining is needed. Cases reopened on a post-employment
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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. 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.

(1) 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.

(2) Post-employment services may also be provided for needs that were not anticipated in the original IPE or prior to case closure. 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.

(3) Post-employment services are not to be used in instances of underemployment when extensive retraining is needed.

(4) 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.

(5) 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 Needs. 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 of service 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.

(e) Case recording requirements. 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, the decision to conclude services and the results achieved at the completion or termination of services.

(f) Use of Post-Employment services completed. The case can be closed as soon as the services in the Post-Employment Services amendment have been completed insofar as possible and the client has been consulted regarding the closure decision.

(g) Case recording requirements. Closure from post-employment status is documented in the case record and in a closure letter given to the client.

PART 9. ACTIONS REQUIRING REVIEW AND APPROVAL

612:10-7-87. Actions requiring supervisor’s approval

(a) Actions requiring supervisory approval include:

(1) All actions of a newly employed counselor/teacher.

(2) All IPE’s or amendments when the total of the planned DVR and DSBI expenditures for the entire case exceed $25,000.

(3) All case closures in which an IPE was developed and the case was placed into service status or beyond.

(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).

(5) All IPE’s which include purchase of physical or mental restoration services, prescription drugs or prescribed medical supplies lasting more than three months.
(6) Small Business plans with a cost to the agency in excess of $10,000.00.
(7) Vehicle or home modifications over the DCAMomes-DCAM authority order limit and housing modifications involving structural modifications.
(8) Vehicle repairs that exceed $1,000.00 for the life of a case.
(9) Dental services with a projected cost over $5,000.00,

(b) Documentation in a case note of when verbal approval may be given.

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. Maintenance means monetary support provided to an individual for expenses, such as food, shelter, and clothing, that are in excess of the normal expenses of the individual and that are necessitated by the individual’s participation in an assessment for determining eligibility and vocational rehabilitation needs or the individual’s receipt of vocational rehabilitation services under an individualized plan for employment.

(1) 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. 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 DSBVI client. Maintenance payments must be carefully tied to the achievement of specific VR 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.

(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. DRS will not pay for assistance with room and board expenses if there is a state funded vocational school, college or university within 40 miles of the client’s official residence. In addition, DRS will only sponsor room and board expenses related to on-campus housing options with the lowest cost. Exceptions to this policy may be granted due to issues such as disability requirements. All exceptions must be approved by the Programs Manager and thorough justification must be documented in the case. If DRS is to assist with summer room and board costs or rental assistance for summer semester at any level, there will be a requirement to participate in a minimum of 6 hours.

(4) Maintenance for job search services. Maintenance for job search services requires an IPE with major services directed toward the goal of employment.

(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. 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 DSBVI 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.
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612:10-7-131. Transportation
(a) 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. 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. 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. The cost of vehicle repairs will not exceed $1,000.00 for the life of the case unless approved by the appropriate program manager.
(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.
(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. When expertise is not available within the agency or community to provide effective training in use of public transit, the service may be purchased, with authorization made directly to the vendor or client for actual cost.

(b) Case Recording.
(1) Case narrative documentation is required explaining how the amount was determined.
(2) Documentation as appropriate that the significance of the disability, or the nature of the vocational objective, makes in-state job placement unusually difficult.
(3) Documentation of the agreement made between the counselor and the client regarding the cost of travel for an attendant and allowable expenses before the trip is made.
(4) The justification for providing transportation, the amount of transportation to be provided and time span will be documented in the record of service.

PART 15. TRAINING

612:10-7-142. General guidelines for training services
(a) Types of training. Training provided by DVR and DSBVI may include:

(1) Vocational. Vocational training provides the knowledge and skills necessary for performing the tasks involved in an occupation. Such knowledge and skills may be acquired through training from an institution, on-the-job, by tutors or through a combination of these methods. Vocational training may be provided for any occupation. Vocational and other training services, including personal and vocational adjustment training, advanced training in, but not limited to, a field of science, technology, engineering, mathematics (including computer science), medicine, law, or business; books, tools, and other training materials, except that no training or training services in an institution of higher education (universities, colleges, community or junior colleges, vocational schools, technical institutes, or hospital schools of nursing or any other postsecondary education institution) may be paid for with funds under this part unless maximum efforts have been made by the State unit and the individual to secure grant assistance in whole or in part from other sources to pay for that training.
(2) Pre-vocational. Pre-vocational training includes any form of academic or basic training provided for the preparatory skills needed for entrance into a vocational training program or employment. Pre-vocational training is initiated to enhance occupational knowledge or skills or to remove an educational deficiency interfering with employment.
(3) Personal or work adjustment. Personal or work adjustment training includes any training given for one or a combination of the reasons given in (A) – (D) of this paragraph.

(A) To assist the individual in developing personal habits, attitudes, and skills enabling the individual to function effectively in spite of disability For the first 60 credit hours or during the completion of an Associate's degree, DRS will only sponsor up to the cost of tuition and fees charged by the local state-funded community college or state university within 40 miles of the client's official place of residence. If
the client chooses to attend a different training site, DRS will only sponsor an amount equivalent to the amount that would be sponsored if attending the local college/university. Additional transportation or maintenance costs related to attending another training site will not be sponsored by DRS.

(B) To develop or increase work tolerance prior to engaging in prevocational or vocational training or in employment. For the completion of a Bachelor's degree, DRS will only sponsor up to the cost of tuition and fees charged by the state funded college or university closest to the client's official place of residence that offers a program to reach the vocational objective. Additional transportation or maintenance costs related to attending another training site will not be sponsored by DRS.

(C) To develop work habits and to orient the individual to the world of work. Exceptions to the policies for college/university training must be approved by the Programs Manager through justification and must be documented in the record of service. Possible exceptions include but are not limited to:

(i) The need to attend a school outside of the 40 mile limit due to disability related factors such as the need for accessible on-campus housing.

(ii) The degree major approved by the DRS Counselor for the client is not available at the local college or university.

(D) To provide skills or techniques enabling the individual to compensate for a disability such as the loss of a body part or the loss of a sensory function. Training is provided in those colleges and universities which are accredited by the appropriate accrediting agency, whose credits will be given full recognition by other accredited colleges and universities, and which are under contract. Private and denominational colleges and universities may be used for the training of DRS clients, provided they are accredited and under contract.

(i) The Department will sponsor only the number of semester hours or remaining hours required for a specific degree. Exceptions may be approved by the counselor.

(ii) 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 DSBVI funding will be limited to the number of credit hours needed for the new major minus the number of DVR and DSBVI funded credit hours lost due to the change in majors, unless the change in majors results from circumstances beyond the client's control.

(b) Continued eligibility for college or university training. Training may be provided for clients who:

(1) are mentally, physically and/or emotionally capable of pursuing a course of training to completion; DVR or DSBVI clients in college or university training will be expected to attend classes regularly and make continuous progress toward graduation; and

(2) require training to achieve an employment outcome or other goals established in the Individual Plan for Employment (IPE); and

(3) are determined to have a reasonable opportunity for obtaining employment in the chosen vocation. Carry the minimum number of semester hours determined to be full time at the school attended. Exceptions may be granted by the counselor, based on severity of disability, scheduling problems, or other valid reasons.

(4) Full-time requirement for DVR graduate sponsor- ship would equal the required minimum of hours per semester, (i.e., 9 hours during the regular semester and 4 hours in the summer).

(c) Continued eligibility. Decisions related to training are based on the individual needs and informed choices of the client as identified in the IPE. A client in training at a 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 DSBVI staff in determining the progress of the client. Clients attending vocational technical schools who withdraw or fail course work will be required to pay for a like number of credit or clock hours during the following enrollment period.

(d) Withdrawals and failures. DVR and DSBVI will only pay tuition and fees for courses which meet toward requirements consistent with the vocational goal of the IPE. Training of DVR and DSBVI 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. Clients who withdraw or fail college or university courses paid by DVR and DSBVI will be required to pay for a like number of hours during the following enrollment period subject to the guidelines in (b) section. When a client fails to meet the requirements for continued sponsorship the guidelines in (A-C) of this Subsection are to be followed: A client failing to meet the grade point requirement may continue to receive services not based on financial need.

(1) Payment of training services based on client's financial need will not be provided if the client's grades fall below 1.8 overall GPA.

(2) Training services may be paid for a client having an overall GPA between 1.8 and 1.9 for the first semester that grades fall below 2.0 overall GPA. Subsequent enrollments can only be paid if the student's overall GPA shows progress.

(3) A client failing to meet grade point requirements may be approved by the counselor if there are extenuating circumstances beyond the client's control.

(e) Public institutions of higher learning. Federal regulations require a search for comparable services and benefits with
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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. Tuition and fees for DVR and DSBVI clients attending public 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 DSBVI will pay those fees charged to all students and special fees associated with required courses in the student’s major field of study.

(f) Private institutions of higher learning. Training costs will not be authorized beyond the first year and DSBVI sponsored enrollment until proof of the availability of comparable benefits is received by the counselor. 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. Advanced standing test for college students: DRS can pay for the fee for advanced standing tests. Proof of a passing grade is required prior to payment.

(g) Public or private vocational schools. 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 unless an exception is granted by the counselor due to severity of disability, scheduling problems, or other valid reasons. Training Progress reports or other methods of reporting (i.e., grade reports, transcripts) are utilized to document training progress. Sporadic attendance and reduced training loads causing a delay in the completion of training must be reviewed by the counselor. The client is responsible for advising the counselor of problems encountered during the training program. Schools that have a valid purchasing agreement with DRS, those training costs may be purchased, after use of available comparable benefits such as PELL grants and other federal/state student aid (excluding merit awards).

(h) Out-of-state training. All types of institutional, technical, personal adjustment or employment training are purchased by an authorization issued by the counselor. Out of state training may be approved when one or more of the following applies, and the case record documents the basis for this determination:

(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.

(A) 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. Payment for textbooks and training tools and supplies can be provided for clients in out-of-state training, in accordance with DRS administrative rules.

(B) 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.

(C) The DRS Contracts Unit must complete renewal of contracts no less than two months prior to present contract expiration date to ensure continuance of services. When a contract lapses because renewal was not completed within time frames, the Department cannot pay the institution’s claim.

(i) Training for individuals in custody of the Department of Corrections. DVR and DSBVI funds are not used to defray the cost of training for individuals in the custody of the Department of Corrections. This does not apply to individuals who meet the criteria set forth within a joint memorandum of understanding between DRS and the Department of Corrections.

(j) Distance Education. Distance education may include but is not limited to internet training, correspondence training and talkback TV.

(1) Distance education may be provided if the client needs training which may be obtained most practically by distance education.

(2) Tuition for college and/or vocational distance education cannot exceed the State rate for comparable training.

(3) Distance educational programs will only be approved if institution has recognized accreditation.

(k) Tutorial training. Tutorial training may be provided for clients with significant disabilities who cannot receive training by another method or who may need assistance to complete a formal training course satisfactorily. Persons chosen to provide tutorial training for clients must have the necessary skills to provide assistance to the client and be willing to provide the training at a time and place suitable to the client. Examples of proof of necessary skills are the following:

(1) Letter of recommendation from college or university
(2) Teaching certificate
(3) Transcripts
(4) Other documentation of knowledge, skills or ability to instruct in the designated subject.

(l) Personal or vocational adjustment. Personal or vocational adjustment training includes any training given for one or a combination of the reasons given in (1) - (3) of this paragraph.

(1) Training includes but is not limited to conditioning activities for developing work tolerance, work therapy, occupational therapy, speech training and speech correction, auditory training, gait training, diabetes management courses, driver’s training, and mobility training. It may also include development of personal habits, attitudes, and work habits necessary to orient the individual to the world of work.

(2) To develop or increase work tolerance prior to engaging in prevocational or vocational training or in employment.
(A) Vocational training provides the knowledge and skills necessary for performing the tasks involved in an occupation. Such knowledge and skills may be acquired through training from an institution, on-the-job, by tutors or through a combination of these methods. Vocational training may be provided for any occupation.

(B) Pre-vocational training includes any form of academic or basic training provided for the preparatory skills needed for entrance into a vocational training program or employment. Pre-vocational training is initiated to enhance occupational knowledge or skills or to remove an educational deficiency interfering with employment.

(3) To provide skills or techniques enabling the individual to compensate for a disability such as the loss of a body part or the loss of a sensory function. High school students eligible for this service must be at least 16 years of age and may not participate for more than 18 months unless client and counselor determine additional time is needed.

(m) Federal/State student aid. Federal regulations mandate 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, regardless of whether the student is attending a vocational, trade, public or private institution of higher education.

(n) Payment of training costs. DVR and DSIBV will only pay tuition and fees for courses which count toward requirements consistent with the vocational goal of the IPE. Training of DVR and DSIBV clients is provided by colleges, universities, private business and trade schools, state supported vocational schools, employers in the form of on-the-job training, and other approved training facilities with valid contracts.

(1) Training costs will not be authorized until proof of the availability of comparable benefits is received by the counselor.

(2) After the completion of the first semester, a grade report, proof of enrollment, and an itemized invoice are required documentation to support the authorization for tuition and fees. It is the responsibility of the client to provide this support documentation. The client may provide this documentation electronically or as a printed document in the standard format used by the school.

(3) Each client is responsible for providing the counselor a copy of the college or university's current semester costs before the designated "Drop and Add" date.

(o) Case Recording Requirements.

(1) The record of service will contain testing and/or supportive data to substantiate the reasonable expectation for successful completion of a training program.

(2) Clients approved for college or university training will exhibit the ability to do college work. The counselor will have evidence in the record of service indicating the client's ability to do college work before a program is developed calling for training at the college or university level.

(3) Training progress reports or other methods of reporting (i.e., grade reports, transcripts) are utilized to document training progress.

(4) Documentation will state why the particular out-of-state provider is being used in terms of specific clients, and address the issues of, selection of vocational objective, projected starting and completion dates, breakdown of costs; and extent of comparable services and benefits.

(5) Case notes are necessary when an authorization is completed to include a description of services being provided (i.e., tuition and fees) and the date of service on all direct authorizations. Include number of hours enrolled, what semester, date of service.

612:10-7-162. Textbooks, supplies, training tools and equipment

(a) For clients attending training, an allowance may be provided to cover the actual cost of required books, supplies, training tools and equipment, after available comparable benefits have been applied. When an allowance is provided, the client will be required to furnish documentation of the costs of required books, supplies, tools or equipment. 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 or DSIBV. Only textbooks for the current semester's enrollment will be provided.

(b) Training tools and equipment costing more than $500 will be purchased directly from the vendor/provider in accordance with DRS policy/administrative rules.

(c) 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 DSIBV will pay for repairs to supplies and training tools purchased with DVR and DSIBV 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.

(d) Gun "kits", but not operable firearms, used as training tools may be purchased for students in gun-smithing school only.

(e) 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 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, DRS at its discretion may take steps to repossession the tools to transfer to another client.

(f) 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 (OJT) 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, this type of training focuses on specific job skills by a prospective employer, and OJT can be provided in conjunction with any other DRS services. 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 business or 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, remain in the same or similar job upon successful completion.
6. The employer must be willing to consider the client for any open position, full or part time, after the initial training period.

(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.

(d) Individuals and businesses which provide on-the-job training are expected to compensate OJT participants according to applicable minimum wage and hour regulations under the Fair Labor Standards Act. 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.

(e) On-the-job training payments are reimbursement for wages and benefits paid by the employer. Reimbursement is paid to the employer who pays the client just like his or her own employees. It is not permissible for the employer to endorse the reimbursement check and give it to the client in lieu of wages.

(f) Reimbursement for on-the-job training is paid on a monthly basis.

(g) On-the-job training, using realistic integrated work settings may be used during a Trial work experiences.

(h) Case Recording

1. Direct contact with an employed individual to provide support with issues arising from employment, such as on-the-job performance, or with addressing employment barriers, such as absenteeism or tardiness, that could jeopardize employment will be documented in a case note.

2. Progress narratives on a monthly basis that assess the individual's progress toward employment goal and OJT outcome.

PART 19. SPECIAL SERVICES FOR INDIVIDUALS WHO ARE BLIND, DEAF, OR HAVE OTHER SIGNIFICANT DISABILITIES

612:10-7-195. Personal assistance services

(a) Personal assistance services is a range of services including, among other things, training in managing, supervising, and directing personal assistance services, provided by one or more persons, that are designed to assist an individual with a disability to perform daily living activities on or off the job that the individual would typically perform without assistance if the individual did not have a disability. The services must be designed to increase the individual's control in life and ability to perform everyday activities on or off the job. Services may include training in managing, supervising, and directing personal assistance services. The services must be necessary to the achievement of an employment outcome and may be provided only while the individual is receiving other vocational rehabilitation services.

1. Designed to assist an individual with a disability to perform daily living activities on or off the job that the individual would typically perform without assistance if the individual did not have a disability;
2. Designed to increase the individual's control in life and ability to perform everyday activities on or off the job;
3. Necessary to the achievement of an employment outcome and may be provided only while the individual is receiving other vocational rehabilitation services.
4. Services may include training in managing, supervising, and directing personal assistance services, as found in 361.5 (c) (38).

(b) Fees for these services are negotiable at or above minimum wage by the counselor. This service does not require consideration of client participation in cost.

(c) Case Recording

1. The justification for providing the services must be documented in the record of service.
2. Documentation of the negotiated amount of monthly payment that is agreed to by both counselor and client.

612:10-7-196. Interpreter services

An individual who is deaf or has a hearing impairment may require interpreter services to communicate effectively. This service is especially important when information regarding the individual's rights and access to services is being presented. Interpreter services do not require client participation in cost of services. In training situations, the counselor must determine that interpreter services are not available through the training facility or other sources before interpreter services are
provided. Interpreter services are authorized directly to the individual who will provide the service. The authorization will include the number of hours to be provided and the period of time over which the service is to be provided in addition to the per-hour fee. The interpreter will submit a claim at the end of each specified time period.

(a) Interpreter services. Interpreter services are sign language or oral interpretation services for individuals who are deaf or hard of hearing and tactile interpretation services for individuals who are deaf-blind. Specially trained individuals perform sign language or oral interpretation. Interpreter services also include real-time captioning services for persons who are deaf or hard of hearing as found in 34 CFR 361.5 (c) (10) and 361.48 (b) (10).

(1) Does not include spoken language interpretation.
(2) Interpreter services do not require client participation in cost of services.
(3) The interpreter will submit a claim at the end of each specified time period.

(b) Deaf-Blindness Specialist. To promote and coordinate appropriate services for persons with dual losses of vision and hearing, the Division of Services for the Blind and Visually Impaired employs a Deaf-Blindness Specialist. This specialist works with counselors, rehabilitation teachers and others who provide services directly to clients who are deaf-blind. A major role served by this specialist is coordinating services and ensuring dialogue among schools, programs, agencies and organizations serving the deaf and blind.

(1) Due to the overwhelming impact upon the individual with a combination disability of deafness and blindness, a multiple disciplinary approach is needed to adequately serve these individuals. Unique problems in mobility and communication can cause severe social, recreational, academic deprivation and long term prevocational training may be necessary.
(2) Persons who are deaf-blind are capable of competitive employment and the counselor will carefully evaluate expected employment outcomes.

(c) Case Recording. In training situations, the counselor must document that interpreter services are not available through the training facility or other sources before interpreter services are provided.

612:10-7-199. Reader/recording services

(a) Reader services may be purchased for individuals who are blind, visually impaired or have difficulty reading standard print books/materials due to any other disability. Reader services may be provided for those consumers who are involved in educational or vocational training, employment search or entry into employment. Clients will be expected to utilize any comparable services, including available assistive technology devices and services prior to authorization of reader services.

(b) Reader services are exempt from client participation in cost of service. DRS will pay up to five (5) hours of reader service per month. Additional hours of reader service may be approved by the Programs Manager with justification.

(c) Payment for reader services will be based on the Federal Minimum Wage. However, the counselor may authorize up to $2.00/hour above minimum wage with consideration being given to factors such as the significance of the event and the likelihood of technical/foreign language being used. Reader services may not be paid in advance. Payment is authorized directly to the client in the same manner as maintenance or transportation and may be included on the same authorization with either or both of these other services.

(d) The individual receiving the service shall maintain a record of the reading time he/she has been provided. The record must be signed and dated by the reader and the individual, and returned to the counselor at the end of each month. The record shall include:

(1) Individual’s name;
(2) Reader’s name and address;
(3) Date service started and ended;
(4) Subjects read and time devoted to each.

(e) Individuals who have difficulty reading or using standard print materials will be referred to existing resources for recorded, large print, Braille and digital books and materials. Any required fee or materials cost for a recorded/digital textbook service, reading or scanner app may be paid through DVR and DSBVI funds and is not based on financial need determination.

(f) Case Recording is documentation in record of service of the approved additional hours by the Programs Manager.

612:10-7-203. Orientation and Mobility (O & M)

DVR and DVS DSBVI clients who are legally blind, visually impaired, or function as such can receive direct instruction from O & M specialists employed by the Department. O & M specialists assist these clients to adjust to their surroundings.

PART 21. PURCHASE OF EQUIPMENT, OCCUPATIONAL LICENSES AND CERTIFICATIONS

612:10-7-216. Tools, occupational equipment, initial stocks and supplies

(a) Tools, occupational equipment and supplies will be provided to eligible clients to the extent necessary to achieve their vocational goal providing the client has adequate resources available for the proper maintenance and upkeep of such tools and equipment. The client, or client’s family or authorized representative as appropriate, is responsible for maintaining tools, occupational equipment, initial stocks, and supplies in good working order. DVR and DSBVI will not pay for repairs to tools, occupational equipment, initial stocks and supplies purchased with DVR and DSBVI funds once title has been released to the client. DVR and DSBVI will not pay for repairs before title is released when there is clear evidence that the damage resulted from abuse or neglect.

(b) The client will retain possession and control of articles while engaging in the job or occupation for which articles were provided, or when title is released to client. Occupational tools, occupational equipment, and initial stocks and supplies are defined as follows:
(1) Occupational tools are considered to be those minimum tools required for a designated trade, necessary to the employment of the individual, and not furnished by the employer. DRS will NOT purchase operable firearms even if required for employment. Counselor will assist the individual in finding resources to help in this purchase if necessary.

(2) Occupational equipment is equipment required to meet the minimum needs of an individual in starting and conducting a business of his or her own.

(3) Initial stocks and supplies are those materials and merchandise necessary for the client to become operational in a business.

(c) Purchase of occupational tools, equipment and initial stocks and supplies will be made in accordance with current DRS purchasing rules. If the client is required to participate in cost of services, the payment will be made to the nonmedical vendor. When the equipment is received and/or installed, the appropriate rehabilitation professional completes the Receipt for Equipment and Title Agreement. If the purchase total is $5,000 or more, the rehabilitation professional then signs the vendor's invoice and routes it to DRS state office.

(d) Used tools or equipment may be purchased when it is evident considerable savings may be affected. Used equipment or tools are to be appraised piece-by-piece by at least three shop owners or managers in the same type of work, and who are not acquainted with the vendor.

(e) If the counselor, after a thorough check of the tools or equipment, finds they are not being used for the purpose for which they were purchased, the counselor is to repossess the tools or equipment by executing the Release or Receipt of Equipment form.

(f) Occupational licenses are those licenses required by law to obtain and practice a particular profession or trade. Fees for such licenses and teacher certification tests may be provided for DRS clients. The training facility may arrange for necessary certification and it may be included as a separate item on the training authorization. If training is not involved, the license fee is authorized upon evidence of a skill. Clients will be responsible for renewal of licenses purchased by DRS.

612:10-7-222. Rehabilitation technology, assistive technology devices and assistive technology services

(a) Rehabilitation technology is the systematic application of technologies, engineering methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas which include education, rehabilitation, employment, transportation, independent living and recreation. The term includes rehabilitation engineering, assistive technology devices, and assistive technology services. Engineering means the systematic application of engineering sciences to design, develop, adapt, test, evaluate, apply, and distribute technological solutions to problems confronted by individuals with disabilities in functional areas, such as mobility, communications, hearing, vision, and cognition, and in activities associated with employment, independent living, education, and integration into the community.

(b) Rehabilitation technology services may be provided to any individual under the provisions of an Individualized Plan for Employment (IPE). Rehabilitation technology services such as assessment or consultation are not based on financial status, however equipment, appliances, and aids will be based on available financial resources of the client. Rehabilitation technology is the systematic application of technologies, engineering methodologies, or scientific principles to meet the needs of, and address the barriers confronted by individuals with disabilities in areas which include education, rehabilitation, employment, transportation, independent living and recreation. The term includes rehabilitation engineering, assistive technology devices, and assistive technology services.

(1) Home and vehicular modification, telecommunications, sensory, and other technological aids and devices, other assistive devices including, but not limited to hearing aids, low vision aids and wheelchairs. This includes the hardware portion of prosthetic devices, such as cochlear implants, visual prosthetics, and motor prosthetic devices.

(2) Does not include medical and surgical procedures required for implantation of neuromuscular prosthetic devices.

(c) Rehabilitation technology services, including prescribed adaptive aids and devices, must be provided by qualified persons. Prescriptions/recommendations for nonmedical adaptive technology may be accepted from individuals listed in 74 O.S. 85.7(12) including physicians, rehabilitation engineers, qualified rehabilitation technicians or sensory aids specialists and from qualified assistive technology specialists and assistive technology professionals.

(d) Assistive technology devices, including prescribed adaptive aids and devices, may be purchased commercially or designed and manufactured by a rehabilitation engineer, assistive technology or sensory aids specialist depending on individual need. Under ADA title II, 35 CFR 104 Definitions, "auxiliary aids and services" includes: Qualified interpreters on-site or through video remote interpreting (VRI) services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunications products and systems, including text telephones (TTYS), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing.

(e) Assistive Technology Devices are any items, piece of equipment, or product system, whether acquired commercially off the shelf, modified or customized, that is used to increase, maintain, or improve the functional capabilities of a VR customer.
Assistive Technology Services are any services that directly assist an individual with a disability in the selection, acquisition, or use of an assistive technology device. Services may include:

1. the evaluation of the needs of an individual, including a functional evaluation of the individual in his/her customary environment;
2. purchasing, leasing, or otherwise providing for the acquisition by an individual of an assistive technology device;
3. selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
4. coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
5. training or providing technical assistance for an individual or, if appropriate, the family members, guardians, advocates, or authorized representatives of the individual; and
6. training or providing technical assistance for professionals (including individuals providing education and rehabilitation services), employers, or others who provide services to, employ, or are otherwise substantially involved in the major life functions of individuals with disabilities, to the extent that training or technical assistance is necessary to the achievement of an employment outcome.

Rehabilitation technology services such as assessment or consultation are not based on financial need; however equipment, appliances, and aids will be based on available financial resources of the client.

Rehabilitation technology services, including prescribed adaptive aids and devices, must be provided by qualified persons. Prescriptions/recommendations for nonmedical adaptive technology may be accepted from individuals listed in 74 O.S. 85.7(12) including physicians, rehabilitation engineers, qualified rehabilitation technicians or sensory aids specialists and from qualified assistive technology specialists and assistive technology professionals.

Assistive technology devices, including prescribed adaptive aids and devices, may be purchased commercially or designed and manufactured by a rehabilitation engineer, assistive technology or sensory aids specialist depending on individual need.

Counselors and rehabilitation teachers may refer clients with visual disabilities to the Division of Services for the Blind and Visually Impaired assistive technology laboratory for blindness and low vision which may provide or procure:

1. assistive technology evaluations;
2. recommendation of assistive technology devices and services to meet individual needs;
3. training in use of technology and devices, referral to training sources and information on training options;
4. information on technologies and devices to meet specific individual needs;
5. technical assistance for installation and operation of select applications and devices; and
6. demonstration and loan of adaptive aids, devices, electronic and computer technologies and other assistive technology products.

PART 25. TRANSITION FROM SCHOOL TO WORK PROGRAM

612:10-7-240. Overview of transition from school to work services

(a) Transition services is a coordinated set of activities for a student with a disability that promotes movement from the public schools to post-school activities. The Individuals with Disabilities Education Act (IDEA) and the Rehabilitation Act use the same language to describe transition services and their purpose. No break in required rehabilitation services will occur for eligible students exiting the secondary school when a case has been open while in high school. Transition services represent the next set of services on the continuum of VR services available to eligible individuals. Transition services, for eligible students with disabilities, provide for further development and pursuit of career interests with postsecondary education, vocational training, job search, job placement, job retention, job follow-up, and job follow along. The transition process is outcome based, leading to post-secondary education, vocational training, competitive integrated employment (including supported employment), continuing and adult education, adult services, independent living, and/or community participation consistent with the informed choice of the individual. The goal of the Transition from School to Work Program is to help eligible individuals with disabilities make the transition from school to work in order to function as a productive member of society.

(b) The Transition from School to Work Program is implemented through a cooperative agreement between DRS and each participating local secondary school district, private school, charter school, home school organization and Career and Technology Education Center, through an MOU with the State Department of Education. The Transition Coordinator in DRS State Office acts as the liaison with the State Department of Education, and provides statewide coordination and technical assistance for the Transition from School to Work Program.

(c) Transition services must be based on the individual student's needs, taking into account the student's preferences and interests. Transition planning will include, to the extent needed, services in the areas of:

1. instruction;
2. community services experiences;
3. development of employment and other post-school adult living objectives, including job skill training available through vocational-technical schools;
4. if appropriate, acquisition of daily living skills and a functional vocational evaluation;
5. supported employment services can be initiated during the final graduating semester of high school that
promotes or facilitates the achievement of the employment outcome identified in the student's or youth's individualized plan for employment; and

(6) that includes outreach to and engagement of the parents, or, as appropriate, the representative of such a student or youth with a disability or other needs specific to the individual.

(7) supported employment services can be initiated during the final graduating semester of high school, 34 CFR 361.5 (c) (54) (iii-v).

(d) The Transition from School to Work Program is based upon effective and cooperative working relationships between the Special Education Section of the State Department of Education, the Department of Rehabilitation Services, and the Local Educational Agency. Each agency retains responsibility for providing or purchasing any transition service that the agency would otherwise provide to students with disabilities who meet the eligibility criteria of that agency.

34 CFR 300.520.

612:10-7-242. Pre-Employment Transition Services

(a) Students with a Disability. Vocational Rehabilitation (VR) must collaborate with local educational agencies (LEAs) to provide, or arrange for the provision of, Pre-employment Transition Services (Pre-ETS) for all students with a disability in need of such services.

(1) A "Student with a Disability" as defined in Oklahoma is ages 16 through 21 and eligible for and receiving special education or related services under an Individualized Education Program (IEP); or an individual with a disability for purposes of Section 504 (individual does not need to have a 504 plan to meet the definition requirements).

(2) An individual as young as 14 years old may be considered a "Student with a Disability" if Pre-ETS is determined necessary by the IEP team.

(3) The definition of "Student with a Disability" applies to all students enrolled in educational programs, including postsecondary education programs or other recognized education programs, so long as they satisfy the age requirements. The definition is inclusive of secondary students who are homeschooled, as well as students in other non-traditional secondary educational programs.

(4) A student with a disability receiving pre-employment transition services is a client for whom goods and services may be procured in the same manner as for clients with an approved Individualized Plan for Employment pursuant to OAC 612:10-1-7.

(5) Students with disabilities do not need to apply and be determined eligible for the VR program to receive pre-employment transition services. However, these students may not receive any VR services other than pre-employment transition services until they apply, and are determined eligible, for VR services, and have an approved IPE.

(6) Eligible students with disabilities, that is, those students who have applied and been determined eligible for the VR program, are able to receive any VR services, including pre-employment transition services, necessary to assist them in achieving their employment outcome, so long as those services are identified on their IPEs.

(b) Required Activities. Services may be provided to students, or groups of students, with disabilities who are eligible or potentially eligible for VR services in the following areas.

The following pre-employment transition services represent the earliest set of services available for students with disabilities under the VR program. These are short-term services designed to help students identify career interests:

(1) Job exploration counseling.

(2) Work-based learning experiences, which may include in-school or after school opportunities or experience outside the traditional school setting, including internships, that is provided in an integrated environment to the maximum extent possible.

(3) Counseling on opportunities for enrollment in comprehensive transition or postsecondary educational programs at institutions of higher education.

(4) Workplace readiness training to develop social skills and independent living.

(5) Instruction in self-advocacy, including instruction in person-centered planning, which may include peer mentoring, including peer mentoring from individuals with disabilities working in competitive integrated employment.

(6) Auxiliary aids or services. Any "student with a disability" with a sensory or communicative disorder who needs auxiliary aids or services to access pre-employment transition services, regardless of whether the student has applied or been determined eligible for the VR program.

(A) The provision of pre-employment transition services to pay for auxiliary aids and services for students with disabilities with sensory and communicative disorders who need such aids and services in order to access or participate in pre-employment transition services.

(B) DRS is required to work in collaboration with education agencies to identify how these funds can be used for such costs. The VR agency may use the funds to pay for auxiliary aids and services needed to access or participate in pre-employment transition, no other public entity is required to provide such aids or services.

(C) DRS need not conduct a search for comparable services and benefits when providing auxiliary aids and services to either eligible or potentially eligible students with disabilities to the extent that these aids and services constitute "rehabilitation technology" and are necessary for the student with a disability to participate in pre-employment transition services.

(c) Delivery of Services. Pre-ETS may be delivered in collaboration with school districts/LEAs via any combination of:

(1) Vocational rehabilitation counselors
(2) The vocational rehabilitation counselor will coordinate Pre-ETS with other entities who maybe delivering these services.

(3) Other entities contracted with VR such as:
   (A) Community Rehabilitation Programs
   (B) Independent Living Centers

(d) **Considerations under 00s.** VR must continue to provide Pre-ETS to students with disabilities who were receiving such services prior to being determined eligible for SBVI and are placed in a closed category.

(e) **Pre-Employment Transition Coordination.**
   (1) District office staff will be responsible for attending IEP meetings for students with disabilities when invited; using conference calls and video conferences, when necessary;
   (2) working with local workforce development boards, job centers and employers to develop work opportunities for students with disabilities, including apprenticeships, internships, summer employment and other employment opportunities available throughout the school year;
   (3) working with schools to coordinate and ensure the provision of Pre-ETS; and
   (4) attending person-centered planning meetings for individuals with developmental disabilities receiving SSI/D/Medicaid when invited.

(f) **Eligible students with disabilities are able to access.** any other VR services needed to participate in pre-employment transition services or other VR services that are unrelated to pre-employment transition services, none of which would be available to them without approved IPEs, these eligible students with disabilities may need certain VR services to fully benefit from pre-employment transition services. By receiving other VR services and supports, along with the pre-employment transition services, enables eligible students with a disability to develop the skills to experience competitive, integrated employment as they leave school and enter the workforce.

612:10-7-248. **Coordination of Individualized Education Program and Individualized Plan for Employment**

The Local Educational Agency and DRS must document coordination of objectives and services planned in an individual's IEP/Section 504 Plan and IPE. Both documents, as well as other case documentation, must reflect the effective interaction of the two agencies in providing the services necessary for a smooth transition from school to work. While it is understood that it is not possible for a VR counselor to attend all formal IEP/Section 504 Plan meetings in assigned schools, the counselor will collaborate in transitional planning in the most effective manner possible.

(a) The individualized plan for employment for a student with a disability must be coordinated with the individualized education program or 504 services, as applicable, for that individual in terms of the goals, objectives, and services identified in the education program. 34 CFR 361.46 (d)

(b) The development and approval of an individualized plan for employment as early as possible during the transition planning process and not later than the time a student with a disability determined to be eligible for vocational rehabilitation services leaves the school setting or, if the State agency is operating under an order of selection, before each eligible student with a disability able to be served under the order leaves the school setting. 34 CFR 361.22 (a) (2). No break in required rehabilitation services will occur for eligible students exiting the secondary school when a case has been opened while in high school.

(c) **Case recording.**
   (1) The Local Educational Agency and DRS must document coordination of objectives and services planned in an individual's IEP/Section 504 Plan and IPE. Both documents, as well as other case documentation, must reflect the effective interaction of the two agencies in providing the services necessary for a smooth transition from school to work.
   (2) Documentation of attended IEP meetings and results of those meetings.

**SUBCHAPTER 13. SPECIAL SERVICES FOR THE DEAF AND HARD OF HEARING**

**PART 3. CERTIFICATION OF INTERPRETERS**

612:10-13-20. **Certification maintenance**

(a) General provisions for certification maintenance. Certification for levels I, II, and III are good for a period of OAST certification in Interpreting and Transliterating, for levels I-V, are valid for a term of two years at which time the certification will expire unless the interpreter may re-test. Certification for Level IV is good for a three-year period at which time the certification will expire or the interpreter may re-test. Certification for Level V is considered to be permanent. Interpreters are permitted to re-test before their certification has expired. Certification will remain valid for an interpreter who has applied for re-evaluation and cannot be scheduled for testing prior to his/her certificate's expiration date, provided the application is received no later than 90 calendar days before the expiration date. However, any certification will lapse if the maintenance fee is not paid and/or continuing education requirements are not met by stipulated due dates, and/or if the performance application is not submitted 90 days before levels expire. Individuals who have allowed certification to lapse must take and pass the CRC/QAST written portion before becoming eligible for the performance evaluation. The exception for re-testing applies to those that achieve a certification level in Transliterating: V and Interpreting: V; those are the only levels that will not expire providing the annual CEUs and the maintenance fee is satisfied.

(1) **Level V certification:** An interpreter holding a certification level V in either Transliterating or Interpreting,
but not both, will be required to re-test. Testing will include the ethical situation interview and the performance section the interpreter does not hold a level V in. The interpreter must pass the ethical situation interview with 80% before a level is granted. If a level V is not obtained, the interpreter will be required to re-test until a V/V is achieved. 

2. Level I-IV certification: An interpreter with levels I, II, III, IV are required to take the ethical situation interview, Interpreting and Transliterating. The interpreter must pass the ethical situation interview with at least an 80% before a level is granted.

3. Any combination of levels other than a V/V obtained during testing will expire 2 years from the test date. Interpreters are required and permitted to re-test before their certification expires.

4. Certification will remain valid for an interpreter who has applied for re-evaluation and cannot be scheduled for testing prior to his/her certificate's expiration date, provided the application is received no later than 90 calendar days before the expiration date. However, any certification will lapse if the maintenance fee is not paid and/or continuing education requirements are not met by stipulated due dates, and/or if the performance application is not submitted 90 days before levels expires. Individuals who have allowed certification to lapse due to non-compliance with requirements must take and pass the ICRC/QAST written portion before they are eligible for the performance evaluation.

(b) Continuing education requirements. QAST certified interpreters are required to satisfy one (10) hours Continuing Education Unit (CEU) annually, with .1 (1 hour) of this in the category of Ethics. It is the interpreter's responsibility to ensure all supportive CEU documentation is submitted to the Interpreter Certification Resource Center (ICRC) staff before or on December 31st, to avoid certification becoming invalid. If certification becomes invalid, the individual must re-test, and will be required to take and pass the written ICRC/QAST test before becoming eligible for the performance portion.

(c) Certification maintenance fee. A certification maintenance fee and maintenance fee renewal form is due by January 31st each year. The renewal form must be postmarked on or before January 31st to avoid certification becoming suspended.

(d) Certification suspension and reinstatement. If the certification maintenance fee and renewal form are submitted after January 31st, the interpreter will become suspended, but has an option to make application for reinstatement. The reinstatement application, a $100 reinstatement fee and payment of the annual certification maintenance fee will be required for reinstatement. The reinstatement fee and certification maintenance fee are due before or on February 28th to avoid certification becoming invalid. If certification becomes invalid, the individual must re-test, and will be required to take and pass the written ICRC/QAST test before becoming eligible for the performance portion.

(e) Expiration of certification. If an interpreter does not submit an application for re-testing 90 days prior to the level(s) expiration date, the interpreter's level(s) will be considered invalid on the expiration date. If level(s) become invalid, the individual must re-test, and will be required to take and pass the ICRC/QAST written test before becoming eligible for the performance portion. If an interpreter's certification becomes invalid twice in a four (4) year period due to non-compliance with either the CEU or maintenance fee requirements, the interpreter will not be allowed to take the written portion or the performance portion of the ICRC/QAST test until one (1) year from the date of the second documented non-compliance.

[OAR Docket #21-426; filed 6-14-21]

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TITLE 612. STATE DEPARTMENT OF REHABILITATION SERVICES
CHAPTER 15. OKLAHOMA LIBRARY FOR THE BLIND AND PHYSICALLY HANDICAPPED (OLBPH)

[OAR Docket #21-427]

RULEMAKING ACTION: PERMANENT final adoption

612:15-1-3. Library functions and legal basis [AMENDED]

AUTHORITY: Commission for Rehabilitation Services; 74 O.S.166.2

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n/a

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
Revisions to Chapter 15 consist of division name change of Visual Services (VS) to Services for the Blind and Visually Impaired (SBVI).

CONTACT PERSON:
Tina Calloway, Administrative Programs Officer, State Department of Rehabilitation Services, Executive Division, 3535 N.W. 58th Street, Suite 500, Oklahoma City, OK 73112-4824, (405) 951-3552.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS
612:15-1-3. Library functions and legal basis

(a) The Oklahoma Library for the Blind and Physically Handicapped (OLBPH), operated by the Division of Visual Services for the Blind and Visually Impaired within the Department of Rehabilitation Services, is the regional library for Oklahoma as part of the national network of libraries of the Library of Congress National Library Service (NLS) for the Blind and Physically Handicapped.

(b) On March 3, 1931, the Pratt-Smoot bill authorized the Library of Congress to arrange with other libraries to serve as local or regional centers to circulate books to blind or visually-impaired users. By the end of fiscal 1966, Congress passed Public Law 89-522 extending the service to library users who could not read standard print because of physical disability, which can include certain reading disabilities. State law (7 O.S. Section 8 and 74 O.S. 166.4(B)(3)(b) and 166.5) establish that the Section of Services to the Blind (Visual Services for the Blind and Visually Impaired) of the Commission for Rehabilitation Services has the authority and duty to provide special library services to blind and visually impaired citizens.

(c) Functions of the Library include but are not limited to:

1. Loan of books and periodicals in accessible formats for eligible adults and children with visual, physical or learning disabilities that prevent effective use of standard print materials;
2. Production of recorded and Braille materials on request and on a limited basis, subject to availability of resources. Fees may be established to cover the cost of production. Services provided by OLBPH as part of the National Library Service will be given priority over requests for production of reading materials in alternate formats;
3. Acquisition, housing and circulation of Braille textbooks and other accessible instructional materials for students with print disabilities in grades pre-K through 12;
4. Improving access to print information for Oklahomans with print disabilities by providing, through contract or directly, services that supply audio or electronic access to newspapers, books, works by Oklahoma authors, educational programming, local and state activities, and information on resources.
5. Recruitment and training of volunteers to support library functions.

[OAR Docket #21-427; filed 6-14-21]

TITLE 612. STATE DEPARTMENT OF REHABILITATION SERVICES
CHAPTER 20. SPECIAL SCHOOLS

[OAR Docket #21-428]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 2. Contracted Instructional Personnel
612:20-2-7. Employee benefits [AMENDED]

AUTHORITY:
Commission for Rehabilitation Services; 74 O.S.166.2

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Subchapter 2. Contracted Instructional Personnel
612:20-2-7. Employee benefits [AMENDED]

Gubernatorial approval:
December 2, 2020

Register publication:
38 Ok Reg 281

Docket number:
20-931

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
Revisions allow instructional staff working at the Oklahoma School for the Blind and the Oklahoma School for the Deaf to receive a rate of $75 for each full day of unused personal leave at the end of the academic year. Instructional staff receive five (5) days of personal leave per academic year. This allows staff to remain in the classroom and be paid for unused personal leave and avoid the expense of hiring a substitute teacher. Oklahoma Session Laws 2019, ch. 159 (SB 77) amended 10 O.S. § 1419. The rule is necessary as an emergency pursuant to 75 O.S. § 253(A) to comply with deadlines in the agency's governing law and to avoid violation of state law. This rule replaces the emergency rule currently in effect.

CONTACT PERSON:
Tina Calloway, Administrative Programs Officer, State Department of Rehabilitation Services, Executive Division, 3535 N.W. 58th Street, Suite 500, Oklahoma City, OK 73112-4824, (405) 951-3552.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

SUBCHAPTER 2. CONTRACTED INSTRUCTIONAL PERSONNEL

612:20-2-7. Employee benefits
(a) Personal leave. Contracted instructional staff will receive five days each academic year. Such leave shall vest at the beginning of each academic year and may be taken with the approval of the school superintendent. Personal leave may not be charged to sick leave and any unused personal leave will not be cumulative. Unused personal leave and will not be paid to the employee at the rate of $75 for each full day
of unused leave after the end of each academic year upon separation from the Department.

(b) **Sick leave.** Contracted instructional staff will receive ten days sick leave per academic year. Such leave shall vest at the beginning of each academic year and unused sick leave shall be cumulative up to a total of sixty working days. Such leave is to be used when the employee is required to be absent due to personal injury, illness or pregnancy, or injury or illness of an immediate family member requiring the employee's care. In instances where a contracted instructional staff person has exhausted all accrued sick leave and continues to be absent due to personal injury, illness, or pregnancy, that employee is entitled to an additional twenty days at full salary less the amount actually paid to employ a substitute to temporarily assume the absent employee's position; as long as the total leave does not exceed the total number of days in the contract period. Sick days may be accrued as credit toward retirement. Otherwise, all accumulated sick leave will be canceled upon separation from the Department.

(c) **Family and medical leave.** Family and medical leave will be granted in accordance with the Family Medical Leave Act.

(d) **Educational leave.** A teacher may apply for up to 80 hours per academic year for educational leave. Such leave must be pre-approved by the immediate supervisor and Superintendent.

(e) **Jury duty.** Contracted instructional personnel will be granted leave for jury service in a criminal, civil, or juvenile proceeding and will receive the full, current contract salary during such service; provided that the Department may deduct any compensation received for serving as a juror from the employee's salary during such service.

(f) **Armed forces leave.** Contracted instructional personnel who are members of the Reserve Forces of the Army, the Navy, the Marine Corps, the Coast Guard, the Air Force, or any other component of the Armed Forces of the United States, including members of the Air or Army National Guard, shall, when ordered by the proper authority to active duty or service, be entitled to a leave of absence from employment with the Department for the period of such service without loss of status or efficiency rating.

(g) **Shared leave.** The state leave sharing program permits state employees to donate leave to a fellow state employee who is suffering or has a relative who is suffering from an extraordinary or severe illness, injury, impairment, or physical or mental condition which has caused, or is likely to cause, the employee to take leave without pay or terminate employment. Contracted instructional personnel may contribute sick leave under this program. The shared leave will be credited on a dollar for dollar basis.

(h) **Other leave.** Any leave not defined in this Section shall be treated as personal leave.

(i) **Health and life insurance.** Each Department employee receives health and life benefits coverage as prescribed by the agency at no cost. The employee may elect to purchase additional individual or family benefit options.

(j) **Retirement.** Contracted instructional personnel employed before July 1, 1995 may continue participation in either the State Teachers Retirement System or the Oklahoma Public Employees Retirement System. Contracted instructional personnel employed on or after July 1, 1995 will be enrolled in the State Teachers Retirement System. The employee and employer will contribute the amount prescribed by statute.

(k) **Longevity.** Contracted instructional personnel hired prior to July 1, 1995 will retain longevity as long as they remain in continuous service. Any break in service will result in the loss of longevity. New hires after July 1, 1995 will not be entitled to longevity unless provided by law.

[OAR Docket #21-428; filed 6-14-21]

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**TITLE 710. OKLAHOMA TAX COMMISSION**

**CHAPTER 1. ADMINISTRATIVE OPERATIONS**

[OAR Docket #21-471]

**RULEMAKING ACTION:**

PERMANENT final adoption

**RULES:**

710:1-1-1[AMENDED]
710:1-1-2[AMENDED]
Subchapter 3. Public Policy
710:1-3-2[AMENDED]
Part 5. Filing and Mailing of Documents
710:1-3-30[AMENDED]
Part 9. Execution of Tax Warrants
710:1-3-54[AMENDED]
710:1-3-61[AMENDED]
Part 11. Public Records
710:1-3-70[AMENDED]
710:1-3-71[AMENDED]
710:1-3-73[AMENDED]
Subchapter 5. Practice and Procedure
Part 3. Description of Administrative Review and Hearings
710:1-5-15 through 710:1-5-17[AMENDED]
Part 5. Administrative Proceedings Related to Tax Protests
710:1-5-20[REVOKED]
Part 8. Settlement of Tax Liability
710:1-5-84[AMENDED]
710:1-5-86[AMENDED]
710:1-5-90[AMENDED]
Subchapter 13. Consumer Compliance Initiative
710:1-13-3[AMENDED]

**AUTHORITY:**

68 O.S. § 203; Executive Order 2020-03; Oklahoma Tax Commission

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n/a
INCORPORATIONS BY REFERENCE:
n/a
GIST/ANALYSIS:
The amendment to Section 710:1-1-1 provides that the implementation of the Oklahoma Tax Commission's administrative rules in Title 710 of the Oklahoma Administrative Code are contingent upon availability of funding for the Tax Commission to administer the rules.
The amendment to Section 710:1-1-2 updates the Tax Commission's areas of administration.
The amendment to Section 710:1-3-2 clarifies the Tax Commission's authority to require any person filing a report or return required by the provisions of any state tax law to file the report or return by electronic means.
[68 O.S. §203]
The revocation of Section 710:1-5-20 is in response to the Governor's Executive Order 2020-03 to streamline content by removing unnecessary and duplicative wording.
The amendments to the remaining Sections are to clarify policy, improve readability, correct scrivener's errors, remove obsolete language, update or correct citations, update contact information, and ensure accurate internal cross-references.
CONTACT PERSON:
Lisa Haws, Tax Policy and Research Division, Oklahoma Tax Commission, Oklahoma City, OK 73194; 405-521-3133; lhaws@tax.ok.gov.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS

710:1-1-1. Purpose
(a) The provisions of this Chapter have been adopted for the purpose of compliance with the Oklahoma Administrative Procedures Act, 75 O.S. §§250.1 et seq., and to facilitate the administration, enforcement, and collection of taxes and other levies enacted by the Oklahoma Legislature for the general maintenance and welfare of the State of Oklahoma.
(b) In particular, the purpose of Subchapter 1 is to set out a general description of the Oklahoma Tax Commission, review the functions performed by the Commission, and briefly present an overview of the statutory role of the Commission, its organization and structure.
(c) Any and all provisions in Title 710 of the Oklahoma Administrative Code which require actions to be taken by the Commission shall be contingent on availability of funding and should there be a reduction or elimination thereof, the Commission may reduce or suspend performance of the obligation until such time as funding is provided or secured.

710:1-1-2. General description of the Oklahoma Tax Commission
(a) History. The Oklahoma Tax Commission, from its inception in 1931, has been responsible for the collection and administration of various tax sources and the apportionment of these revenues to state funds which provide monies for education, transportation, recreation, social welfare, and the myriad of other services provided for the citizens of Oklahoma.
(b) Composition. The Tax Commission is comprised of three members (Chairman, Vice Chairman, and Secretary-Member) who are appointed by the Governor with the advice and consent of the State Senate and serve terms of six years each. The Commission appoints an administrator who is the administrator-administrative officer of the Tax Commission and manages the activities of its employees. The title of the administrative officer shall be Executive Director.
(c) Duties. It is the Commission's responsibility to supervise the administration and enforcement of state tax laws and the collection of a majority of all state-levied taxes and fees. The Commission directs the collection and distribution of the tax and license sources under its administration and, by statute, is responsible for apportioning such tax revenues to the various state funds. In addition, the Oklahoma Tax Commission allocates directly to local units of government certain state-collected levies earmarked to counties, school districts and municipalities. On a contract basis with individual municipalities and counties, the Tax Commission is involved with the administration, collection and distribution of city and county sales taxes and city use taxes.
(d) Areas of administration. The public may make submissions and requests to the Commission in the following areas of taxation and licensing:

1. Admission Tax
2. Aircraft Excise Tax
3. Aircraft License Fee
4. Alcoholic Beverage Tax
5. Alternative Fuels Surcharge
6. Amateur Radio Operators License Plate
7. Beverage Tax & License
8. Bingo Tax
9. Charity Games Tax
10. Cigarette Tax & License
11. Coin Device Decals and Distributor Permits
12. Compressed Natural Gas
13. Computer Enhancement Fund
14. Controlled Dangerous Substances Tax Stamps
15. County Clerk Fees
16. Diesel Fuel Excise Tax
17. Documentary Stamp Tax
18. Driving Record Fee
19. Energy Resources Assessment
20. Estate Tax
21. Farm Implement Tax Stamp
22. Fireworks License
23. Franchise Tax
24. Freight Car Tax
25. Gasoline Excise Tax
26. Gross Production Tax
27. Horsetrack Gaming Fees
28. Income Tax
29. Income Tax - Check-Offs
30. Indigent Health Care
31. Liquefied Natural Gas
Permanent Final Adoptions

SUBCHAPTER 3. PUBLIC POLICY

PART 1. GENERAL PROVISIONS

710:1-3-2. Required forms and where available
(a) The Oklahoma Tax Commission utilizes a wide variety of forms in the administration of the tax laws. The forms are subject to frequent change because of changes in the law and for administrative reasons. The Commission attempts to make a wide distribution of the commonly used forms needed by taxpayers for whom there is a current, valid mailing address available, such as: Sales Tax permit holders, businesses registered under Income Tax Withholding provisions, and business entities licensed under Franchise Tax provisions.

(b) Current Oklahoma Income Tax forms are available from Taxpayer Assistance Division, at the main offices of the Oklahoma Tax Commission, 2501 North Lincoln Boulevard, Oklahoma City and may be accessed through the Tax Commission website at www.tax.ok.gov.

(c) The Commission maintains a Forms Catalog containing sample taxpayer forms required by the Oklahoma Tax Commission in the administration of the various tax levies. The Forms Catalog may be viewed in the Communications Division, M. C. Connors Building, 2501 North Lincoln Boulevard, Oklahoma City, Oklahoma, 73102 during normal business hours. The Tax Commission may require any person filing a report or return required by the provisions of any state tax law to file the report or return by electronic means or may allow, upon a written request, a taxpayer to file a return on paper that is required to be filed electronically. [68 O.S. § 203]

PART 5. FILING AND MAILING OF DOCUMENTS

710:1-3-30. Timely filing
(a) General definition. When the last date for filing any document or performing any act required by the Oklahoma Tax Commission falls on a day when the offices are not open for business, the filing of the document or performance of the act shall be considered timely if it is performed by the end of the next business day.

(b) When filing is by mail, timely filing shall be defined as follows. If any claim, statement, or other document required by law or agency rule to be filed within a prescribed period, or on or before a prescribed date, is delivered after the prescribed period or date, by the United States Postal Service or other delivery service designated by OAC 710:1-3-33 to the Oklahoma Tax Commission, at 2501 Lincoln Boulevard, Oklahoma City, the date of the United States postmark, stamped on the cover in which the claim, statement, or other document is mailed or the date recorded pursuant to OAC 710:1-3-33 by a designated delivery service shall be considered to be the date of delivery.

(c) Application. This provision shall apply:
(1) Determined with regard to any extension of time granted for the filing;
(2) Only if the postmark date or date recorded by a designated delivery service falls within the prescribed period, or on or before the prescribed date for filing the claim, statement, or other document; and,
(3) Only if the claim, statement, or other document was, within the prescribed time, deposited in the mail in the United States or placed with a designated delivery service, in an envelope or other appropriate wrapper, postage prepaid, properly addressed to the agency, office, or officer with which the claim, statement, or other document is required to be filed.

PART 9. EXECUTION OF TAX WARRANTS

710:1-3-54. Release of tax warrants

A tax warrant issued by the Oklahoma Tax Commission shall only be released by the Commission, after a determination by the Warrant Office of the Account Maintenance Income Tax Accounts Division of the Oklahoma Tax Commission that:

(1) The tax, penalty and interest to date has been paid in full.
(2) The penalty imposed by law and all other fees authorized by law have been paid in full.
(3) Such release shall be processed under Commission procedures, after clearance by the Warrant Office of the Account Maintenance Income Tax Accounts Division.

710:1-3-61. Validity of tax warrant

Any questions about the validity of a tax warrant, (i.e., wrong name, wrong business, incorrect address, etc.) should be referred to the Warrant Office of the Account Maintenance Income Tax Accounts Division.

PART 11. PUBLIC RECORDS

710:1-3-70. Records in general

(a) Confidentiality of records. Generally, the law provides that the records and files of the Oklahoma Tax Commission are confidential except as specifically provided otherwise by statute. [See: 68 O.S. § 205]
(b) Classes of exceptions to the general rule of non-disclosure. Certain documents are available to the public by specific exception to the general law set out in (a) of this Section. In addition, some documents are considered public in nature, pursuant to the Open Records Act. [See: 68 O.S. §§ 205, 205.2, 205.5 and 205.6; 51 O.S. § 24A.4]
(c) Records available under specific provisions of law. By specific statutory mandate and by exceptions to the general rule of confidentiality set out in 68 O.S. § 205, there are a number of sources of information available to the public and maintained by the Commission.

(1) List of income tax filers. A list of persons who filed Oklahoma income tax returns is prepared annually and made available for inspection at the Taxpayer Assistance Division, 2501 N. Lincoln Blvd., Resource Center, 123 Robert S Kerr Ave, Oklahoma City, OK 73104-73102, during normal business hours.
(2) Register of tax warrants filed. A register of current outstanding tax warrants issued is updated monthly and made available for inspection at the Taxpayer Assistance Division, 2501 N. Lincoln Blvd., Resource Center, 123 Robert S Kerr Ave, Oklahoma City, OK 73104-73102, during normal business hours.
(3) Oklahoma aircraft registry. A list of aircraft registered with the State of Oklahoma is maintained and available for public inspection at the Taxpayer Assistance Division, 2501 N. Lincoln Blvd, Resource Center, 123 Robert S. Kerr Ave, Oklahoma City, OK 73104-73102, during normal business hours.
(4) Decedents’ list. A list of decedents within the state, county of probate, and probate number is maintained by and available for public inspection at the Compliance Division Estate Tax Section Audit Services Division, 123 Robert S. Kerr Ave, Oklahoma City, OK 73102, during normal business hours.
(5) Permits, licenses, exemptions. Information regarding the issuance or revocation of licenses and permits and documents evidencing exemption are available for most applicable tax types. The elements or items of information available regarding permits, licenses and exemptions may vary by tax type. In addition, the format in which a particular record is available may be limited to that normally used by the agency. Items of permit-related information may include permit number, permittee name, name of business, and business address. Inquiries should be made to the Taxpayer Assistance Business Tax Services Division.

(d) Limited disclosure in some instances. Some records and information from records maintained by the Commission may be accessible only by certain persons, or for certain limited uses. In these instances, the release of information must be one permissible by statute. The Commission may require that the request be written and may require supporting documentation or identification, if the release of information sought is one statutorily limited in scope.
(e) Requesting records: fees. Where a person desires the Commission to make photocopies of public records, the request should be made in writing, specifying the record requested. The Commission may collect a fee for the copying of records, as well as other fees required by statute, and may structure the manner of response to requests so as to protect the normal business of the agency from undue disruption or delay. [For specific fee information, see Appendix A of this Chapter, Schedule of fees.]

710:1-3-71. Rules of the Oklahoma Tax Commission

(a) Rules described. "Rules" of the Oklahoma Tax Commission are formal statements of policy which set out procedures to be followed in the administration of various tax levies and fees. Rules describe broad interpretations of the tax laws, often prescribe forms, and may set out informal and formal procedures for filing, remitting, registering and objecting to the various taxing provisions. Rules may also prescribe procedures for the granting, denial, suspension, renewal, or revocation of various permits and licenses administered by the
Commission. Rules are subject to the provisions of Article I of the Oklahoma Administrative Procedures Act (APA), in Title 75 of the Oklahoma Statutes and must be promulgated under the terms of the APA before they are considered effective. Rules which have been promulgated have the full force and effect of law and continue in effect until amended or revoked under APA provisions.

(b) **Availability.** Current rules, both permanent and emergency, of the Oklahoma Tax Commission are available on the Oklahoma Tax Commission website at www.tax.ok.gov or from the Taxpayer Assistance Division, M. C. Connors Building, 2501 North Lincoln Boulevard Resource Center, 123 Robert S Kerr Ave, Oklahoma City, Oklahoma OK 73102, during normal business hours.

710:1-3-73. **Opinions and letter rulings**

(a) **Opinions not issued by the Commission.** An "opinion" is a formal document, generally prepared by legal counsel, expressing conclusions that interpret or apply the law to a set of assumed facts. As so defined, the Oklahoma Tax Commission does not issue "opinions". However, legal counsel may prepare such a document to advise the Commission or a taxing division within the Commission.

(b) "Opinion" defined. Thus, an "opinion," with respect to the Oklahoma Tax Commission, means a written communication embodying formal legal advice, upon which the Commission may base, in whole or in part, administrative decisions, decisions in individual tax proceedings, or prospective policy decisions. Opinions, being advisory to the Commission, do not constitute authority by any party for challenging any matter pending before the Commission.

(c) **Opinion may impact policy, rulemaking.** To the degree that a policy of the Commission, based upon such a legal opinion, impacts broad segments of taxpayers and is to be given future effect by the Commission, such policy may be promulgated as a rule of the Commission.

(d) **Availability of opinions.** Such opinions as may be made available to the public, pursuant to the provisions of Section 302(A)(4) of Title 75, as further defined and limited by the terms of Section 24A.1, et seq., of Title 51, will be limited to those which are, or will be embodied in policy of the Commission.

(e) "Letter ruling" described. The Tax Policy and Research Division and the Office of the General Counsel may draft and issue letter rulings, which are informal written statements of policy or treatment of specific fact situations under Oklahoma tax law. Such a letter ruling may generally be relied upon by the taxpayer to whom it is issued, provided that all facts have been accurately and completely stated, and that there has been no change in applicable law.

(f) **Requests for letter rulings.** Requests by individuals or groups of taxpayers for letter rulings will be honored by the Commission, at its discretion, and in consideration of the time and resources available to respond to such requests. Requests for letter rulings should be made to the Tax Policy and Research Division, Oklahoma Tax Commission, 2501 N. Lincoln 123 Robert S. Kerr Ave, Oklahoma City, OK 73102.

(g) **Letter ruling may initiate rulemaking.** To the degree that a letter ruling impacts broad segments of taxpayers and is to be given future effect by the Commission, such letter ruling may become the basis for a rule of the Commission.

(h) **Availability of letter rulings.** Letter rulings may be viewed at the Taxpayer Assistance Division at the M. C. Connors Building, 2501 North Lincoln Boulevard Resource Center, 123 Robert S. Kerr Ave, Oklahoma City, Oklahoma OK 73102, during normal business hours.

**SUBCHAPTER 5. PRACTICE AND PROCEDURE**

**PART 3. DESCRIPTION OF ADMINISTRATIVE REVIEW AND HEARINGS**

710:1-5-15. **Requests for rulemaking action**

(a) Any interested person may petition the Commission, requesting the adoption, amendment, or revocation of an existing rule of the Oklahoma Tax Commission. Such a request need not take any particular form, but must be written and include the following information:

1. The full text, or identifiable portion thereof, of a proposed rule or rules;
2. The identification and the full text, or identifiable portion thereof, of an existing rule or rules, as proposed to be amended, clearly indicating proposed changes;
3. The identification of the rule or rules for which repeal is sought;
4. A statement in support of the proposal made. This statement shall make reference to the statutory basis for the proposal, including, when appropriate, judicial and administrative interpretations of the statute or statutes in question. The supporting statement should include specific objections to existing rules, practices, or interpretations, and set forth the policy considerations which support adoption of the proposal; and,
5. A statement describing in detail the interest of the petitioner in making the proposal. This description shall include a statement as to whether the proposal is intended to affect the tax consequences of any transaction or transactions entered into or contemplated by the petitioner, its vendors, customers, clients, or any person upon whose request or upon whose behalf the proposal is made, the taxability of which are known by the petitioner to be the subject of an inquiry, audit, refund, or assessment proceeding by the Commission and shall contain an explanation of the circumstances surrounding the inquiry, audit, refund, or assessment proceeding, if any.

(b) The Commission shall consider each request for rulemaking action which is filed in conformity with this Section and, at its discretion, direct that rulemaking proceedings be initiated in response thereto or deny the request. The Commission may also, at its discretion and with a view to agency resources, direct the rulemaking action be deferred until the next regularly scheduled rulemaking proceedings are commenced. If the rulemaking request is denied, the Commission
shall timely so notify the requesting party, in writing, stating the reason(s) for denial. The determination of rulemaking requests shall be solely within the province of the Commission, and no individual proceeding shall be afforded any party in conjunction therewith.

c) Pursuant to the terms of Section 305 of Title 75 (The Oklahoma Administrative Procedures Act, "APA") any petition for which rulemaking action has not commenced within 30 calendar days is deemed to be denied.

d) Requests may be made to the Tax Policy and Research Division, 2501 N. Lincoln 123 Robert S. Kerr Ave, Oklahoma City, Oklahoma, 73104-73102.

710:1-5-16. Rulemaking procedure and hearings

(a) "Hearing" for rulemaking purposes defined. Rulemaking hearings of the Oklahoma Tax Commission are a forum in which interested parties may express views, make suggestions, and generally have input into the process by which the Commission formulates policy set out in proposed rules. The "hearing" in a rulemaking action consists of:

1. a period for public comment, during which written submissions are accepted (will be "heard") by the Commission for the rulemaking actions previously announced; and,

2. a meeting at which interested persons may attend and express opinions, give views, make suggestions, or argue orally.

(b) Who may appear. Any persons interested in or affected by proposed rulemaking actions may appear at a rulemaking hearing. An appearance may be made individually, or by a representative.

c) Commencement of rulemaking.

1. The Commission may commence action to promulgate, amend, or revoke a rule at any time on its own initiative.

2. The Commission may commence action to promulgate, amend, or revoke a rule pursuant to a Request or Petition for Rulemaking action described in 710:1-5-15.

3. The Commission may commence action to promulgate, amend, or revoke a rule pursuant to applicable judicial or statutory mandate.

d) Applicable procedures. Rulemaking procedure, as it applies to the Commission, is set out in general by the terms of the Oklahoma Administrative Procedures Act ("APA"), 75 O.S. §§ 250.1, et seq. Rulemaking hearings required by the APA will substantially conform to the provisions thereof. The following general provisions will apply to rulemaking hearings held by the Oklahoma Tax Commission:

1. Unless expressly stated otherwise in a Notice of Rulemaking Intent, rulemaking hearings will be held at the Oklahoma Tax Commission, M.C. Connors Building, 2501 North Lincoln Boulevard 123 Robert S. Kerr Ave, Oklahoma City, Oklahoma 73102.

2. Unless expressly stated otherwise in a Notice of Rulemaking Intent, persons wishing to present views orally should notify the Commission in advance of the hearing. To assure efficient use of the forum, the Commission, in its discretion, may limit the amount of time available to each speaker.

3. All written submissions and requests to be placed on the agenda to make oral submission shall be directed to the Oklahoma Tax Commission, Tax Policy and Research Division, 2501 N. Lincoln 123 Robert S. Kerr Ave, Oklahoma City, OK 73104-73102.

4. All persons in attendance at a rulemaking hearing, whether offering input or not, will be requested to identify themselves for the rulemaking record.

5. All persons in attendance at a rulemaking hearing who desire to make oral comment will be requested to provide a name and mailing address for the rulemaking record.

6. All persons in attendance at a rulemaking hearing will limit oral comments to the merits of the proposed rules for which the hearing is commenced, as announced by the applicable Notice of Rulemaking Intent.

7. A rulemaking hearing being non-adversarial in nature, all persons in attendance at such hearing will offer input in such a fashion as to comport with the purpose of gathering effective and meaningful information for the guidance of the Commission in formulating policy.

8. Summaries or audio recordings (or both) will be made of rulemaking hearings and maintained as a part of the rulemaking record. No transcript of the rulemaking hearing will be prepared. Should an interested party desire a transcription or recording of a rulemaking hearing, the taxpayer is directed to contact a certified court reporter, and make the necessary arrangements for the presence of the reporter at the hearing, and the cost thereof. The cost of transcribing will be borne by the party seeking such transcript, who must furnish the original of the transcript to the Commission.

9. All records required to be kept pertaining to rulemaking will be maintained and may be viewed at the Oklahoma Tax Commission, Tax Policy and Research Division, located on the Fifth Floor of the M.C. Connors Building, 2501 North Lincoln Boulevard 123 Robert S. Kerr Ave, Oklahoma City, Oklahoma 73102, during normal business hours (7:30 a.m. to 4:30 p.m.). Interested persons may obtain copies of both current and proposed rules of the Commission from this source.

10. Interested persons may request individual notice of proposed rulemaking intent by a written request to the Oklahoma Tax Commission, Tax Policy and Research Division, Rulemaking Liaison, 2501 N. Lincoln 123 Robert S. Kerr Ave, Oklahoma City, Oklahoma, 73104-73102. Requests for individual notice should specify the area of tax or procedure for which notice is desired and must be renewed annually.

(e) Attendance by Commission representatives; Commission review. To ensure that public input will receive a meaningful hearing, all rulemaking hearings will be attended by a representative from the taxing Division of the Commission initiating the proposed rules. All submissions or summaries thereof, both written and oral, will be reviewed and considered.
by the Commission prior to the adoption or promulgation of any proposed rules.

710:1-5-17. Petitions for declaratory rulings
(a) General provisions. The Commission or its duly authorized agent may issue declaratory rulings, as to the applicability of any rule or principle of law embodied in a precedential decision of the Commission, which is requested by or on behalf of a person directly affected thereby, subject to the terms and conditions set forth in this Section.
(b) Form of petition; where to file. A declaratory ruling petition must be made in writing and sent in duplicate to the Secretary-Member, Oklahoma Tax Commission, 2501 N. Lincoln Boulevard, 123 Robert S. Kerr Ave, Oklahoma City, Oklahoma 73102.
(c) Contents of a petition for a declaratory ruling. A declaratory ruling petition must specifically state:
   (1) That a "declaratory ruling is requested pursuant to 710:1-5-17."
   (2) The petitioner's
      (A) Name (the name of the person, partnership, corporation or entity to whom the facts presented in the petition apply);
      (B) Address and phone number;
      (C) Federal identification number, if applicable; and
      (D) Appropriate OTC license, registration or identification number, where applicable.
   (3) The type of tax, fee, bond, registration, license, or permit at issue;
   (4) The issue(s) on which a declaratory ruling is requested, stated clearly and concisely;
   (5) A complete, clear and concise statement of all relevant facts on which the declaratory ruling is requested;
   (6) The petitioner's desired result and the legal basis for that result, including reference to the applicable statutes, rules, regulations, and case law;
   (7) Whether the issue, as it regards the petitioner, is presently under investigation or audit by the Commission or any of its agents. The term investigation or audit includes, but is not limited to, an inquiry, audit, refund, assessment, suspension or revocation proceeding by the Commission; and
   (8) Whether the petitioner is presently pursuing any protest, litigation or negotiation on the issue with the Commission or any of its Divisions, as well as the name of any other person, partnership, corporation or entity whom the petitioner or a duly authorized representative knows is involved with the identical issue pending before or with the Commission.
(d) Petition must bear authorized signature. A petition for a declaratory ruling must be signed by the petitioner or an authorized agent of the petitioner.
(e) Proposed draft may be offered. The petitioner may provide a draft ruling for the Commission's consideration.
(f) Commission may require additional information. The Commission or its authorized representative may request additional information from the petitioner as deemed necessary to issue a declaratory ruling. Failure to provide the requested information shall result in denial of the petition to issue the declaratory ruling.
(g) Effect of a declaratory ruling. A declaratory ruling shall have the following effect:
   (1) The declaratory ruling shall apply only to the particular fact situation stated in the declaratory ruling petition;
   (2) The declaratory ruling shall apply only to the petitioner;
   (3) The declaratory ruling shall bind the Commission, its duly authorized agents and their successors only prospectively;
   (4) The declaratory ruling shall bind the Commission, its duly authorized agents and their successors as to transactions of the petitioner that occur within three (3) years after the date of the issuance of the declaratory ruling; and
   (5) The declaratory ruling may be revoked, altered, or amended by the Commission at any time.
(h) Exceptions to binding effect of declaratory ruling. The declaratory ruling shall cease to be binding if:
   (1) A pertinent change is made in the applicable law by the Legislature;
   (2) A pertinent change is made in the Commission's rules;
   (3) A pertinent change in the interpretation of the law is made by a court of law or by an administrative tribunal; or
   (4) The actual facts are determined to be materially different from the facts set out in the petitioner's declaratory ruling petition.
(i) Issuance of a declaratory ruling. The Commission will make a good faith effort to issue a declaratory ruling within ninety (90) days from date of receipt of a complete and proper petition unless, in the Commission's discretion, the issue is of such complexity or novelty that additional time is required.
(j) Contents of a declaratory ruling. A written response from the Commission or from any employee or agent of the Commission to an inquiry from a taxpayer may not be construed to be a declaratory ruling unless made in conformity with this Subsection. A declaratory ruling must contain:
   (1) A statement that: "This is a declaratory ruling issued by the Oklahoma Tax Commission pursuant to 75 O.S. 1991, § 307;" and
   (2) The signature of the Commission or any person duly authorized to issue declaratory rulings on its behalf.
(k) Denial of a petition for declaratory ruling. The Commission, in its discretion, may deny a petition for declaratory ruling for good cause. In this instance, the Commission, in a letter, will indicate the reason(s) for refusing to issue the declaratory ruling. Good cause includes, but is not limited to, the following:
   (1) The petition does not substantially comply with the information required by this Section;
   (2) The petition involves hypothetical situations or alternative plans;
   (3) The petitioner requests the Commission to interpret or apply a statute, or requests a determination as to whether a statute is constitutional under the Oklahoma Constitution or the United States Constitution;
(4) The facts or issue(s) presented in the petition are unclear, overbroad, insufficient or otherwise inappropriate as a basis upon which to issue the declaratory ruling;
(5) The issue about which the declaratory ruling is requested is primarily one of fact;
(6) The issue is presently being considered in a rule-making proceeding, protest proceeding or other agency or judicial proceeding that may definitively resolve the issue;
(7) The issue cannot be reasonably resolved prior to the issuance of rules;
(8) The petitioner is under investigation or audit relating to that issue, or the issue is the subject of investigation, audit, administrative proceeding or litigation;
(9) The issue relates to the application of the law to members of a business, trade, professional or industrial association or other similar group(s); or
(10) The petitioner is not identified or is anonymous.

(l) Withdrawal of a petition for declaratory ruling. The petitioner may withdraw the petition for a declaratory ruling, in writing, prior to the issuance of the declaratory ruling.

(m) Response when declaratory ruling inappropriate. When a declaratory ruling petition requests the Commission to interpret or apply a statute or case law to a specific set of facts, the Commission will issue a letter ruling, as described in OAC 710:1-3-73, instead of a declaratory ruling.

PART 5. ADMINISTRATIVE PROCEEDINGS RELATED TO TAX PROTESTS

710:1-5-20. Purpose and general overview of taxpayer protest procedure [REVOKED]

(a) The purpose of this Part is to give the taxpayer, or the taxpayer's representative, a reasonable way to have the case considered fairly, and to give the taxpayer an opportunity to resolve disagreements with the Tax Commission or one of its various divisions without having to go through a formal hearing.
(b) The provisions of this Part are provided to taxpayers who wish to challenge a tax liability assessed by the Oklahoma Tax Commission, or to seek a refund of taxes. They are available at the Oklahoma Tax Commission, M. C. Connors Building, 2501 Lincoln Boulevard, Oklahoma City, Oklahoma 73104, and are routinely mailed to a taxpayer or his authorized representative when a case is docketed.
(c) If a case cannot be resolved informally, the provisions of this Part provide for a formal hearing before the Administrative Law Judge, who is independent of the various tax divisions of the Tax Commission and the General Counsel's Office. The Administrative Law Judge makes proposed Findings, Conclusions and Recommendations which are reviewed and acted on by the Commission.
(d) The taxpayer retains the right to seek relief by way of appeal to the Commission en banc or Supreme Court of Oklahoma from an Order of the Oklahoma Tax Commission.

PART 8. SETTLEMENT OF TAX LIABILITY

710:1-5-84. Application for a Settlement Agreement

(a) Application. The forms necessary to make application for a Settlement Agreement may be obtained from the Account Maintenance Division, 2501 Lincoln Boulevard, Oklahoma City, OK, 73104, are available online at www.tax.ok.gov. Completed Settlement Agreement Applications and any documents in support thereof must be submitted to the same address.
(b) When a Power of Attorney is Required. Applications being tendered on behalf of a taxpayer by an attorney, CPA, or other person, must be accompanied by a properly acknowledged Power of Attorney Form, signed by the taxpayer, authorizing the person to act on behalf of the taxpayer.
(c) Additional information. The Account Maintenance Division may request additional financial or other information deemed necessary to supplement the Settlement Agreement Application.
(d) Presentation of the application. The Account Maintenance Division shall present a completed application to the Commission during a regularly scheduled meeting of the Commission.
(e) Notice of the determination of the application. The Account Maintenance Division shall notify the applicant in writing of the decision of the Commission and make any required adjustments to the applicant's account.
(f) Withdrawal of application. An application for a Settlement Agreement may be withdrawn by the taxpayer at any time prior to its acceptance.

710:1-5-86. Review by Commission

(a) Unanimous vote required. A unanimous vote of the members of the Commission is required for approval of a Settlement Agreement.
(b) Discretionary act. The determination of settlement is within the sole discretion of the Commission.
(c) Facts and other considerations. In making its decision, the Commission will consider, but not be limited to, the following matters:
(1) The likelihood of collection of the debt;
(2) The amount of the debt;
(3) Efforts made by the Applicant to pay a part of the debt prior to filing an application for settlement;
(4) The taxpaying record of the Applicant;
(5) Applicant's current and possible future earning capacity;
(6) The portion of the tax itself which would be paid under the terms of the proposed Settlement Agreement;
(7) The composition of the balance of tax, penalty, and interest due;
(8) The percentage of the tax debt proposed to be settled;
(9) The Applicant's age and health;
(10) The Applicant's net worth;
(11) The acceptance by the Internal Revenue Service of an offer in compromise and the amount;
(12) The age of the debt;
(13) The existence of liens;
(14) Current operating status of any business;
(15) Bankruptcy status;
(16) The amount determined to be collectible. This amount is generally based upon the Commission's evaluation of the reasonable collection potential of the taxpayer's assets and revenue. The collectible amount is one factor used to determine if an offer is reasonable.
(17) Other liable parties;
(18) Whether tax debt due is a trust tax collected by Applicant but not remitted to the Commission;
(19) What other persons are liable;
(20) Whether the Applicant is located within Oklahoma or not;
(21) The accuracy and veracity of the Applicant's representations to the Commission;
(22) The recommendations of the Account Maintenance Income Tax Accounts Division; and
(23) The expense and time expended in future collection efforts by the Commission on the Applicant's debt.

(d) Other circumstances which may be considered. In addition to the factors set out in (c) of this Section, the Commission may consider any other aggravating or mitigating circumstances contributing to the request for settlement, including, but not limited to:

(1) Good faith efforts made by taxpayer to comply with the tax laws of this state.
(2) Benefit received by taxpayer from nonpayment of the tax.
(3) Involvement of taxpayer in economic activity which gave rise to tax liability.

(e) No appeal of denial. The decision by the Commission to decline a proposed Settlement Agreement is final and is not appealable.

(f) Court approval required. If the amount of the tax liability to be abated exceeds Twenty-five Thousand Dollars ($25,000.00), the Settlement Agreement requires the approval of a judge of the district court of Oklahoma County.

(g) Resubmission of application. If a taxpayer has previously submitted an application for a Settlement Agreement and that application was not accepted, the taxpayer may apply at a later date if financial conditions have changed, or to submit additional information not previously provided for review by the Commission.


Relief granted under Initiative. Taxpayers who qualify under the Initiative will be granted a waiver of penalty, interest and other collection fees and the Tax Commission will refrain from assessing use tax for more than one year prior to the date the taxpayer registers to pay consumer use tax.

(1) Eligibility. Only businesses that make regular purchases of tangible personal property outside the State of Oklahoma for their own use, storage or consumption in this State are eligible for the relief granted under the Initiative.

(2) Qualification. To qualify for the relief granted under the Initiative the taxpayer must:

(A) Voluntarily file delinquent use tax returns and pay the delinquent consumer use taxes reflected thereon; and
(B) Apply with the Oklahoma Tax Commission for an Oklahoma consumer use tax account to report and remit use tax on a monthly basis.

(iii) No fee is required to obtain the account.

(ii) Application is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N Lincoln Blvd., Div 123 Robert S. Kerr Ave, Oklahoma City, OK 73102, a completed Business Registration Packet A available telephonically at (405) 521-3160 or online at www.tax.ok.gov.

(iii) Upon receipt and review of the completed Packet A, application and review by the Tax Commission, a consumer use tax account will be assigned.

(3) Exceptions. The relief provided under the Initiative is not available to a taxpayer with respect to:

(A) Any matter or matters for which the consumer received notice of the commencement of an audit and which the audit is not yet finally resolved including any related administrative and judicial processes; and

(B) Use taxes already paid or remitted to the state.

(4) Applicability. The relief provided pursuant to the Initiative applies only to use taxes due from a taxpayer in its capacity as a buyer not to use taxes due from a taxpayer in its capacity as a seller.

[OAR Docket #21-471; filed 6-15-21]
710:10-2-5 [REVOKED]
710:10-2-6 [REVOKED]
Subchapter 9. Manufactured Homes
710:10-9-1 [AMENDED]
710:10-9-15 [AMENDED]
710:10-9-16 [AMENDED]

AUTHORITY:
68 O.S. § 203; Executive Order 2020-03; Oklahoma Tax Commission

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
December 22, 2020

COMMENT PERIOD:
January 15, 2021 through February 16, 2021

PUBLIC HEARING:
February 22, 2021

ADOPTION:
March 9, 2021

SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:
March 16, 2021

LEGISLATIVE APPROVAL:
Approved June 11, 2021 by HJR 1046

FINAL ADOPTION:
June 11, 2021

EFFECTIVE:
September 1, 2021

SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
The amendment to Section 710:10-2-1 provides that personal property surveys are no longer conducted or needed due to advances in technology and the availability of information.

The amendment to Section 710:10-2-2 and the proposed revocation of Sections 710:10-2-3, 710:10-2-4, 710:10-2-5 and 710:10-2-6 are to comply with Executive Order 2020-3 wherein Governor Stitt required a review of all agency administrative rules to find and revoke those rules that have become obsolete and are no longer necessary. In a review of the rules of the Oklahoma Tax Commission, it was found that some of the language in these rules is outdated and no longer necessary.

The amendment to Section 710:10-9-1 removes outdated language.

The amendments to Sections 710:10-9-15 and 710:10-9-16 remove language requiring the assessor’s office to include on the real estate assessment roll and personal property assessment roll the title number and the VIN (vehicle identification number) of a manufactured home; the records and files of the Tax Commission are confidential. [68 O.S. §205]

CONTACT PERSON:
Lisa Haws, Tax Policy and Research Division, Oklahoma Tax Commission, Oklahoma City, OK 73194; 405-521-3133; lhaws@tax.ok.gov.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 2. BUSINESS PERSONAL PROPERTY VALUATION SCHEDULES

710:10-2-1. General provisions
(a) Purpose. The provisions of this Subchapter have been adopted, pursuant to 68 O.S. § 2875(D)(4), to provide information regarding the schedules of values of personal property given to county assessors to assist in the assessment of personal property.

(b) Schedules of values. Schedules of values are intended only to provide the user with an approximation of value for the personality "typical" for the class, not an absolute value.

(c) Schedules of trending and depreciation. Trending schedules are used to adjust historical cost to a current estimated replacement cost new. Depreciation schedules are used to estimate normal depreciation as applied to replacement cost new to estimate current value of the asset. The factors or percentages used are taken from Marshall and Swift Valuation Service, a national valuation service contracted by the Division to provide values and schedules of trending and depreciation for real and personal property. This service is updated on a monthly basis.

(d) Caveat. Nothing in this Subchapter, nor any other guidelines, procedures, or rates provided to assessors by the Oklahoma Tax Commission Ad Valorem Division ("Division") is intended to relieve property owners or assessing officials of their obligations by law to report, value, or assess personal property at its fair cash value. Though the schedule of values referred to in this Subchapter are typical values for business personal property, actual value of any particular asset may be affected by conditions or use.

(e) Disclosure. A copy of the "Business Personal Property Valuation Schedule" may be obtained by accessing the Tax Commission website at www.tax.ok.gov.

(f) Surveys. Individuals and organizations who wish to participate in surveys conducted by the Ad Valorem Division may notify the Division by emailing jbittner@tax.ok.gov.

710:10-2-2. Agricultural products and related equipment

(a) Agricultural products. The term "agricultural products" includes, but is not limited to: wheat, milo, peanuts, alfalfa hay, grass hay, corn, soybeans, native pecans, improved pecans, grains, and cotton.

(b) Source. The source for values of agricultural products is determined by reference to the current average Oklahoma market prices, as of May of each year, provided by the Oklahoma Department of Agriculture.

(c) Livestock. The term "livestock" includes, but is not limited to: horses, cattle, commercial pigs, commercial chickens, commercial turkeys, table eggs, and other livestock.

(d) Source. The source for values of livestock is determined by reference to the current average Oklahoma market prices, as of May of each year, provided by the Oklahoma Department of Agriculture.

(e) Agricultural related equipment. The term "agricultural related equipment" includes, but is not limited to: balers, combines, cotton pickers and strippers, forage harvesters, mower conditioners, sweepers and brooms, tractors, and windrowers.

(f) Source. The source for values of agricultural related equipment is the Interactive Realtime Online Network (IRONs), Farm Equipment Guide for the Southwest Region. The guide uses data collected from new equipment manufacturers and dealers, used equipment dealers, and auctioneers in the southwest region, and is updated annually.
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(a) Specialized agricultural industries. The Oklahoma State University Department of Agricultural Economics provides reviews of selected types of values for specialized agricultural industries. This is completed on an "as needed" basis.

(d) Business related equipment. "Business related equipment" includes, but is not limited to: computers, computer components, copiers, facsimile machines, office equipment, office furniture, office machines, printers, including peripherals, safes, and typewriters.

(e) Industrial related equipment. "Industrial related equipment" includes, but is not limited to: air equipment, asphalt distributors and finishers, compaction equipment, cranes, crawlers, loaders, crushing equipment, ditches (trenchers), excavators (hydraulic and mechanical), forestry equipment, generator sets, motor graders, motor scrapers, pavement millers, pumps, reclaimers/stabilizers, skid steer loaders, sweepers/brooms, tractor (backhoes), tractor (crawlers), tractor (wheel), and wheel loaders.

(f) Petroleum related equipment. "Petroleum related equipment" includes, but is not limited to: cable tool rigs, casing and tubing, crude oil, drill pipe, drilling rigs, gas compressors, meters, natural gas, pipeline costs, tanks, and valves.

(g) Exploration related equipment. All taxable personal property used in the exploration of oil, natural gas, or other minerals, including drilling equipment and rigs shall be assessed annually at its fair cash value, based upon the value set by the first Hadco International monthly bulletin published for the current tax year and such other available relevant and reliable market data, if any, concerning the fair cash value of property of the same kind, using the appropriate depth rating assigned to the drawworks by its manufacturer and actual condition of the rig. [See: 68 O.S. § 2817(L)]

(b) Miscellaneous equipment. "Miscellaneous equipment" means, but is not limited to, coin changers, food merchandisers, game machines, golf cars, industrial motors, organs, phonographs, pianos, and vending machines.

710:10-2.4. Industrial related equipment
[REVOKED]

(a) Industrial related equipment. "Industrial related equipment" includes, but is not limited to: air equipment, asphalt distributors and finishers, compaction equipment, cranes, crawlers, loaders, crushing equipment, ditches (trenchers), excavators (hydraulic and mechanical), forestry equipment, generator sets, motor graders, motor scrapers, pavement millers, pumps, reclaimers/stabilizers, skid steer loaders, sweepers/brooms, tractor (backhoes), tractor (crawlers), tractor (wheel), and wheel loaders.

(b) Sources. The sources utilized for valuation of industrial related equipment is the Green Guide, The Hand Book of New and Used Equipment. The Green Guide, published by Equipment Watch, Primedia Business Directories, is a listing of construction and industrial equipment based on equipment dealers' average retail price of new equipment and average sale price of used equipment. This guide is contracted yearly with quarterly updates for the various equipment.

710:10-2.5. Petroleum related equipment
[REVOKED]

(a) Petroleum related equipment. "Petroleum related equipment" includes, but is not limited to: cable tool rigs, casing and tubing, crude oil, drill pipe, drilling rigs, gas compressors, meters, natural gas, pipeline costs, tanks, and valves.

(b) Exploration related equipment. All taxable personal property used in the exploration of oil, natural gas, or other minerals, including drilling equipment and rigs shall be assessed annually at its fair cash value, based upon the value set by the first Hadco International monthly bulletin published for the current tax year and such other available relevant and reliable market data, if any, concerning the fair cash value of property of the same kind, using the appropriate depth rating assigned to the drawworks by its manufacturer and actual condition of the rig. [See: 68 O.S. § 2817(L)]

(c) Sources. Values of petroleum related equipment are determined from the following sources:

(1) For cable tool rigs, values are determined by reference to catalogs of equipment manufacturers and dealers.

(2) For casing, tubing, drill pipe, collars, and drilling rigs the source for values utilized is Hadco International, an appraisal and data firm specializing in the petroleum industry which measures current market conditions and values of various assets. This is a monthly publication.

(3) For crude oil, values are determined from the Oklahoma market twelve month average.
(4) For valves and tanks, values utilized are taken from Marshall and Swift Valuation Service, a national valuation service contracted by the Division to provide tables of values for real and personal property, depreciation schedules, and trending tables for historical costs. The service is updated on a monthly basis.

(5) For natural gas in storage, value is determined by reference to the New York Mercantile Exchange (NYMEX), which provides average cost of natural gas purchased from the storage facility, including data on well head gas purchase price, pipeline transportation, and storage fees.

(6) For gas compressors, meters, pipeline costs, and related equipment, values are determined from surveys of Oklahoma companies, research of records filed in the various counties, and other available sources. Such values may be adjusted using Marshall and Swift Valuation Service tables as provided in OAC 710:10-2-1(c).

710:10-2-6. Other equipment [REVOKED]

(a) Miscellaneous equipment. "Miscellaneous equipment" means, but is not limited to, coin changers, food merchandisers, game machines, golf cars, industrial motors, organs, phonographs, pianos, and vending machines.

(b) Sources. The Division utilizes a national valuation service to provide tables of values for personal property, depreciation schedules, and trending tables for historical cost of the various industries. The current service prescribed by the Division is the Marshall and Swift Valuation Service. This service is contracted yearly and updated on a monthly basis.

SUBCHAPTER 9. MANUFACTURED HOMES

710:10-9-1. Listing and assessment of manufactured homes for ad valorem taxes

(a) Manufactured homes subject to ad valorem taxation. On the first day of January of each year, the county assessor of the county in which a manufactured home is located shall list, assess and tax such manufactured homes as required by the Ad Valorem Tax Code as it pertains to real and personal property. [See: 68 O.S. §§2811-2813] If a manufactured home is permanently affixed to the real estate, the original document of title may be surrendered to the Oklahoma Tax Commission for cancellation, in accordance with 47 O.S. § 1110, provided there is no outstanding lien recorded on the title. Thereafter, these homes will be assessed as other real property improvements.

(b) New manufactured homes sold and properly registered between December 1st and January 31st. New manufactured homes which are sold and properly registered between December 1st and January 31st pursuant to this subsection shall be exempt from ad valorem taxes for the assessment period beginning January 1st. [See: 710:10-9-4 for proper listing and assessment of used manufacturers homes held for resale.]

(c) New manufactured homes. The purchaser of a new manufactured home will not be subject to ad valorem taxes until January 1st of the following year, if the new manufactured home is properly registered, titled, and tagged, as required by law.

(d) Information required. Data elements required for listing a manufactured home with a completed certified OTC Form 936 (Manufactured Home Certificate 936) consist of:

1. Receipt or Release for taxes paid;
2. Type of manufactured home transaction;
3. Date to be moved;
4. Name of current manufactured home owner(s);
5. Seller's current mailing address;
6. Seller's new mailing address;
7. Name of manufactured home buyer;
8. Buyer's current mailing address;
9. Buyer's new mailing address;
10. Information describing where manufactured home is being moved from, such as:
   A. Landowner's or park's name,
   B. City,
   C. County, and
   D. Legal description, or
   E. Situs description;
11. Current physical address;
12. Real property account number or personal property account number;
13. Information describing where manufactured home is being moved to, such as:
   A. Landowner's or park's name,
   B. City,
   C. County, and
   D. Legal description, or
   E. Situs description;
14. New physical address;
15. School district;
16. Certificate of Title information, consisting of:
   A. Vehicle identification number (VIN);
   B. Year of manufacture;
   C. Size;
   D. Make;
   E. Title number;
   F. Body type;
   G. Model;
   H. Agent number;
   I. Factory delivered price;
   J. Total delivered price.
17. Fair cash value;
18. Total current estimated taxes due;
19. Taxes due from prior years, if unpaid;
20. Total of prior years' taxes due, if unpaid;
21. Signature of applicant and date;
22. Certification by assessor's office, evidenced by signature and date;
23. Certification by treasurer's office that all current and prior years' taxes have been paid, evidenced by signature, date, and a statement substantially as follows: "THIS DOCUMENT SHALL NOT BE CERTIFIED BY THE TREASURER'S SIGNATURE UNLESS ALL SPACES HAVE BEEN COMPLETED WITH THE INFORMATION REQUESTED"
(24) Column for remarks;
(25) Instructions as to who receives colored copies of the Manufactured Home Certificate 936:
   (A) The white copy is retained by the assessor issuing the certificate;
   (B) The yellow copy is forwarded to the county assessor of the county receiving the Manufactured Home Certificate 936;
   (C) The pink copy is retained by the homeowner or applicant;
   (D) The blue copy is retained by the county treasurer signing the certificate;
(26) Legal certification of the Manufactured Home Certificate 936 requires the signatures of the assessor and treasurer;
(27-26) Other information necessary for CAMA valuation;
(28-27) Such other information as may be required by the Oklahoma Tax Commission.

710:10-9-15. Preparation and content of assessment rolls
(a) Authority to prescribe forms.
   (1) The Oklahoma Tax Commission is authorized by law to prescribe forms for the use of the county assessors in the ad valorem assessment process.
   (2) The annual assessment roll prepared by each county assessor shall be prepared in such form as may be prescribed by the Oklahoma Tax Commission.
(b) Assessment roll preparation and content.
   (1) Real estate.
      (A) Land and improvements will be listed and valued separately on the assessment roll.
      (B) An additional column contiguous to the land and improvement assessment will show the assessed value of the manufactured home.
      (C) The assessment roll will also contain the TITLE number and the VIN (vehicle identification number) of the manufactured home.
   (2) Personal Property.
      (A) The manufactured home section of the personal property assessment roll shall be prepared by the method prescribed by law for personal property assessment roll.
      (B) The personal property assessment roll will also contain the TITLE number and the VIN (vehicle identification number) of a manufactured home list on the assessment roll.

710:10-9-16. Preparation and content of tax rolls
(a) Authority to prescribe forms. The ad valorem tax rolls shall be made up as required by and in the form prescribed by the State Auditor and Inspector. The tax rolls shall contain such other information as may be required by the State Auditor and Inspector.
(b) Tax rolls content. The tax roll will show the presence of a manufactured home as prescribed by the State Auditor and Inspector. The following information shall be included:
   (1) The taxes for the manufactured home will be calculated separate and apart from the land and other improvements; and
   (2) The VIN (vehicle identification number) of the manufactured home will be placed on the tax roll.

[OAR Docket #21-472; filed 6-15-21]

TITLE 710. OKLAHOMA TAX COMMISSION
CHAPTER 15. AIRCRAFT
[OAR Docket #21-473]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 2. Aircraft Dealer Licenses
710:15-2-5 [AMENDED]
Subchapter 3. Registration
Part 3. Original Applications
710:15-3-10 [AMENDED]

AUTHORITY:
68 O.S. § 203; Oklahoma Tax Commission

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n/a

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
The amendments clarify policy, improve readability, correct scrivener's errors, remove obsolete language, update or correct citations, and update contact information.

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., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 2. AIRCRAFT DEALER LICENSES
710:15-2-5. Application
(a) Application for an Aircraft Dealer License may be made to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, Box 26920, Oklahoma City, OK 73126-0920.
(b) All applications must be accompanied by the fee of $250.00 which shall be refundable if the application is denied.
(c) The application shall be on the form prescribed by the Oklahoma Tax Commission and complete and correct in all material aspects.
(d) The application must be verified under the oath or affirmation of the applicant.
(e) Each application, whether for a new license or for renewal of an existing license, must be accompanied by a listing of the aircraft owned by the applicant, as of the day the application is made, using the Aircraft Dealer Report form.
(f) Each applicant must timely submit an Aircraft Dealer Report form showing all subsequent purchases and sales, if any, during the time that the license is pending.

SUBCHAPTER 3. REGISTRATION

PART 3. ORIGINAL APPLICATIONS

710:15-3-10. Procedures for making original application for registration of aircraft
(a) Duty to register.
(1) An application for registration of an aircraft operating on or from any airport within the State of Oklahoma shall be supplied to each purchaser of an aircraft by the dealer of the aircraft, if purchased within the state. The Oklahoma Tax Commission shall supply blank application forms to Oklahoma dealers of aircraft for dissemination.
(2) An application for registration of an aircraft purchased outside the State of Oklahoma which is operating on or from any airport within the state with the intent to remain for more than thirty (30) cumulative days, shall be supplied by the Oklahoma Tax Commission upon request of the owner. Application forms shall be made available upon request at all airports within the State of Oklahoma.
(3) Aircraft not registered in any other state which are operating on or from any airport within the state for an accumulation of thirty (30) days shall be presumed to be operating with the intent to remain in Oklahoma, and therefore are subject to Oklahoma registration laws.
(b) When registration is due. The certified application is to be filed with the Oklahoma Tax Commission within twenty (20) days of purchase if purchased within the state or within twenty (20) days of entry into the state for other aircraft.
(c) Information required. The application must contain the following information:
(1) A description of each aircraft to be registered, including the name of the manufacturer, aircraft registration number, type and gross weight.
(2) Name and address of the owner of the aircraft and county where the aircraft is based, i.e., location and/or address on the Federal Aviation Administration Certificate of Registration for the aircraft.
(d) Oklahoma Certificate of registration; display; inspection. Upon receipt of the application and the fee due the Aircraft Section of the Taxpayer Assistance Business Tax Services Division of the Oklahoma Tax Commission will issue the registrant a certificate of registration to be displayed on the aircraft in a conspicuous location and is subject to inspection by agents of the Commission.

[OAR Docket #21-473; filed 6-15-21]
FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 3. ALCOHOLIC BEVERAGES

710:20-3-3. Monthly tax reports required
(a) General requirements. Every licensed distributor and wholesaler and every bonded houseman who is licensed by the Oklahoma Alcoholic Beverage Laws Enforcement (ABLE) Commission to ship or cause to be shipped into this State to sell, distribute, use, possess or in any manner deal with alcoholic beverages in this State, shall report monthly to the Oklahoma Tax Commission, all sales, distributions, receipts and shipments of all such alcoholic beverages in this State during the preceding month. All required reports must be filed electronically in the format prescribed by the Compliance Division of the Oklahoma Tax Commission. Each such monthly report shall include the minimum information required by the Oklahoma Alcoholic Beverage Control Act and any additional information and attachments that may be required by the prescribed tax report form.
(b) Incomplete or insufficient reports. Any monthly alcoholic beverage tax report form that does not include all information requested on the prescribed form or that is not duly executed and verified shall not constitute the mandatory report.
(c) Failure to file. In the event a complete monthly report is not filed on or before the due dates in accordance with 710:20-3-4, of the Oklahoma Tax Commission Rules, the report shall be delinquent. [See: 37A O.S. §§ 5-101 et seq.]

710:20-3-7. Issuance of distributor or wholesaler permit
The Taxpayer Assistance Business Tax Services Division of the Oklahoma Tax Commission is authorized to issue non-transferable permits, upon the permit form or forms approved by the Commission, to distributors and wholesalers who are licensed by the Oklahoma Alcoholic Beverage Laws Enforcement (ABLE) Commission to ship or cause to be shipped into this State to sell, distribute, use or possess alcoholic beverages in the State of Oklahoma, upon receipt of the following:
(1) Completed, executed and verified permit application form to the Taxpayer Assistance Business Tax Services Division from the applicant;
(2) Completed and executed Alcoholic Beverage Tax Bond from the applicant in an amount approved by the Commission. [See: 37A O.S. § 5-112]

SUBCHAPTER 5. MIXED BEVERAGES

710:20-5-2. Designation of agent of the Oklahoma Tax Commission
The Director of the Taxpayer Assistance Business Tax Services Division is hereby designated as the agent, servant and employee of the Oklahoma Tax Commission for the following purposes:
(1) Issuance of mixed beverage tax permits;
(2) Cancellation of mixed beverage tax permits upon delinquency in reporting or paying the gross receipts tax or sales tax;
(3) Temporary suspension of mixed beverage tax permits upon revocation or suspension of the mixed beverage, caterer, hotel beverage, public event, or special events licenses issued by the ABLE Commission;
(4) Establishing amounts of required bonds; and,
(5) Seizure of containers or cases of alcoholic beverages declared to be contraband.

[OAR Docket #21-474; filed 6-15-21]

TITLE 710. OKLAHOMA TAX COMMISSION
CHAPTER 25. COIN OPERATED VENDING DEVICES

[OAR Docket #21-475]
SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

710:25-1-15. Cities may levy license or tax in addition to decals [REVOVED]

The coin operated vending device decal fee is in lieu of state, city and county sales tax. The cities, municipalities and towns are authorized to levy a license or occupation tax upon coin operated devices or persons operating the same or premises where same are located, in an amount not in excess of seventy-five percent (75%) of the decal fee imposed by the State. [See: 68 O.S. §1511]

[OAR Docket #21-476; filed 6-15-21]

TITLE 710. OKLAHOMA TAX COMMISSION
CHAPTER 30. DOCUMENTARY STAMPS

[OAR Docket #21-477]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
710:30-1-2 [AMENDED]

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GIST/ANALYSIS:
The amendment to Section 710:30-1-2 updates agency contact information.

CONTACT PERSON:
Lisa Haws, Tax Policy and Research Division, Oklahoma Tax Commission, Oklahoma City, OK 73194; 405-521-3133; lhaws@tax.ok.gov.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

710:30-1-2. 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 Director of the Business Tax Services Division of the Oklahoma Tax Commission. It is the intent of this Chapter that as Division Director, the actions and activities of the administrator shall be in compliance with directives established by the Commissioners of the Oklahoma Tax Commission.

"Attorney General" means the chief legal officer of the State of Oklahoma.

"Commission" means the Oklahoma Tax Commission.

"Consideration" means the actual pecuniary value exchanged or paid or to be exchanged or paid in the future, whether in money or otherwise, for the transfer or conveyance of an interest of realty, or minerals, including any assumed indebtedness. At the time of recording the instrument of transfer or conveyance, the consideration shall be stated, upon forms prescribed by the Oklahoma Tax Commission, and signed by the grantee, in accordance with the procedures prescribed by the Oklahoma Tax Commission.

"Deed" means any instrument or writing whereby realty or minerals are assigned, transferred, or otherwise conveyed to or vested in, the purchaser or, at his direction, any other person.

"Grantee" means the person receiving property.

"Grantor" means the person selling, giving or conveying the property.

"Mineral Deed" means the instrument which conveys a mineral interest in land.

"Mineral Interest" means the property interest created in oil or gas or other minerals by a mineral deed.

"Realty" includes those interests in real property, which endure for a period of time, the termination of which is not fixed or ascertained by a specific number of years; and, those interests enduring for a fixed period of years but which, either by reason of the length of the term or grant of a right to extend the term of renewal, consists of rights closely approximating interests in real property which endure for a period of time the termination of which is not fixed or ascertained by a specific number of years.

"Sold" means a transfer of interest for a valuable consideration, which may involve money or any other item of value.

[OAR Docket #21-476; filed 6-15-21]

TITLE 710. OKLAHOMA TAX COMMISSION
CHAPTER 35. ESTATES [REVOKED]

[OAR Docket #21-477]
710:35-1-1. Purpose [REVOKED]

The provisions of this Chapter have been promulgated for the purpose of compliance with the Oklahoma Administrative Procedures Act, 75 O.S. §§250.1 et seq., and to facilitate the administration, enforcement, and collection of taxes and other levies enacted by the Oklahoma Legislature with respect to decedents' estates.

710:35-1-2. Definitions [REVOKED]

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

"Qualified disclaimer" means an irrevocable and unqualified refusal by a person to accept an interest in property. The disclaimer must be timely made as provided by statute. [See: 84 O.S. §§22 et seq.; 60 O.S. §§751 et seq.]

710:35-1-3. Annual report available to public [REVOKED]

(a) After July 1, 1988, an annual listing of years for which an index is available will be displayed for public inspection at the offices of the Estate Tax Section of the Oklahoma Tax Commission during normal working hours.

(b) The Annual Report will contain the following information:

1. Name of Decedent
2. Date of Death
3. Address of Decedent
4. Probate County
5. Probate Number

(c) Any reproduction costs will be based on the current rates prescribed by the Commission. [See: 68 O.S. §116]

SUBCHAPTER 3. RETURNS; REMITTANCE; RELEASES [REVOKED]

PART 1. FILING AND PAYMENT [REVOKED]

710:35-3-1. Duty to file estate tax return [REVOKED]

The executor or administrator of a decedent's estate must file the Estate Tax Return. If there is no duly qualified executor or administrator appointed, qualified and acting within this State, the person actively or constructively in possession of the decedent's property shall file a return.

710:35-3-2. Time for filing relating to weekends and holidays [REVOKED]

When the last day prescribed for the performance of any act required by the Oklahoma Estate Tax Law falls on a Saturday, Sunday or legal holiday, the act shall be considered performed timely if done on the next day which is not a Saturday, Sunday or legal holiday.
710:35-3.3. Extension to file estate tax return [REVOKED]

The time for filing the Estate Tax Return may be extended, up to a maximum of six (6) months, upon request by the representative of the estate for an extension of time to file. Written application is to be addressed to the Estate Tax Section.

710:35-3.4. Liability for payment of estate tax [REVOKED]

(a) Individuals Liable. The Oklahoma Estate Tax imposed by statute with respect to the estates of residents and nonresidents, is payable by the executor or administrator of the decedent's estate. This duty applies to the entire tax, regardless of the fact that the gross estate consists in part of property which does not come within the possession of the executor or administrator. If there is no executor or administrator appointed, qualified and acting in this state, any person in actual or constructive possession of any property of the decedent is required to pay the entire tax to the extent of the value of the property in his possession. This is applicable to any interest due and owing. [See: 68 O.S. §§802, 804, 806]

(b) Accountability for Debts—Paid—Prior to Payment of Tax. Every executor, administrator or assignee, or other person, who pays, in whole or in part, any debt due by the person or estate for whom or for which he acts before he satisfies and pays the tax due to Oklahoma from such person or estate, shall become accountable to the extent of such payments for the tax so due to Oklahoma, or for so much thereof as may remain due and unpaid.

710:35-3.5. Payment plans [REVOKED]

Requests for estate tax payment plans should be made in writing to the Estate Tax Section Administrator. [See: 68 O.S. §806(b)]

710:35-3.6. Computation and due date of interest [REVOKED]

Interest on Oklahoma Estate Taxes is due and payable nine (9) months from the date of the death of the decedent, except as otherwise provided in 710:35-5-72. Interest is computed at the following rates and increments:

<table>
<thead>
<tr>
<th>FOR TIME PERIOD</th>
<th>RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1, 1988 to present</td>
<td>1 1/3 percent per month</td>
</tr>
<tr>
<td>March 23, 1983 to June 30, 1988</td>
<td>1 1/3 percent per month</td>
</tr>
<tr>
<td>Prior to March 23, 1983</td>
<td>1 percent per month</td>
</tr>
</tbody>
</table>

710:35-3.7. Application for reduction of interest [REVOKED]

(a) Notice. Notice of application to a District Court for the reduction of interest on Oklahoma Estate Taxes shall be served on the Division Administrator of the Estate Tax Section, who shall determine the correctness of the action. [See: 68 O.S. §806(b)]

(b) Qualifications for reduction. The application must set out the reason(s) as specified by statute that qualify for the reduction of interest and the portion of the estate so affected. [See: 68 O.S. §806(b)]

(c) Procedure. Upon issuance of a court order stating that a situation reasonably exists that would warrant the reduction, a certified copy shall be delivered to the Division Administrator of the Estate Tax Section.

(d) Interested party defined. The terms "pending litigation", "contingent claims", or "disagreements between interested parties" as used in 68 O.S. §806(b) shall relate only to inclusion or exclusion of those specific properties to which the litigation, claim or disagreement pertains. The reduction of interest does not apply to the remaining property reported in the estate. Neither the Oklahoma Tax Commission, nor the Internal Revenue Service, are considered to be interested parties. [See: 68 O.S. §806(b)]

710:35-3.8. Taxes paid under protest [REVOKED]

In any case where a taxpayer files a written protest of a proposed estate tax assessment with the Commission, the taxpayer may pay the taxes or additional taxes, as the case may be, and designate that the payment is being made under protest. Such payment will stop the accrual of interest, if any, upon the taxes so paid. If the Commission sustains the protest in whole or in part, the amount determined by the Commission not to be due shall be refunded to the taxpayer, without interest. [See: 68 O.S. §221]

710:35-3.9. Estate tax lien [REVOKED]

(a) General rule. For decedents who die on or before December 31, 2009, Oklahoma estate taxes shall be and remain a lien upon all property which is part of the gross estate of the decedent, as defined in 68 O.S. § 807, immediately upon the death of the decedent.

(b) Exceptions. The Oklahoma estate tax lien does not attach to the following categories of property:

(1) Property used for the payment of charges against the estate and expenses of administration, allowed by the court having jurisdiction thereof;

(2) Property reported to the Oklahoma Tax Commission by the responsible party or parties which shall have passed to a bona fide purchaser of value in which case the tax lien shall attach to the consideration received from such purchaser by the heirs, legatees, devisees, distributes, donees or transferees; and

(3) Property passing to the surviving spouse, either through the estate of the decedent, by joint tenancy, or otherwise.

(e) Duration. The Oklahoma estate tax lien shall continue as a lien on all property of the decedent's gross estate, except for the categories of property described in subsection (b), for ten (10) years from the death of the decedent, unless an order releasing taxable estate or order exempting the estate from estate tax is obtained from the Tax Commission. The Oklahoma
estate tax lien is extinguished upon the expiration of ten (10) years from the date of the death of the decedent unless prior thereto the Tax Commission causes a tax warrant to be filed and appear of record in which case the Oklahoma estate tax lien then shall continue as a lien on all property of the decedent’s gross estate, except for the categories of property described in subsection (b), until a release of the tax warrant is obtained and filed of record.

PART 3. RELEASES [REVOKED]

710:35-3-20. Estate tax releases [REVOKED]
(a) For purposes of this Part and administration of the Oklahoma Estate Tax Code, the word "release" shall mean and include the words "acquittance," "waiver," "disclaimer," "order-exempting" or other similar language used in the Estate Tax Code.
(b) The Division Administrator of the Estate Tax Section of the Oklahoma Tax Commission is authorized to issue releases of Oklahoma Estate Tax liability and liens thereby as to all property listed in the Oklahoma Estate Tax Return or other information filed with the Oklahoma Tax Commission in accordance with 710:35-3-21 and 710:35-3-24. Such releases shall be upon forms approved by the Commission, issued under facsimile signature of the Commissioners and the official seal of the Oklahoma Tax Commission, and shall constitute orders of the Commission.
(e) The Division Administrator of the Estate Tax Section of the Tax Commission or his designee shall have authority to attest the signatures and affix the official seal of the Oklahoma Tax Commission to releases and liens associated with Estate Taxes. [See: 68 O.S. §806(c)]

710:35-3-21. Release upon full payment; order releasing taxable estates [REVOKED]
(a) Upon payment of all Estate Tax and interest, an Order Releasing Taxable Estates will be issued as to both real and personal property of the estate either:
(1) Listed upon the Oklahoma Estate Tax Return which reports Oklahoma Estate Tax to be due and payable; or
(2) Listed in an audit performed by the Estate Tax Section. The Order Releasing Taxable Estate shall include a recitation of the name of the decedent, the amount of tax paid, the account number, receipt number and date of payment and that the reported estate of said decedent, consisting of real property or personal property or both, is released from Oklahoma Estate Tax liability and lien therefor. Recitation of legal description of real property or of the personal property of the estate shall not be set out in the Order Releasing Taxable Estates.
(b) For deaths occurring on or after January 1, 2010, no release of estate tax liability is required.

710:35-3-22. Order exempting non-taxable estates [REVOKED]
(a) Upon audit by the Estate Tax Section of any Oklahoma Estate Tax Return and determination made that no Oklahoma Estate Tax is due, an Order Exempting Non-Taxable Estate will be issued as to both real and personal property of the Estate.
(b) The Order Exempting Non-Taxable Estates shall include a recitation of the name of the decedent and that the net value of the estate of said decedent reported to the Commission is less than the applicable statutory exemptions and credits, and that the reported estate of the said decedent, consisting of real property or personal property or both, is released from Oklahoma Estate Tax liability and any associated lien. Recitation of the legal description of real property or of personal property of the Estate will not be set out in the Order Exempting Non-Taxable Estates. [See: 68 O.S. §821]

710:35-3-23. Order releasing property subject to Oklahoma Estate Tax liability and lien; partial release of specific property subject to the determination of tax [REVOKED]
(a) In matters where the Oklahoma Estate Tax Return has been filed with the Commission, or arrangements for filing the return have been made with the Estate Tax Section, the Division Administrator may issue an Order Releasing Property Subject to Estate Tax Liability and Lien upon therefor and a showing that payment of any Estate Tax liability has been otherwise provided for.
(b) The Order Releasing Specific Property Subject to Estate Tax Liability and Lien shall recite the legal description of the real property or the full description of the personal property for which the partial release is requested.
(c) For deaths occurring on or after January 1, 2010, no release of estate tax liability is required.

710:35-3-24. Estate passing to a surviving spouse [REVOKED]
(a) Order Exempting Estate Passing to a Surviving Spouse.
(1) Upon audit by the Estate Tax Section and a determination that no Oklahoma Estate Tax is due, an Order Exempting Estate Passing to a Surviving Spouse will be issued as to both real and personal property of the Estate.
(2) An Oklahoma Estate Tax affidavit must be submitted by the surviving spouse, along with a certified Death Certificate. [See: 68 O.S. §815]
(b) Contents. The Order Exempting Estate Passing to a Surviving Spouse shall include a recitation of the name of the decedent and that all of decedent’s property included in estate passing to the Surviving Spouse is released from any Estate Tax Lien.
(c) Requirements. No Order described in this Section will be issued without submission of either:
(1) An Oklahoma Estate Tax Return; or
(2) An Oklahoma Estate Tax Affidavit and accompanying certified Death Certificate.
(d) Effect. No Order described in this Section will be issued where the estate does not pass wholly and solely to the surviving spouse; nor where there is any Oklahoma Estate Tax liability determined to be due; nor where there is tax determined to be due under 68 O.S. §804.

SUBCHAPTER 5. DETERMINATION OF OKLAHOMA TAXABLE ESTATE [REVOKED]

PART 1. PROPERTY TO BE DISCLOSED ON RETURN [REVOKED]

710:35-5-1. Identification fully of all property [REVOKED]
All property included in the Estate Tax Return shall be fully identified. This shall include, but not be limited to:
(1) Real estate—Complete legal description and address.
(2) Minerals—Complete legal description, interest owned.
(3) Stocks: Issue name, identifying number and number of shares, documentation to support non-traded stock values.
(4) Bonds: Issue name, identifying number, par value, value at valuation date, and issue date.
(5) Personal property:
(A) Accounts at financial institutions—account number, name of institution, type of account, accrued interest to date of death, account balance at date of death.
(B) Accounts Receivable, Contracts of Sale, Partnerships within or without the State of Oklahoma, Notes, Mortgages, Liens: List name of payer, due date of amount owing, accrued interest to date of death, copy of instrument and amortization schedule, Federal Form K-1 for year of death. The interest of a nonresident decedent in a partnership will be taxed by the state where the partnership does business.
(C) Other personal property—description and fair market value.
(D) Proceeds received as a result of a "wrongful death" claim are not includable as an asset of the estate, but where it can be established that the wrongful death proceeds represent damages to which the decedent became entitled during his lifetime (such as for pain and suffering and medical expenses) rather than damages for his premature death, the value of these amounts will be includable.
(6) Life insurance: Company, policy number, beneficiaries and addresses, face value and amount payable. This includes cash surrender value for policies owned by the decedent on the lives of others.
(7) Prior transfers: Property description, date of actual transfer, any consideration and Federal Gift Tax Return Form 709 or schedule G of Federal Estate Tax Return concerning information on the transfer(s).

(8) Property outside Oklahoma—total gross value.

710:35-5-2. Transfers in contemplation of death [REVOKED]
Any transfer of property referred to in 68 O.S. 807(A)(2) is to be disclosed in the Oklahoma Estate Tax Return (Form 454-R82). In addition, copies of Federal Gift Tax, Form 709, shall be included with the Oklahoma Estate Tax Return. This requirement is made notwithstanding a determination by an executor or administrator that the transfer was not made in contemplation of death or was not a material part of the estate.

710:35-5-3. Joint interests [REVOKED]
(a) Joint interests. In general, a decedent’s gross estate includes the value of property held jointly at the time of the decedent’s death, by the decedent and another person or persons with right of survivorship, as follows:
(1) To the extent that the property was acquired by the decedent and the other joint owner or owners by gift, devise, bequest or inheritance, the decedent’s fractional share of the property is included.
(2) In all other cases, the entire value of the property is included except such part of the entire value as is attributable to the amount of consideration in money or money’s worth furnished by the joint owner or owners.
(b) Definition. “Property held jointly” specifically covers but is not limited to:
(1) Property held jointly by the decedent and any other person or persons, whether listed individually or as a member of a partnership or other legally constituted entity;
(2) Property held by the decedent and spouse as tenants by the entirety; and
(3) Deposit of money, or a bond or other instrument, in the name of the decedent and any other person and payable to either of the survivor.
(c) Applicability. This Section applies to all classes of property, whether real or personal, and regardless of when the joint interests were granted. Furthermore, it makes no difference that the survivor takes the entire interest in the property by right of survivorship and that no interest therein forms a part of the decedent’s estate for purposes of administration. The joint tenancy provision has no application to property held by the decedent and any other person or persons as tenants in common.
(d) Claims. Where a joint owner claims an interest in property included in decedent’s estate, and the interest was acquired from the decedent, the claimant must submit facts to show that the transfer was supported by adequate consideration.
(e) Proof. Whether consideration is adequate may be determined, in part, by a comparison of the consideration furnished to the total cost of acquisition plus capital additions for the property. The ratio the consideration furnished bears to the total value of the property must be proportional to the quantum of property transferred.
(f) Determination. The executor, administrator, or claimant may submit facts to show that property included in decedent’s estate was not acquired entirely with consideration
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furnished by the decedent; or was acquired by the decedent
and the other joint owner or owners by gift, bequest, devise or
inheritance... [See: 68 O.S. §807(A)(4)]

710:35-5-4. Cash surrender value of life insurance
[REVOKED]
There shall be included in the Estate Tax Return the cash
surrender value of any life insurance policy owned by the deced-
ent on the life of any other person or persons.

710:35-5-5. Unreported assets discovered
[REVOKED]
Assets that are not reported or disclosed in an Estate Tax
Return shall be subject to the tax if discovered by the Commiss-
on within ten (10) years of the date of death.

PART 3. VALUATION [REVOKED]

710:35-5-20. Valuation of all properties [REVOKED]
(a) Fair market value. Valuation of all property included
in the Estate Tax Return shall be at fair market value and, in
the case of real property, shall not be valued at the rate it is
assessed for local taxes, nor shall it be valued at the "special use
valuation" applicable for some Federal Estate Tax purposes.
(b) Appraisals. If an appraisal has been obtained, submit
with filing. The Oklahoma Tax Commission is not restricted
to the appraised value submitted in determining the value of
the taxable estate.

710:35-5-21. Mineral values [REVOKED]
In the absence of an evaluation of mineral value by a geolo-
gist or petroleum engineer, the minimum value to be reported
on the Estate Tax Return is:

(1) Producing minerals. Except as noted, oil income
should be valued at 18 times the average monthly income
for the six months preceding the six months after the date of
death. Gas should be valued at 8.4 times the average
income for the period six months before to six months after
the date of death. The Oklahoma Tax Commission shall not be bound by the submitted evaluation.

(2) Non-producing leased. For non-producing leased
properties, the value should be one and one half (1 1/2)
times the lease bonus if the last lease was made within
one year of the date of death.

(3) Non-producing non-leased. The value for
non-producing non-leased interests should be computed
by reference to monthly lease values.

710:35-5-22. Valuation of stocks and bonds
[REVOKED]
Stocks and bonds are to be valued on the Estate Tax Return
as follows:

(1) If publicly traded the value shall be the average of
the high and low quotation on the valuation date.

(2) Non publicly traded items shall be valued in acor-
dance with IRS Revenue Ruling 59-60.

(3) Oklahoma Turnpike Bonds are exempt from Okla-
homa Estate Tax. [First National Bank and Trust Com-
pany of Tulsa v. Oklahoma Tax Commission, 447 P.2d
441 (1968)]

710:35-5-23. Valuation of household goods and other
tangible personal property [REVOKED]
Valuation of household goods and other tangible personal
property is to be either by professional appraisal with an inven-
tory included with the Estate Tax Return or by estimation
of the appraised value of the property in which the household
goods are located subject to approval by the Estate Tax Sec-
tion. Whether an appraisal or estimation is used, an inventory
of items is to be submitted with the return.

710:35-5-24. Valuation of partnership or
proprietorship [REVOKED]
The fair market value of any interest of a decedent in a
business, whether a partnership or proprietorship, is the net
amount which a willing purchaser, whether an individual or
a corporation, would pay for the interest to a willing seller,
neither being under any compulsion to buy or to sell and both
having a reasonable knowledge of relevant facts. The net value
is determined on the basis of all relevant factors including but
not limited to:

(1) The fair market value as of the applicable valuation
date of all assets of the business, tangible and intangible,
including goodwill;

(2) The demonstrated earning capacity of the business;
and

(3) IRS Revenue Ruling 59-60.

PART 5. ALTERNATE VALUATION [REVOKED]

710:35-5-30. Alternate valuation election; properties
inccludable in the estate; explanation of
"lapse of time" [REVOKED]
(a) Alternate valuation of estate property: election by ex-
cutor/administrator; when election must be made. At the
election of the executor or administrator, all values will be de-
termined by using the alternate valuation date, and for prop-
erty sold within six (6) months of the date of death, the actual
sale price. The election is made with the timely filing of the
Estate Tax Return or an extension period granted by the Com-
mission. The election is revocable within the filing period or the
extended filing period. [See: 68 O.S. §816]

(b) Properties includable. If a binding contract for the sale,
exchange or other disposition of estate property is entered into,
the property is considered as sold, exchanged, or otherwise
disposed of on the effective date of the contract, unless the
contract is not subsequently carried out substantially in ac-
cordance with its terms. The phrase "distributed, sold, ex-
changed or otherwise disposed of" comprehends all possible
ways by which property ceases to form a part of the gross estate. The term does not, however, extend to transactions which are mere changes in form. Nor does it include an exchange of stock or securities in a corporation for stock or securities in the same corporation or another corporation in a transaction, such as a merger, recapitalization, or reorganization. [See: 68 O.S. § 816(D)(1)]

(c) **Explanation of lapse of time.** Properties, interests, or estates which are "affected by mere lapse of time" include patents, estates for the life of a person other than the decedent, remainders, reversions, and other like properties, interests, or estates. The phrase "affected by mere lapse of time" has no reference to obligations for the payment of money, whether or not interest-bearing, the value of which change with the passing of time. [See: 68 O.S. § 816(D)(1)(C)]

710:35-5.31. **Minerals - alternate valuation**

Upon election of alternate valuation date, producing minerals owned by the estate will be valued at the alternate valuation date and inclusion of production income between date of death and alternate valuation date will be made in addition to alternate valuation date value. [See: 68 O.S. § 816]

710:35-5.32. **Debts and expenses - alternate valuation**

Debts and expenses incurred in relation to income earned between date of death and alternate valuation date are not allowable as estate deductions.

**PART 7. DEBTS AND EXPENSES**

710:35-5.40. **Verification of debts and expenses**

All debts or administrative expenses of an estate are subject to verification by the Estate Tax Section.

710:35-5.41. **Selling expenses**

Expenses for selling property, including documentary stamps purchased for deed recordation, auction fees and abstract costs of the estate are deductible, to the extent of the decedent's interest in the property, with approval of the Court.

710:35-5.42. **Interest expense**

The amounts that may be deducted as claims against the decedent's estate are such only as represent personal obligations of the decedent existing at the time of death, whether or not then matured, and interest thereon which has accrued at the time of death. Only interest that had accrued at the date of death is deductible even though the executor or administrator may elect the alternate valuation date.

710:35-5.43. **Claims based on contracts**

The allowance of a deduction on the Estate Tax Return for a claim founded upon a promise or agreement is limited to the extent that the liability was contracted bona fide and for adequate and full consideration in money or money's worth.

710:35-5.44. **Federal gift taxes**

Unpaid federal gift taxes on gifts made by the decedent before his death are deductible; however, if a gift is considered as made one-half by decedent and one-half by spouse under 26 U.S.C.A. § 2513, the gift tax deductible is the amount attributable to a gift in fact made by the decedent only. No portion of gift tax considered attributable to spouse's one-half of a gift is deductible.

710:35-5.45. **Losses from casualties and theft**

A deduction is allowed for losses incurred during the settlement of the estate arising from fires, storms, shipwrecks, or other casualties, or from theft, if the losses are not compensated for by insurance or otherwise. If the loss is partly compensated for, the excess of the loss over the compensation may be deducted. Losses which are not the nature described are not deductible. In order to be deductible a loss must occur during the settlement of the estate. If a loss with respect to an asset occurs after its distribution to the distributees it may not be deducted. Notwithstanding the foregoing, no deduction is allowed under this section if the estate has elected to take this deduction pursuant to the alternative provisions for income tax purposes.

710:35-5.46. **Income taxes**

(a) **General Rule.** Unpaid income taxes are deductible on the Estate Tax Return if they are on income properly includable in an income tax return of the decedent for a period before his death. Taxes on income received after the decedent's death are not deductible.

(b) **Income included on joint return.** If income received by a decedent during his lifetime is included in a joint income tax return filed by the decedent and his spouse, or by the decedent's estate and his surviving spouse, the portion of the joint liability for the period covered by the return for which a deduction will be allowed is the amount for which the decedent's estate would be liable under Oklahoma law, as between the decedent and his spouse, after enforcement of any effective right of reimbursement or contribution.

(c) **Presumption.** In the absence of evidence to the contrary, the deductible amount is presumed to be an amount bearing the same ratio to the total joint tax liability for the period covered by the return that the amount of income tax for which the decedent would have been liable if he had filed a separate return for that period bears to the total of the amounts for which the decedent and his spouse would have been liable if they had both filed separate returns for that period. Thus, in the absence of evidence to the contrary, the deductible amount is a sum equal to the decedent's separate tax, divided by both spouses' separate taxes, times the joint tax liability.

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Limitation. However, the deduction cannot in any event exceed the lesser of:

(1) The decedent's liability for the period (as determined in this paragraph) reduced by the amounts already contributed by the decedent toward payment of the joint liability, or

(2) If there is an enforceable agreement between the decedent and his spouse or between the executor and the spouse pertaining to the payment of the joint liability, the amount which pursuant to the agreement is to be contributed by the estate toward payment of the joint liability.

Refunds. If the decedent's estate and his surviving spouse are entitled to a refund on account of an overpayment of a joint income tax liability, the overpayment is an asset includable in the decedent's gross estate in the amount to which the estate would be entitled under Oklahoma law, as between the estate and the surviving spouse. In the absence of evidence to the contrary, the includable amount is presumed to be the amount by which the decedent's contributions toward payment of the joint tax exceed his liability determined in accordance with the principles set forth in this Section. [See: 68 O.S. §808(b)]

Property taxes [REVOKED]

Property taxes are not deductible on the Estate Tax Return unless they accrued before the decedent's death. However, they are not deductible merely because they have accrued in an accounting sense. Property taxes in order to be deductible must be an enforceable obligation of the decedent at the time of his death on property within the State of Oklahoma. [See: 68 O.S. §808(a)]

Unpaid mortgages [REVOKED]

A deduction is allowed from a decedent's gross estate of the full unpaid amount of a mortgage upon, or of any other indebtedness in respect of any property of the gross estate, including interest which had accrued thereon to the date of death. Only interest accrued to the date of the decedent's death is allowable even under the alternate valuation method. [See: 68 O.S. §808.816]

Attorney fees [REVOKED]

Reasonable attorney fees allowed by the court and paid for by the legal representative as a cost of administering the estate shall be allowed as a deduction on the Estate Tax Return. [See: 68 O.S. §808]

Executor's fees [REVOKED]

Executor fees shall be allowed as a deduction on the Estate Tax Return as provided for by statute. [See: 58 O.S. §527]

Interest on federal estate tax not deductible [REVOKED]

Interest on Federal Estate Taxes is not deductible on the Oklahoma Estate Tax Return.

Miscellaneous and administration expenses [REVOKED]

Miscellaneous administration expenses include such expenses as court costs, accountants' fees, appraisers' fees. Expenses necessarily incurred in preserving and distributing the estate are deductible on the Estate Tax Return. Expenses for preserving and caring for the property may not include outlays for additions or improvements; nor will such expenses be allowed for a longer period than the executor is reasonably required to retain the property.

PART 9. DEDUCTIONS; EXCLUSIONS; EXEMPTIONS [REVOKED]

Public, charitable and religious deductions [REVOKED]

The deduction for transfers for public, charitable and religious uses is allowed from the gross estate of a decedent who was a citizen or resident of the United States at the time of death for the value of property included in the decedent's estate and transferred by the decedent during his lifetime or by will. This deduction shall only apply to transfers to organizations that have received a tax exempt classification from the Internal Revenue Service. The value of the charitable deduction shall be reduced by a proration of expenses, debts, taxes or other obligations if such reduction is determined as a result of an Oklahoma Estate Tax audit and review. Qualifying organizations will be determined by reference to 26 U.S.C.A. §501(C)(3), which grants tax exempt status. [See: 68 O.S. §808]

Qualified terminal interest property; life estates [REVOKED]

The qualified terminal interest property election provided for Federal Estate Tax use is not allowable for purposes of Oklahoma Estate Tax, except that a life estate for a surviving spouse may be deducted.

Wrongful death claim [REVOKED]

Court approved proceeds paid as a result of a "wrongful death" claim are excludable for purposes of Oklahoma Estate Taxes. [But See: 710:35-5-1(S)(D)]

Not lineal exemptions [REVOKED]

Neither step-grandparents nor step-grandchildren are eligible for a lineal exemption in the Oklahoma Estate Tax Return.

PART 11. FEDERAL ESTATE TAX CREDIT AND ADDITIONAL ASSESSMENT OF OKLAHOMA ESTATE TAX [REVOKED]

Separate credit provision [REVOKED]

The credit against Oklahoma Estate Tax provided for by statute on certain prior transfers may not be used to offset any
additional assessment levied to absorb federal credit pursuant to 68 O.S. § 804. [See: 68 O.S. § 802.1]

710:35-5-71. Federal credit for state death taxes
[REVOKED]
The amount of the federal credit for state death taxes due the State of Oklahoma shall be adjusted, if necessary, after determination and adjustments, if any, of the value of the property to be taxed in this State. The percentage of the credit due the State shall be determined based on the ratio of the adjusted value of the property in Oklahoma to the adjusted value of the total estate. [See: 68 O.S. § 804]

710:35-5-72. Interest on federal credit [REVOKED]
Interest accruing on taxes imposed under 68 O.S. § 804 shall begin nine months after date of death or thirty (30) days from the date of the Internal Revenue Service assessment letter for additional taxes.

710:35-5-73. Adjustments affecting federal credit [REVOKED]
Any adjustments by the IRS affecting the State Death Tax Credit shall be submitted to the Oklahoma Tax Commission within thirty (30) days of agreed settlement along with a copy of the revenue agents report. [See: 68 O.S. § 804]

[OAR Docket #21-477; filed 6-15-21]

TITLE 710. OKLAHOMA TAX COMMISSION
CHAPTER 45. GROSS PRODUCTION

[OAR Docket #21-478]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 3. Payment; Remittance; Refunds
710:45-3-5 [AMENDED]
Subchapter 5. Required Returns and Reports
710:45-5-1 [AMENDED]
710:45-5-2 [AMENDED]
Subchapter 9. Exemptions and Exclusions
Part 21. Marketing Costs Deduction
710:45-9-102 [AMENDED]
Subchapter 11. Transporters
710:45-11-2 [AMENDED]
710:45-11-6 [AMENDED]
Subchapter 13. Refiners and Processors
710:45-13-1 [AMENDED]
Subchapter 15. Reclaimers and Reclaiming Operations
710:45-15-2 [AMENDED]

AUTHORITY:
Oklahoma Tax Commission; 68 O.S. §§ 203 and 1001.4

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N/A

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N/A

GIST/ANALYSIS:
The amendment to Section 710:45-9-102 clarifies the documentation required to verify a claim for deduction of marketing costs. [68 O.S. § 1001.4]
The amendments to the remaining Sections clarify policy, improve readability, correct scrivener’s errors, remove obsolete language, update or correct citations, update contact information, and ensure accurate internal cross-references.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 3. PAYMENT; REMITTANCE; REFUNDS

710:45-3-5. Issuance and release of order to stop payment
(a) The Director of the Compliance Division Audit Services Division of the Oklahoma Tax Commission, or a designee, is delegated the duty and authority to issue orders to withhold payment for production and orders releasing payment for production to purchasers of oil and gas produced in Oklahoma. (b) Orders to withhold payment for production shall be issued if and when the required reports and/or forms have not been filed or when the Gross Production Tax gross production tax penalty and interest on any production are unreported, unpaid or delinquent. Orders releasing payment for production shall be issued if and when all required reports have been filed and all tax, penalty and interest accrued have been paid. (c) Orders to withhold payment for production and orders to release payment for production shall be upon forms approved by the Commission and shall be issued under facsimile signatures of the Commissioners, attested with the official seal of the Oklahoma Tax Commission affixed thereto. [See: 68 O.S. § 1007]

SUBCHAPTER 5. REQUIRED RETURNS AND REPORTS
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710:45-5-1. Monthly production reports
(a) Minimum requirements of monthly production report. All producers or purchasers of asphalt or ores bearing lead, zinc, jack, or copper or petroleum oil, mineral oil, other crude oil, condensate, reclaimed oil, gas, natural gas, casinghead gas, or liquid hydrocarbons from oil or gas produced in this state shall report volume and value of such production monthly on OTC Form 300 or any other form as may be prescribed and required by the Oklahoma Tax Commission. Each monthly report shall include the following information:
1. Commission assigned purchaser reporting number;
2. Commission assigned producer reporting number;
3. Commission assigned production unit number, sub-number, and merge number for each lease from which production is reported;
4. Assigned product code number for the product reported;
5. Gross amount of the product reported from each lease from which production is reported;
6. Value of the product reported from each lease from which production is reported; and, the Gross Production Tax, gross production tax and the Petroleum Excise Tax, petroleum excise tax for said lease;
7. Taxpayer identification number or, if applicable, the federal employer identification number (FEI).
(b) Reports must be filed electronically. OTC Forms 300 and 300C must be filed electronically in the format prescribed by the Compliance Division of the Oklahoma Tax Commission.

710:45-5-2. Incomplete monthly production report forms filed shall constitute no report
(a) Any Monthly Production Report monthly production report form filed with the Oklahoma Tax Commission shall include the minimum information specified in 68 O.S. §1010 and in 710:45-5-1. Any such required monthly report form that does not include these minimum requirements shall not constitute the mandatory report required by statute.
(b) Any Gross Production, gross production or Petroleum Excise Tax, petroleum excise taxes remitted with an incomplete report form shall be accepted as payment of taxes due, and upon receipt of a proper report, the tax payment shall be apportioned.
(c) Upon receipt of a Monthly Production Report, Tax Commission-approved monthly production report form, which has been approved by the Commission, from a person required to report monthly, which does not include the required information, the Director of the Compliance Division, Audit Services Division of the Oklahoma Tax Commission, or a designee, shall notify the reporting taxpayer that:
1. The monthly report form filed with the Commission does not contain the minimum information required by 68 O.S. §1010 and 710:45-5-1 and such form does not constitute a valid Monthly Production Report, monthly production report;
2. Pursuant to this Section, the person has failed to file a Monthly Production Report, monthly production report;
3. The amount of penalties accrued; and,
4. Any remittance or payment made therewith has been accepted and will be apportioned by the Commission in accordance with the applicable statute. [See: 68 O.S. §1010]

SUBCHAPTER 9. EXEMPTIONS AND EXCLUSIONS

PART 21. MARKETING COSTS DEDUCTION

710:45-9-102. Qualifying criteria
Qualified deductions of marketing costs shall comply with the provisions of must meet the following criteria: (1) through (4) of this Subsection. The marketing cost deduction may be disallowed by the Tax Commission for failure to submit sufficient documentation to support the deduction.
1. Marketing costs shall not include any costs incurred in the production of gas, oil or condensate or in the separation thereof from any product subject to gross production tax.
2. Taxes shall be computed on gross proceeds, including tax reimbursement, less the cost of gathering, compressing and treating the gas sold.
3. Invoices for all costs claimed shall be made available upon request and must clearly indicate the facility incurring the cost and include a detailed description of the cost. If the invoice does not specify the cost was incurred on allowable equipment, a job/work ticket must accompany the invoice describing the work that was done.
4. Any claimed depreciable equipment must be supported by documentation showing the original depreciable value. If the depreciable equipment was purchased, the original invoice is required. If the depreciable equipment was obtained through an acquisition of wells, documents from the acquisition indicating how the value of the depreciable equipment was determined must be provided.

SUBCHAPTER 11. TRANSPORTERS

710:45-11-2. Transporter license and permits
The Compliance Division, Audit Services Division of the Oklahoma Tax Commission is authorized to issue and renew non-transferable licenses and vehicle permits, upon license and permit forms approved by the Commission, to transporters, other than railroad or pipeline transporters, of any product subject to the Oklahoma Gross Production Tax, gross production tax, upon receipt of the following:
1. A properly completed Application for Transporters License, OTC Form 309 upon a form approved by the Oklahoma Tax Commission;
2. Completed and duly executed Gross Production Tax Bond, gross production tax bond in the amount of One Thousand Dollars ($1,000.00), which has been approved by the Commission; and

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(3) Payment of a fee in the amount of One Hundred Fifty Dollars ($150.00) for each license issued, renewed or reinstated and for the first vehicle permit, and Five Dollars ($5.00) for each additional vehicle permit. [See: 68 O.S. § 1013]

710:45-11-6. Display of license and permit; strict compliance; employer liability

(a) The petroleum transporter license issued pursuant to this Subchapter shall be posted in the office of the licensee's place of business and the vehicle permits shall be displayed in the cabs of the vehicles for which they are issued. The licensee shall maintain in the office of the licensee's place of business a file in his office of the duplicates of the vehicle permit duplicates. Licensees shall promptly notify the Registration Audit Services Division of the sale or discontinuance of the use of any vehicle and surrender the permit therefor. They shall apply for a Gross Production Vehicle Permit for any additional vehicle before it is placed into use. Permits may not be exchanged from one vehicle to another. Licensees shall have painted or affixed by decalcoma process, in four-inch letters and numbers on the door of each vehicle, their company name and the Gross Production Vehicle Permit number, which shall be preceded by the initials "O.T.C."

(b) Every person or firm required to be licensed hereunder shall be responsible for seeing that the driver of any vehicle or conveyance owned or leased by the licensee and used in the transportation of any substance covered herein has read this regulation and complies with its requirements. The licensees of such vehicles shall be strictly accountable for the actions of their employees.

SUBCHAPTER 13. REFINERS AND PROCESSORS

710:45-13-1. Refiner or processor license

(a) The Director of the Compliance—Audit Services Division of the Oklahoma Tax Commission, or a designee, is authorized to issue non-transferable licenses, upon the license form approved by the Commission, to refiners, or other processors of any product subject to the Oklahoma Gross Production Tax, upon receipt of the following:

(1) Completed and duly executed Request for Assignment of Oklahoma Tax Commission Production Unit Number, OTC Form 420320-A, from the applicant; and,

(2) Completed and duly executed Application for Refiner's License to Process Petroleum Oil or Casinghead Gas, OTC Form 400309-C, in triplicate, from the applicant; and,

(3) Completed and duly executed Gross Production Tax Bond, Gross production tax bond from the applicant, which has been approved by the Commission.

(b) Any refiner-applicant, who has established that it has tangible assets in this state of sufficient value to protect the State against loss of Gross Production tax, may obtain a refiner's license without bond. [See: 68 O.S. § 1015.1]

SUBCHAPTER 15. RECLAIMERS AND RECLAIMING OPERATIONS

710:45-15-2. Reclaimer licenses

The Compliance—Audit Services Division of the Oklahoma Tax Commission is authorized to issue and renew non-transferable licenses, upon license forms approved by the Commission, to reclaimers of products subject to the Oklahoma Gross Production Tax, gross production tax, upon receipt of the following:

(1) A properly completed Application for Reclaimers License, OTC Form 309-B, upon a form approved by the Oklahoma Tax Commission.

(2) A surety bond or other security approved by the Tax Commission, as guaranty for payment of all taxes, penalties and interest. Security shall be in the amount of Ten Thousand Dollars ($10,000.00) or three months tax liability, whichever is greater, for each license issued, except when issued for a salt water disposal well. Security for each license issued for a salt water disposal well shall be in the amount of Two Hundred Fifty Dollars ($250.00) or $2,500 or three months tax liability, whichever is greater. A person or firm having five or more licenses shall be required to post security in the total amount of fifty thousand dollars. Fifty Thousand Dollars ($50,000.00) or three months tax liability, whichever is greater; except that for persons or firms having five or more licenses for salt water disposal facilities, the security requirement shall be a total of ten thousand dollars Ten Thousand Dollars ($10,000.00) or three months tax liability, whichever is greater.

(3) A One Hundred Fifty Dollar ($150.00) three-year license fee for each new, renewed, or reinstated license. [See: 68 O.S. § 1015.1]

[OAR Docket #21-478; filed 6-15-21]
CONTACT PERSON:
Lisa Haws, Tax Policy and Research Division, Oklahoma Tax Commission, Oklahoma City, OK 73194; 405-521-3133; lhaws@tax.ok.gov.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 1. GENERAL PROVISIONS

710:50-1.5. Public records
The annual list of persons making and filing an Income Tax Return Oklahoma income tax return shall be made available for public inspection in the Taxpayer Assistance Division Resource Center during the normal working hours of the Tax Commission. [See: 68 O.S. §§ 205(D), 2385.20]

710:50-1.6. Requests for copies of income tax returns and associated documents
The Taxpayer Assistance Division Tax Commission will provide, to any taxpayer or to his designated representative, copies of the taxpayer's return and/or accompanying documents in accordance with the procedures set out in this Section.
(1) Requests shall be made either in writing to the Income Tax Accounts Division, or in person at the Taxpayer Resource Center.
(2) If the request is in writing it must be signed by the taxpayer involved, or if the request is from a taxpayer's representative it must be accompanied by an authorization signed by the taxpayer.
(3) If the request is in person the taxpayer must have a valid identification, or in the case of a taxpayer's representative the representative must have an authorization signed by the taxpayer.

SUBCHAPTER 3. RETURNS AND REPORTS

PART 1. GENERAL INFORMATION

710:50-3. Due dates; timely filing of returns
(a) Income Tax Returns tax returns of individuals are due on the 15th day of the fourth month following the close of the taxable year unless the returns are filed electronically. If the individual income tax returns are filed electronically, the returns are due on the 20th day of the fourth month following the close of the taxable year. This change to the due date will be effective for tax year 2007 returns and subsequent tax years.
(b) If the Internal Revenue Code provides for a later due date for returns of individual filers, the Oklahoma income tax returns may be filed by the later due date and will be considered timely filed. This change to the due date will be effective for tax year 2007 returns and subsequent tax years.
(c) To be considered timely filed, Income Tax Returns income tax returns are to be filed with and received by the Oklahoma Tax Commission at 2501 Lincoln Blvd, 123 Robert S. Kerr Ave, Oklahoma City, Ok. 73101 before the statutory filing date. However, dates placed on returns by the Oklahoma Tax Commission corresponding to postmarks that indicate timely mailing will be accepted as timely filed. In the case of electronically filed returns, any payment of taxes due on the 20th day of the month following the close of the taxable year must also be remitted electronically in order to be considered timely paid. If balances due on electronically filed returns are not remitted to the Oklahoma Tax Commission electronically, penalty and interest will accrue from the 15th day of the month following the close of the taxable year.

PART 5. FILING STATUS; ELECTIONS; ACCOUNTING PERIODS AND METHODS

710:50-3.47. Pass-Through Entity Tax Equity Act of 2019

(a) An entity that is required to file either an Oklahoma partnership income tax return or an Oklahoma Subchapter S corporate income tax return may elect to pay income tax at the entity level, effective for tax year 2019 and subsequent tax years by filing a pass-through entity (PTE) election. [68 O.S. § 2355.1 et seq.]

(b) A PTE election may be made by a qualifying PTE at any time during the preceding tax year or two (2) months and fifteen (15) days after the beginning of the current tax year by filing OTC Form 586. The Oklahoma Tax Commission shall send an acknowledgement letter to each PTE that files a pass-through entity election. Each electing PTE shall provide its shareholders, partners or members, with a copy of the Oklahoma Tax Commission acknowledgement letter and advise the shareholder, partner or member of the requirement to attach a copy of the Oklahoma Tax Commission acknowledgement letter to the Oklahoma income tax return of the partner, shareholder or member.

(c) For income distributed to estates, trusts or individuals, electing entities are taxed at the highest marginal individual income tax rate. For income distributed to corporations, electing entities are taxed at the corporate income tax rate. [68 O.S. §2355]

(d) Oklahoma income or losses the electing PTE included in computing its tax will not be used to calculate the Oklahoma taxable income of the partners, members or shareholders of the electing entity.

(e) For tax years beginning on or after January 1, 2020, estimated tax payments shall be required of an electing PTE as provided in 68 O. S. § 2385.9.

(f) A PTE election is binding until revoked by the electing PTE or by the Oklahoma Tax Commission.

(1) An electing PTE may revoke the election by filing OTC Form 586. The effective date of a PTE’s revocation of an election made within two (2) months and fifteen (15) days of the electing PTE’s taxable year shall be the first day of such taxable year. If the revocation is made after this time period, the revocation is effective on the first day of the following taxable year.

(2) If the amount of tax required to be paid by an electing PTE is not paid when due, the Oklahoma Tax Commission may, in its discretion, revoke the PTE’s election effective for the first year for which the tax is not paid.

PART 7. OTHER REQUIRED REPORTING

710:50-3.54. Income tax withholding for pass-through entities

(a) General provisions. Generally, any pass-through entity that makes a distribution to a non-resident member is required to deduct and withhold Oklahoma income tax from distributions of taxable income being made with respect to Oklahoma source income.

(b) Definitions. The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) "Member" means:
(A) A shareholder of an S Corporation; Subchapter S Corporation;
(B) A partner in a general partnership;
(C) A partner in a limited partnership;
(D) A partner in a limited liability partnership;
(E) A member of a limited liability company; or,
(F) A beneficiary of a trust.

(2) "Non-resident" means an individual who is not a resident of, or domiciled in, this state; a business entity which does not have a commercial domicile in this state; or a trust which is not organized in this state.

(3) "Pass-through entity" means:
(A) A corporation that is treated as an S Corporation under the Internal Revenue Code;
(B) A general partnership;
(C) A limited partnership;
(D) A limited liability partnership;
(E) A trust; or;
(F) A limited liability company that is not taxed as a corporation for federal income tax purposes. [68 O.S. § 2385.29]

(4) "Pass-through entity" does not include an entity which is disregarded for income tax purposes under the Internal Revenue Code.

(c) Subchapter S Corporations; general, limited, or limited liability partnerships; limited liability companies. In the case of S Corporations Subchapter S Corporations; general, limited, or limited liability partnerships; and limited liability companies, withholding of five percent (5%) is required on the Oklahoma portion of the taxable income distributed to each non-resident member. In the case of S Corporations Subchapter S Corporations paying the tax on behalf of non-resident shareholders (68 O.S. § 2365) or partnerships filing composite returns on behalf of non-resident partners, the non-resident members withholding can be
claimed on the return filed by the S-Corporation Subchapter S Corporation or the partnership.

d) Trusts. For trusts, withholding of five percent (5%) is required on the Oklahoma portion of the taxable income distributed to each beneficiary of the trust.

e) Non-resident members not subject to withholding. The following persons and organizations are not subject to required withholding by a pass-through entity:

1. Persons, other than individuals, who are exempt from federal income tax;
2. Organizations granted an exemption under Section 501(c)(3) of the Internal Revenue Code;
3. Insurance companies subject to the Oklahoma Gross Premium Income Tax gross premium income tax and therefor exempt from Oklahoma income tax pursuant to 68 O.S. § 2359(C); and
4. Non-resident members who have submitted a Non-resident Member Withholding Exemption Affidavit to the pass-through entity and which pass-through entity has submitted the affidavit information on behalf of the member to the Tax Commission. In the affidavit, the non-resident member agrees to be subject to the personal jurisdiction of the Tax Commission in the courts of this state for the purpose of determining and collecting any Oklahoma taxes, including estimated tax payments, together with any related interest and penalties. See (k) of this Section for the procedure to be followed in filing the affidavit.

   A) For non-resident partners included in a composite partnership return under OAC 710:50-19-1 and filing a Nonresident Member Withholding Exemption Affidavit, the inclusion of the partner's income within the composite partnership return will satisfy the requirements contained in the affidavit.

   B) For non-resident shareholders filing a Nonresident Member Withholding Exemption Affidavit and electing not to file Oklahoma income tax returns under 68 O.S. § 2365, inclusion of the non-resident shareholder's income in the Subchapter S corporate income tax return will satisfy the requirements contained in the affidavit.

   C) For non-resident beneficiaries included in a trust return and filing a Nonresident Member Withholding Exemption Affidavit, the inclusion of the beneficiary's income within the trust return will satisfy the requirements contained in the affidavit.

f) When pass-through entities are not required to withhold. Withholding is not required in the following instances:

1. When an entity is not required to file a federal income tax return, or properly elects out of such duty;
2. When a pass-through entity is making distributions of income not subject to Oklahoma income tax;
3. When a pass-through entity has withheld tax on royalty interest income pursuant to 68 O.S. § 2385.25 et seq.;
4. When a pass-through entity is making distributions to another pass-through entity. Provided however, the exception set out in this paragraph does not relieve the lower-tiered pass-through entity from the duty to withhold on distributions it makes which are not otherwise exempt;
5. When a pass-through entity is a publicly traded partnership, as defined by Section 7704(b) of the Internal Revenue Code, and is treated as a partnership for purposes of the Internal Revenue Code. Provided the publicly traded partnership has agreed to file an annual information return reporting the name, address, taxpayer identification number, and other information requested by the Tax Commission of each unit-holder with an income in the state in excess of Five Hundred Dollars ($500.00); or
6. When a distribution made by a pass-through entity has been determined to be not subject to the provisions of this Section by the Commissioner; or
7. When a pass-through entity that is required to file either an Oklahoma partnership income tax return or an Oklahoma Subchapter S corporate income tax return makes an election to pay income tax at the entity level pursuant to the Pass-Through Entity Tax Equity Act of 2019. [68 O.S. § 2355(IP-1 et seq.]

(g) Due dates for payment of pass-through entity withholding. Pass-through entities that withhold income tax on distributions of taxable income to non-resident members are required to remit the amount of tax withheld from each non-resident member on or before the due date of the pass-through entity's income tax return, including extensions. Any pass-through entity that can reasonably expect the total amount of income tax withheld from all non-resident members to exceed Five Hundred Dollars ($500.00) for the taxable year must make quarterly estimated tax payments. Oklahoma Nonresident Distributed Income Estimated Withholding Tax Report is to be used to remit the quarterly estimated tax payments. The required estimated tax payments are due on or before the last day of the month after the end of the calendar quarter and must be made in equal quarterly installments. The total of the required quarterly estimated tax payments is the lesser of seventy percent (70%) of the withholding tax that must be withheld for the current taxable year, or one hundred percent (100%) of the withholding tax withheld for the previous taxable year. Any pass-through entity that can reasonably expect the total amount of tax withheld from all non-resident members to be less than Five Hundred Dollars ($500.00) for the taxable year may, at their option, make quarterly estimated tax payments.

(h) Required reports. The pass-through entity is required to provide non-resident members and the Oklahoma Tax Commission an annual written statement showing the name of the pass-through entity, to whom the distribution was paid, the amount of taxable income distributed, and the amount of Oklahoma income tax withheld. Further, the statement must also furnish the non-resident member's name, address, and social security number or Federal Employer Identification Number. To accomplish this:

1. Each pass-through entity must provide non-resident members with Oklahoma Tax Commission Form 500-B on or before the due date of the pass-through entity's income tax return, including extensions. Copies of OTC
Form 500-B, along with OTC Form 501, must be sent to the Oklahoma Tax Commission by the same date.

(2) Each pass-through entity must file with the Oklahoma Tax Commission the appropriate income tax withholding return on or before the due date of the pass-through entity's income tax return, including extensions.

(3) Each nonresident member must enclose a copy of OTC Form 500-B with the Oklahoma income tax return as verification for this withholding.

(i) Non-resident members entitled to credit, or refund, from Oklahoma income taxes paid. Any nonresident member from whom an amount is withheld pursuant to the provisions of this Section, and who files an Oklahoma income tax return is entitled to a credit for the amount withheld. If the amount withheld is greater than the tax due, the nonresident member will be entitled to a refund of the amount of the overpayment.

(j) Pass-through entities must register. Pass-through entities that make distributions subject to Oklahoma withholding must register with the Oklahoma Tax Commission.

(k) Affidavit filing procedures. Nonresident members who elect to file a Nonresident Member Withholding Exemption Affidavit agreeing to be subject to the personal jurisdiction of the Tax Commission in the courts of this state for the purpose of determining and collecting any Oklahoma taxes, including estimated tax payments, and any related interest and penalties, must remit the affidavit to the appropriate pass-through entity. The pass-through entity is to retain the affidavit and file the following information with the Oklahoma Tax Commission by the due date of the required annual tax return of the pass-through entity.

(1) Content. The name, address, and social security number or federal identification number of the nonresident member having signed an affidavit. All pass-through entities are required to file the nonresident member affidavit information on a diskette or CD with the Oklahoma Tax Commission - Audit Services Division.

(2) Format. The format for filing the diskette or CD will be in either a spreadsheet format (i.e. Lotus 1-2-3 or Excel) or a database format (i.e. dbf or Access).

(3) Waiver. Pass-through entities may obtain a waiver from the diskette or CD filing requirement if the pass-through entity can demonstrate that a hardship would result if it were required to file on a diskette or CD. Direct waiver requests to the Oklahoma Tax Commission - Audit Services Division.

PART 9. "INNOCENT SPOUSE" RELIEF PROCEDURE

710:50-3-60. Relief of spouse from Oklahoma income tax liability on joint Oklahoma Income Tax Return

If a joint Oklahoma Income Tax Return income tax return was filed on which there is, or there is subsequently determined to be, a liability attributable to income or activity for one spouse, the other spouse may be relieved of the liability for the Oklahoma Income Tax return, including interest and penalty, if the spouse requesting relief can establish, by a preponderance of the evidence, that:

(1) The liability is attributable to the income or business activity of the non-requesting spouse; and

(2) It would be inequitable to hold the requesting spouse liable for the tax liability. Factors, not all-inclusive, which may be considered in determining whether it would be inequitable to hold the requesting spouse liable are:

(A) Whether the requesting spouse received a benefit, such as a lavish gift, increased standard of living or additional money from the nonpayment of tax;

(B) Whether the spouse requesting relief has been deserted, divorced, separated, or widowed;

(C) Business background or education of the requesting spouse;

(D) Involvement of the requesting spouse in the financial affairs of the family; and

(E) Involvement of the requesting spouse in the business or transaction giving rise to the tax liability.

710:50-3-61. Docketing of request for relief [REVOKED]

All requests for relief of one spouse from income tax attributable to a joint Oklahoma Income Tax Return shall be forwarded to the Office of the General Counsel. The General Counsel's office will assign a case number to a request for relief, create a file, assign an attorney, and notify the requesting spouse of the assignment.

710:50-3-62. Initial review, determination of recommendation

The General Counsel or a designated Income Tax Accounts Division will review the request all requests for relief and the supporting documentation submitted and will make a recommendation that the Tax Commission grant the requested relief if the documentation has established that the liability is attributable to the income or business activity of the non-requesting spouse and that to hold the requesting spouse liable for the deficiency for the tax year involved would be inequitable.

710:50-3-63. Procedure upon adverse recommendation

If the General Counsel Income Tax Accounts Division does not intend to recommend that the Commission grant the requesting spouse relief, the General Counsel Division shall notify the requesting spouse of the recommendation. The notification letter shall state prominently that should the applicant wish to pursue the request, the applicant should do so by
contacting the General Counsel's officeIncome Tax Accounts Division, in writing, within thirty days of the mailing of the notification. Failure of the applicant to request the petition within thirty days of the mailing of the notification shall constitute grounds for the denial of relief.

710:50-3-64. Presentation of relief request to Commission
(a) All requests for relief, whether recommended or not, shall be presented to the Commission at a regularly scheduled meeting. The assigned attorneyIncome Tax Accounts Division shall set forth the facts in writing, have the request placed on the Commission's docket, and notify the applicant of the day the request will be heard by the Commission. The applicant may appear before the Commission and present documentary evidence and testimony in the form of affidavit(s).
(b) No hearing other than the appearance at a regularly scheduled meeting of the Commission will be held. No transcript of the appearance before the Commission will be prepared.
(c) Should the applicant desire a transcript or recording of taxpayer's appearance before the Commission, the applicant will need to contact a certified court reporter, make the necessary arrangements for the presence of the reporter at the Commission meeting, and the cost thereof. The cost of transcribing will be borne by the applicant, who must furnish the original of the transcript to the Commission.

SUBCHAPTER 5. AUDIT AND ASSESSMENT

PART 3. ASSESSMENTS

710:50-5-11. Protests of assessments [REVOKED]
Protests of an income tax assessment may be made in accordance with the requirements of the Uniform Tax Procedure Code. [See: 68 O.S. §§221 et seq.]

SUBCHAPTER 15. OKLAHOMA TAXABLE INCOME

PART 7. CREDITS AGAINST TAX

710:50-15-103. Credit for qualified railroad reconstruction or replacement expenditures
(a) General provisions. For tax years beginning after December 31, 2005, and ending before January 1, 2025, there is a credit allowed against the tax imposed by Section 2355 of Title 68 equal to 50% of an eligible taxpayer's qualified railroad reconstruction or replacement expenditures. [68 O.S. § 2357.104]
(b) Definitions. The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates otherwise:
(1) "Eligible taxpayer" means any railroad that is classified by the United States Surface Transportation Board as a Class II or Class III railroad.
(2) "Qualified railroad reconstruction or replacement expenditures" means expenditures for track maintenance, natural disasters, and reconstruction or replacement of railroad infrastructure. This includes track, roadbed, crossings, bridges, industrial leads and track-related structures owned or leased by a Class II or Class III railroad as of January 1, 2006. Qualified railroad reconstruction or replacement expenditures can also include new construction of industrial leads, switches, spurs and sidings and extensions of existing sidings by a Class II or Class III railroad.
(c) Limitations.
(1) The amount of the credit may not exceed the product of the number of miles of railroad track owned or leased within this state by the eligible taxpayer as of the close of the taxable year and:
(A) Five Hundred Dollars ($500.00) for tax year 2007 and,
(B) Two Thousand Dollars ($2,000.00) for tax years 2008 through 2019 and the number of miles of railroad track owned or leased within this state by the eligible taxpayer as of the close of the taxable year.
(C) Five Thousand Dollars ($5,000.00) for tax years 2020 through 2024. In tax year 2020 and subsequent tax years, an eligible taxpayer may elect to increase the limit for tax year 2020 to an amount equal to three times the amount specified. However, the taxpayer may only claim one third (1/3) of the credit in any one taxable period. An eligible taxpayer who elects to increase the limitation on the credit will not be granted additional credits during the period of such election.
(2) Effective for tax years beginning on or after January 1, 2016, and ending before January 1, 2020, the credit is limited to seventy-five percent (75%) of the otherwise allowable credit. [68 O.S. § 2357.104(H)]
(d) Transferability. The credits allowed pursuant to this Section that are not used are freely transferable by written agreement, to subsequent transferees, at any time during the five (5) years following the year of qualification.
(1) "Eligible transferee" defined. For purposes of this subsection, an "eligible transferee" shall be any taxpayer subject to the tax imposed by Section 2355 of Title 68.
(2) Written transfer agreement requirements. The person originally allowed the credit and the subsequent transferee must jointly file a copy of the written transfer agreement with the Commission, within thirty (30) days of the transfer. The written agreement must contain the name, address, and taxpayer identification number of the

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parties to the transfer, the amount of credit being transferred, the year the credit was originally allowed to the transferring person, and the tax year or years for which the credit may be claimed.

(c) **Carryover provisions.** Any credit allowed pursuant to the provisions of this Section, to the extent not used, may be carried over in order to each of the five (5) years following the year of qualification.

(f) **Tax credit moratorium.** No credit may be claimed for qualified railroad reconstruction or replacement expenditures occurring during the period of July 1, 2010 through June 30, 2012, for which the credit would otherwise be allowable. Qualified railroad reconstruction or replacement expenditures occurring before July 1, 2010 will qualify for the tax credit regardless of when the Department of Transportation issues the certificate of verification of completion of the project. This credit may be claimed for tax year 2012 and subsequent tax years, for qualified railroad reconstruction or replacement expenditures on or after July 1, 2012.

(g) **Tax credit limitation.** For tax years beginning on or after January 1, 2018, the total amount of credits authorized by this Section used to offset tax shall be adjusted annually to limit the annual amount of credits to Two Million Dollars ($2,000,000.00) for tax years 2018 and 2019 and Five Million Dollars ($5,000,000.00) for tax year 2020 and all subsequent tax years. The Tax Commission shall annually calculate and publish a percentage by which the credits authorized by this Section shall be reduced so the total amount of credits used to offset tax does not exceed Two Million Dollars ($2,000,000.00) per year the applicable annual limit.

710:50-15-117. **Credit for qualified software or cybersecurity employee**

(a) **General provisions.** For tax years beginning on or after January 1, 2020, and ending before January 1, 2030, a qualified software or cybersecurity employee shall be allowed a credit against the tax imposed pursuant to Section 2355 of Title 68, subject to the provisions of (d) of this Section.

(b) **Definitions.** The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates otherwise:

1. **"Qualified software or cybersecurity employee".**
   - (A) A qualified employee is any person newly employed in Oklahoma by a qualified employer in a qualifying industry on or after November 1, 2019.
   - (B) The qualified employee must have been awarded a degree in an accredited program from a degree-producing institution as defined in 68 O.S. § 2357.405(A)(1), or has been awarded a certificate or credential in an accredited program from a technology center.
   - (C) The qualified employee must be employed in a qualifying industry by a qualified employer who pays its qualified employees a qualifying compensation for the county in which the qualified employer has its primary Oklahoma address.

2. "Accredited program", "Degree-producing institution", "Qualified employer", "Qualified industry", "Qualifying compensation", and "Technology center" shall have the same meaning as the terms are defined in Section 2357.405 of Title 68 of the Oklahoma Statutes.

(c) **Credit.**

1. The credit is Two Hundred Thousand Dollars ($2,200.00) for a qualified software or cybersecurity employee who has been awarded a bachelor's or higher degree from an accredited program at a degree-producing institution, and One Hundred Thousand Dollars ($1,800.00) for a qualified software or cybersecurity employee who has been awarded an associate's degree from an accredited program at a degree-producing institution or a credential or certificate from an accredited program at a technology center.

2. The credit may be claimed for a period of time not to exceed seven (7) years.

3. The credit authorized by this Section shall not be used to reduce the tax liability of the taxpayer to less than zero (0).

(d) **Limitation of credit.** Effective for tax years beginning on or after January 1, 2022, no more than Five Million Dollars ($5,000,000.00) of credits may be allowed as an offset in a taxable year. The Tax Commission shall annually determine by the first day of the affected year a percentage by which the credits authorized shall be reduced so the total amount of credits used to offset tax does not exceed Five Million Dollars ($5,000,000.00) per year.

(e) **Letter ruling.** An employer may request a letter ruling to determine whether an employer meets the definition of a "qualified employer". The requesting party must provide sufficient information to demonstrate that the employer meets the following requirements for a qualified employer:

1. Employer is a sole proprietor, general partnership, limited partnership, limited liability company, corporation or other legally recognized business entity, or governmental entity;
2. Employer has at least fifteen full-time employees;
3. Employer's activities are in a "qualified industry", defined or classified in the most recent North American Industry Classification System (NAICS) manual under U.S. Sector Nos. 21, 22, 31-33, 48, 51, 52, 54, 55, 62 and 92;
4. Employer pays its employees a qualifying compensation for the county in which the qualified employer has its primary Oklahoma address.
5. Employer is either not participating in the Oklahoma Quality Jobs Program Act, the Small Employer Quality Jobs Incentive Act or the 21st Century Quality Jobs Incentive Act or, if employer is participating in one of those programs, the qualified software or cybersecurity employees are included in baseline employment for the purposes of the Oklahoma Quality Jobs Program Act, the Small Employer Quality Jobs Incentive Act and the 21st Century Quality Jobs Incentive Act.
SUBCHAPTER 17. OKLAHOMA TAXABLE INCOME FOR CORPORATIONS

PART 1. GENERAL PROVISIONS

710:50-17-3. What constitutes "Nexus"
(a) If a corporation has one or more of the following activities in Oklahoma, it is considered to have "nexus" and shall be subject to Oklahoma income taxes:
   (1) Maintenance of any business location in Oklahoma, including any kind of office.
   (2) Ownership of real estate in Oklahoma.
   (3) Ownership of a stock of goods in a public warehouse or on consignment in Oklahoma.
   (4) Ownership of a stock of goods in the hands of a distributor or other non-employee representative in Oklahoma, if used to fill orders for the owner's account.
   (5) Usual or frequent activity in Oklahoma by employee or representative soliciting orders with authority to accept them.
   (6) Usual or frequent activity in Oklahoma by employee or representative engaged in a purchasing activity or in the performance of services (including construction, installation, assembly, or repair of equipment).
   (7) Operation of mobile stores in Oklahoma (such as trucks with driver-salespersons), regardless of frequency.
   (8) Other miscellaneous activities by employees or representatives in Oklahoma such as credit investigations, collection of delinquent accounts, conducting training classes or seminars for customer personnel in the operation, repair and maintenance of its products.
   (9) Leasing of tangible property and licensing of intangible rights for use in Oklahoma.
   (10) The sale of other than tangible personal property such as real estate, services and intangibles in Oklahoma.
   (11) The performance of construction contracts or service contracts in Oklahoma.
(b) The guidelines expressed in (a) of this Section as to what activities constitute "nexus" should not be considered all-inclusive. Questions may be sent to the Oklahoma Tax Commission, Audit Services Division, 2501 Lincoln Blvd. 123 Robert S. Kerr Ave, Oklahoma City, Oklahoma 73104-73102.

710:50-17-7. Amended income tax returns for corporations
In order to assist in the processing of a Corporation’s Amended Income Tax Return, corporation’s amended income tax return, corporations must use OTC Form 512X for tax years prior to 2013. Beginning with tax year 2013, OTC Form 512 must be used and the appropriate box indicating that the return is an amended return must be marked and attach the following information:
The documentation described in (1) through (4) of this subsection must be included, when applicable, or an explanation when not applicable, or the refund may be denied:
   (1) Copy of the Federal Form 1120X or 1139s. If the taxpayer files a federal consolidated income tax return, Form 1120X must detail the changes by entity.

710:50-19-4. Partnerships that make an election under the Pass-Through Entity Tax Equity Act of 2019
Pursuant to the Pass-Through Entity Tax Equity Act of 2019 (68 O.S. § 2355.1P-1 et seq.), a partnership may elect to pay income tax at the entity level, effective for tax year 2019 and subsequent tax years. The Oklahoma income, gains, losses or deductions of a partnership that is an electing pass-through entity shall not be used to calculate the Oklahoma taxable income of the partners, members or shareholders. [See: 710:50-3-49]

SUBCHAPTER 21. OKLAHOMA TAXABLE INCOME FOR SUBCHAPTER "S" CORPORATIONS

710:50-21-4. S Corporations that make an election under the Pass-Through Entity Tax Equity Act of 2019
Pursuant to the Pass-Through Entity Tax Equity Act of 2019 (68 O.S. § 2355.1P-1 et seq.), a Subchapter S Corporation may elect to pay income tax at the entity level, effective for tax year 2019 and subsequent tax years. The Oklahoma income, gains, losses or deductions of a Subchapter S Corporation that is an electing pass-through entity shall not be used to calculate the Oklahoma taxable income of the partners, members or shareholders. [See: 710:50-3-49]

TITLE 710. OKLAHOMA TAX COMMISSION
CHAPTER 55. MOTOR FUEL

[OAR Docket #21-479; filed 6-15-21]
SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:  
December 22, 2020
COMMENT PERIOD:  
January 15, 2021 through February 16, 2021
PUBLIC HEARING:  
February 22, 2021
ADOPTION:  
March 9, 2021
SUBMISSION OF ADOPTED RULES TO GOVERNOR AND LEGISLATURE:  
March 17, 2021
LEGISLATIVE APPROVAL:  
Approved June 11, 2021 by HJR 1046
FINAL ADOPTION:  
June 11, 2021
EFFECTIVE:  
September 1, 2021
SUPERSEDED EMERGENCY ACTIONS:  
n/a
INCORPORATIONS BY REFERENCE:  
n/a
GIST/ANALYSIS:  
The revocation of Sections 710:55-5-1, 710:55-5-2, 710:55-5-3 and 710:55-5-4 is to comply with Executive Order 2020-3 wherein Governor Stitt required a review of all agency administrative rules to find and revoke those rules that have become obsolete and are no longer necessary. In a review of the rules of the Oklahoma Tax Commission, it was found that these rules are no longer necessary because these responsibilities have been transferred to the Oklahoma Corporation Commission.
CONTACT PERSON:  
Lisa Haws, Tax Policy and Research Division, Oklahoma Tax Commission, Oklahoma City, OK 73194; 405-521-3133; lhaws@tax.ok.gov.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(S) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 5. IMPORTERS FOR USE [REVOKED]

710:55-5-1. Computation of tax on mileage basis [REVOKED]
The total number of gallons of Motor Fuel/Diesel Fuel consumed by a vehicle in Oklahoma can be determined on a mileage basis by the following procedure:

1. Divide the number of miles traveled in all states by the number of gallons of Motor Fuel/Diesel Fuel put into the vehicle in all states. This will arrive at the average miles per gallon for the vehicle.
2. Divide the number of miles traveled in Oklahoma by the average miles per gallon for the vehicle. This will arrive at the total number of gallons of Motor Fuel/Diesel Fuel consumed by the vehicle in Oklahoma.

710:55-5-2. Application [REVOKED]
The Motor Fuel Importer for Use Tax shall not apply to Motor Fuel/Diesel Fuel imported into and used on the highways of this state by a common carrier of persons or property, contract carrier of persons or property, or private commercial carrier of property operating a motor vehicle or combination of vehicles used, designed, or maintained with a gross vehicle weight of less than twenty-six thousand pounds (26,000 lbs.).

710:55-5-3. Required assessment [REVOKED]
Before an application for a Motor Fuel Importer for Use License may be approved, the applicant must pay the non-refundable assessment of $25.00 to obtain the annual Importer for Use License. This $25.00 assessment must be paid to the Importer Indemnity Fund.

710:55-5-4. Credit; refunds [REVOKED]
(a) Where, in any given tax reporting period, a person licensed as a Motor Fuel Importer for Use has paid Oklahoma Motor Fuel/Diesel Fuel tax on an amount of Motor Fuel/Diesel Fuel part of which was subsequently and actually consumed in motor vehicles outside the State of Oklahoma, such person shall be allowed a "credit" in an amount equal to the Motor Fuel/Diesel Fuel tax rate per gallon times the number of gallons used outside of Oklahoma. The burden is upon the Taxpayer to claim the credit and to furnish sufficient evidence to support his claim.
(b) The credit provided for in this section may be carried over and applied to any quarter following the quarter in which the credit arose, provided that under no circumstances shall the credit be allowed to be carried over to any quarter occurring two years or more beyond the first day of any quarter in which the Motor Fuel/Diesel Fuel, giving rise to the credit, was used. EXAMPLE: X consumes one thousand (1,000) gallons of Motor Fuel/Diesel Fuel in Oklahoma during the first quarter of 1988. X purchased Motor Fuel/Diesel Fuel, tax paid, in Oklahoma in the amount of one thousand five hundred (1,500) gallons in the same quarter. Assume that X can show that all one thousand five hundred (1,500) gallons were used during the first quarter of 1988, but that five hundred (500) gallons were consumed outside Oklahoma. X would be entitled to a credit equivalent to the Motor Fuel/Diesel Fuel tax rate times five hundred (500) gallons on the report for the first quarter of 1988. Consequently, the first quarterly report on which the credit could be claimed would be the report for the first quarter of 1988, and the last quarterly report on which the particular credit, or any part thereof, might be claimed is the report of the last quarter of 1989.
(c) Instead of carrying the credit over to succeeding quarters, the Taxpayer is also entitled, under this Section, to claim a refund. Such refund is computed on the same basis as the credit (See (a) of this Section.) The claim for refund must be made within two (2) years from the first day of the quarter in which the Motor Fuel/Diesel Fuel was used.
(d) Upon the expiration of two (2) years, computed from the first day of the quarter in which the Motor Fuel/Diesel Fuel was used, the right to claim the credit or the refund as to any and all of the amount still remaining, shall be deemed extinguished.
(e) If Motor Fuel/Diesel Fuel is purchased in one quarter but the use outside Oklahoma, giving rise to a credit or claim for refund under this section, occurs in more than one quarter, the allowable credit shall be apportioned to each of the quarters.
in which the use occurred, based on the actual use and consumption for each quarter. An allowance for Motor Fuel/Diesel Fuel purchased in Oklahoma within thirty (30) days prior to the first day of a report period can be claimed as credit on the next report period. An allowance for Motor Fuel/Diesel Fuel purchased in Oklahoma within seven (7) days after the last day of the previous report period can be claimed as credit on the previous report period. EXAMPLE: Motor Fuel/Diesel Fuel purchased in Oklahoma from July 1 - July 7 may be claimed on the 2nd Quarter report.

[OAR Docket #21-480; filed 6-15-21]

TITLE 710. OKLAHOMA TAX COMMISSION
CHAPTER 60. MOTOR VEHICLES

[OAR Docket #21-481]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 3. Registration and Licensing
710:60-3-26 [AMENDED]
710:60-3-28 [AMENDED]
Part 13. Manufactured Homes
710:60-3-130 [AMENDED]
Subchapter 5. Motor Vehicle Titles
Part 7. Transfer of Title
710:60-5-76 [AMENDED]
Subchapter 9. Motor Vehicle License Agents/Agencies
Part 1. General Requirements, Duties and Responsibilities of Motor License Agents
710:60-9-10 [AMENDED]
Part 13. Provisions for Motor License Agent Application and Appointment
710:60-9-137 [AMENDED]

AUTHORITY:
47 O.S. §§ 1112.2 and 1140; 68 O.S. § 203; Oklahoma Tax Commission

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
December 22, 2020

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LEGISLATIVE APPROVAL:
Approved June 31, 2021 by HJR 1046

FINAL ADOPTION:
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EFFECTIVE:
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SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
The amendment to Section 710:60-3-26 implements the provisions of HB 4049, requiring that any online system which provides a service that a motor license agent is authorized to provide in accordance with the Oklahoma Vehicle License and Registration Act must include a step where the individual must select a motor license agent in the state to process any online transaction; said motor license agent as defined in 47 O.S. §1102 does not include the Oklahoma Tax Commission. [47 O.S. §1132A]
The amendment to Section 710:60-3-28 implements the provisions of Section 1 of HB 3270 which allows a person to operate a vehicle for fifteen days from the date of purchase, instead of the previous five days, provided that a dated notarized bill of sale is carried in the vehicle. [47 O.S. §1112.2]
The amendment to Section 710:60-3-130 clarifies the resources to be used when determining the value of a manufactured home brought in from out-of-state.
The amendment to Section 710:60-5-76 provides that a certified copy of the divorce decree is no longer required when transferring the title of a motor vehicle which has been awarded in a divorce proceeding; a filed stamped copy of the decree will be sufficient.
The amendment to Section 710:60-9-10 requires a motor license agent to comply with all applicable statutes, including the Motor Vehicle Licensing and Registration Act.
The amendment to Section 710:60-9-137 will no longer require the Commission to conduct a feasibility study when making motor license agent appointments.

CONTACT PERSON:
Lisa Haas, Tax Policy and Research Division, Oklahoma Tax Commission, Oklahoma City, OK 73194; 405-521-3133; lhaas@tax.ok.gov.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 3. REGISTRATION AND LICENSING

PART 1. GENERAL PROVISIONS

710:60-3-26. Online registration renewal
(a) Online registration renewal process. The Commission shall design and implement a web-based online registration renewal process. Owners of eligible vehicle types may utilize the online service to renew the registration of the vehicle. Additional transaction types may be added to the online system, as appropriate.
(b) Online email notification. Renewing a registration via the Commission’s online renewal process will automatically result in an email notification being sent out upon that registration’s expiration. The online system will also provide an independent email sign-up function for taxpayers choosing to receive future email notification of their registration expiration(s). Email notification will supersede any other type of registration expiration notification. Failure to receive the email notification shall not relieve the taxpayer from their responsibility to timely renew their registration(s).
(c) Selection of motor license agent or Commission. The online registration renewal system will include a step where the registrant shall select between any motor license agent in the state and the Tax Commission to complete the processing of their registration renewal.
(1) Motor license agent notification. Following selection by a registrant, the motor license agent will be sent notification of the pending web transaction(s).
motor vehicle owner who sells, trades, or transfers a vehicle must remove the license plate from the vehicle and either:

(A) Retain the plate,
(B) Transfer the plate to a newly acquired vehicle of the same registration classification for which no additional registration fee is due for the remainder of the current registration period pursuant to authorization of the Oklahoma Tax Commission or a motor license agent, or
(C) Transfer the plate to a newly acquired vehicle of the same registration classification but different registration year requiring payment of additional registration fees.

(2) Vehicle buyer. In the event the owner of a license plate purchases, trades, exchanges or otherwise acquires a vehicle for which a license plate has been issued during the current registration period, and the license plate has not been removed by the previous owner in accordance with this Section, the new owner of the vehicle shall remove and return the license plate to the Tax Commission or a motor license agent. If the license plate has expired, the new owner may surrender the license plate to the Tax Commission or motor license agent.

(c) Calculation of registration fee. The registration fee due for the newly acquired vehicle to which a plate is transferred will be prorated based on the full registration months remaining on the transferred plate at the time of assignment.

(d) Refund eligibility. The plate owner shall not be entitled to a refund under the following circumstances:

(1) When the registration fee for the vehicle to which the plate is transferred is less than the registration fee for that vehicle to which the license plate was last assigned, or
(2) When the owner does not have or does not acquire another vehicle to which the license plate may be transferred.

(e) Title, registration and tax/fee payment requirements. The new owner of a motor vehicle must within thirty (30) calendar days from the date of vehicle purchase or acquisition make application to title and register the vehicle by the transfer to, or purchase of, a license plate for the newly acquired vehicle with the Tax Commission or motor license agent and pay excise and sales taxes and applicable title and registrations fees in addition to any delinquent taxes, fees, interest and penalty associated with the plate as provided by law.

(f) Penalty. Delinquent registration penalty begins to apply on the thirty-first (31st) day following assignment of ownership accruing at $1.00 per day, to a maximum penalty assessment of $100.00 (100 days).

(g) Vehicle operation. A vehicle purchased with the license plate having been removed may be lawfully operated on the streets and roadways without number plates for a maximum of fifteen (15) days from the date of acquisition or purchase if a dated notarized bill of sale is carried, for possible presentation to law enforcement, in the vehicle during the five (5) fifteen (15) days. Vehicles purchased from a licensed motor vehicle or used motor vehicle dealer may be operated thirty (30) days from the date of acquisition pursuant to issuance of a temporary license tag by the licensed dealer. See 710:60-3-56.

(h) Vehicle transferring from deceased spouse. A surviving spouse, desiring to operate a vehicle devolving from a deceased spouse, shall present an application for certificate of title to the Tax Commission or motor license agent in the name of the deceased spouse for the license plate for the previously owned vehicle to remain with the surviving spouse. The application will be prorated based on the full registration months of the deceased spouse's ownership of the vehicle registered and the license plate shall not be transferable between motor vehicle owners.

710:60-3-28. License plate remains with owner

(a) General provisions. Effective July 1, 2019, Oklahoma no longer allows a motor vehicle license plate to remain with the vehicle when the vehicle is sold, traded or transferred. The registration license plate and certificate of registration shall be issued to, and remain in the name of, the owner of the vehicle registered and the license plate shall not be transferable between motor vehicle owners.

(b) Registration procedures. When a vehicle is sold or transferred in the state, the following registration procedures apply:

(1) Vehicle owner. Any vehicle owner who sells, trades, or transfers a vehicle must remove the license plate from the vehicle and either:

(A) Retain the plate,
(B) Transfer the plate to a newly acquired vehicle of the same registration classification for which no additional registration fee is due for the remainder of the current registration period pursuant to authorization of the Oklahoma Tax Commission or a motor license agent, or
(C) Transfer the plate to a newly acquired vehicle of the same registration classification but different registration year requiring payment of additional registration fees.

(2) Vehicle buyer. In the event the owner of a license plate purchases, trades, exchanges or otherwise acquires a vehicle for which a license plate has been issued during the current registration period, and the license plate has not been removed by the previous owner in accordance with this Section, the new owner of the vehicle shall remove and return the license plate to the Tax Commission or a motor license agent. If the license plate has expired, the new owner may surrender the license plate to the Tax Commission or motor license agent.

(c) Calculation of registration fee. The registration fee due for the newly acquired vehicle to which a plate is transferred will be prorated based on the full registration months remaining on the transferred plate at the time of assignment.

(d) Refund eligibility. The plate owner shall not be entitled to a refund under the following circumstances:

(1) When the registration fee for the vehicle to which the plate is transferred is less than the registration fee for that vehicle to which the license plate was last assigned, or
(2) When the owner does not have or does not acquire another vehicle to which the license plate may be transferred.

(e) Title, registration and tax/fee payment requirements. The new owner of a motor vehicle must within thirty (30) calendar days from the date of vehicle purchase or acquisition make application to title and register the vehicle by the transfer to, or purchase of, a license plate for the newly acquired vehicle with the Tax Commission or motor license agent and pay excise and sales taxes and applicable title and registrations fees in addition to any delinquent taxes, fees, interest and penalty associated with the plate as provided by law.

(f) Penalty. Delinquent registration penalty begins to apply on the thirty-first (31st) day following assignment of ownership accruing at $1.00 per day, to a maximum penalty assessment of $100.00 (100 days).

(g) Vehicle operation. A vehicle purchased with the license plate having been removed may be lawfully operated on the streets and roadways without number plates for a maximum of fifteen (15) days from the date of acquisition or purchase if a dated notarized bill of sale is carried, for possible presentation to law enforcement, in the vehicle during the five (5) fifteen (15) days. Vehicles purchased from a licensed motor vehicle or used motor vehicle dealer may be operated thirty (30) days from the date of acquisition pursuant to issuance of a temporary license tag by the licensed dealer. See 710:60-3-56.

(h) Vehicle transferring from deceased spouse. A surviving spouse, desiring to operate a vehicle devolving from a deceased spouse, shall present an application for certificate of title to the Tax Commission or motor license agent in the name of the deceased spouse for the license plate for the previously owned vehicle to remain with the surviving spouse.

710:60-3-130. Manufactured homes

(a) Definition. "Manufactured home" means a residential dwelling built in accordance with the National Manufactured Housing Construction and Safety Standards Act of 1974, 42 U.S.C., Section 5401 et seq., and rules promulgated pursuant thereto and the rules promulgated by the Oklahoma Used Motor Vehicle and Parts Commission pursuant to 47 O.S. § 582. Effective November 1, 2016, manufactured home shall not mean a park model recreational vehicle as defined in 47 O.S. § 1102.

(b) Initial title and registration. In most instances, manufactured homes purchased new or brought in from another state are initially titled and registered at motor license agencies. Thereafter, they are placed on county ad valorem tax rolls and will be issued registration renewal decals by the County Treasurer.

(c) License plate and decal required. A manufactured home license plate and registration decal are required on all manufactured homes registered in this State.

(d) Fees may be prorated for remainder of current year. For those manufactured homes purchased new or coming in from another state, license plates and corresponding registration decals shall be issued upon payment of the applicable registration fee for the balance of the year.

(e) Issuance of license and decal for currently registered manufactured homes; proof of payment of ad valorem tax.
For those manufactured homes already located and registered in this State on December 1, 1988, a license plate and registration decal shall be issued upon proof of current ad valorem taxes paid. Proof of payment must be in the form of a Manufactured Home Tag Certification Form or Manufactured Home Certificate. When presented with proof of payment, a license plate and corresponding decal will be issued for a total fee as set forth by statute.

(f) **Basis used for registration fee and excise tax.** Both the registration fee and the excise tax assessment are based upon the selling price of the manufactured home. The selling price will be recorded as both the Factory Delivered Price (FDP) and the Total Delivered Price (TDP) when issuing an original Oklahoma title.

(g) **Excise tax on manufactured homes.** The excise tax on new manufactured homes is levied on one-half 41\(^2\) of the retail selling price. The excise tax on a used manufactured home will be applied to sixty-five percent (65\%) of one-half the resale price. The excise tax rate is levied by the Oklahoma Statutes. Sales tax is not assessed on manufactured homes.

(h) **Sale of manufactured home; transfer of title; change of basis.** If the manufactured home is sold, the title must be transferred to the new owner, who will have the title issued in his/her name. The FDP should be changed to reflect the purchase price. However, the TDP listed on the title will not be changed.

(i) **Proof of payment of ad valorem tax required upon transfer.** Proof of current paid ad valorem taxes must be obtained before transferring ownership of a manufactured home.

(j) **Manner of proof.** Acceptable proof of paid ad valorem taxes will be a Form 936 Manufactured Home Certificate or other receipt issued by a county treasurer which lists the manufactured home being transferred and clearly designates that taxes for the current calendar year have been paid in full.

(k) **When other basis used in determining tax.** Should the manufactured home be repossessed or brought in used from out-of-state, the "blue book" suggested selling price as listed in the automotive reference material prescribed by the Oklahoma Tax Commission will be used as a base price for the registration and collection of excise tax.

(l) **Late registration; penalties.** The penalty for late registration of manufactured homes, which are those not registered within the 30 day period from the date of purchase or the date the manufactured home was brought into this state, shall be an amount equal to the registration fee, less the administrative fee, as set forth by statute.

(m) **Park model recreational vehicle.** A park model recreational vehicle formerly registered as a manufactured home may make application for a change in registration classification by completing an affidavit confirming the unit meets the statutory definition criteria outlined in 47 O.S. \$ 1102 and submitting to the Oklahoma Tax Commission for review.

**SUBCHAPTER 5. MOTOR VEHICLE TITLES**

**PART 7. TRANSFER OF TITLE**

**710:60-5-76. Transfer of title upon divorce**

When a motor vehicle has been awarded in a divorce action, the applicant must present a certified filed stamped copy of the decree. The decree must identify the vehicle by a Vehicle Identification Number (VIN).

**SUBCHAPTER 9. MOTOR VEHICLE LICENSE AGENTS/AGENCIES**

**PART 1. GENERAL REQUIREMENTS, DUTIES AND RESPONSIBILITIES OF MOTOR LICENSE AGENTS**

**710:60-9-10. Strict compliance with laws and rules**

An Agent, or an individual acting on behalf of an Agent, shall strictly comply with all applicable statutes and with the rules, regulations, fee schedule, and procedures as set forth in the "Motor License Agents Manual of Procedure."

**PART 13. PROVISIONS FOR MOTOR LICENSE AGENT APPLICATION AND APPOINTMENT**

**710:60-9-137. Appointment**

(a) Based upon the findings of a feasibility study performed by the Commission and other information as may be deemed applicable, the Executive Director of the Commission may, at his discretion, make motor license agent appointment recommendations to the Commission.

(b) The successful applicant will be furnished a letter of appointment.

(c) If the applicant is rejected, the applicant will be forwarded a notification of rejection along with the reason for rejection.

(d) The successful applicant must accept or reject the appointment, in writing, within thirty (30) days of the appointment letter.

(e) If the applicant accepts the appointment, the applicant will be required to open the agency within fifteen (15) days after acceptance of the appointment, unless a time extension is granted by the Commission.

[OAR Docket #21-481; filed 6-15-21]

**TITLE 710. OKLAHOMA TAX COMMISSION**

**CHAPTER 65. SALES AND USE TAX**

[OAR Docket #21-482]


The amendments to the remaining Sections clarify policy, improve readability, correct scrivener's errors, remove obsolete language, update or correct citations, update contact information, and ensure accurate internal cross-references.

CONTACT PERSON: Lisa Haws, Tax Policy and Research Division, Oklahoma Tax Commission, Oklahoma City, OK 73194; 405-521-3133; lhaws@tax.ok.gov.
Division, P.O. Box

Any taxpayer responsible for the payment of any tax levied by any state tax law shall be liable for payment of interest at the rate set by statute on any amount of tax not paid before it becomes delinquent. Interest shall be computed for each day of delinquency from the date the tax becomes delinquent until it is paid.

(b) Audits; refund/credit for overpayment; assessment inclusive of interest due. When, in the course of an audit, it is found that the tax being audited was overpaid for any period included in the audit, and the taxpayer has not filed a verified claim for refund of the overpayment, the overpayment may be allowed as a credit against the total liability established during the audit. The overpayment shall be applied to the liability as of the date of the overpayment. Whenever an assessment is made for any delinquent tax, the amount of interest due thereon at the time the assessment is made shall be included in the assessment.

(i) Liability for tax, penalty, interest; interest computation. Any taxpayer responsible for the payment of any tax due on a monthly basis.

(c) Semimonthly electronic reporting. Persons owing an average of Two Thousand Five Hundred Dollars ($2,500.00) or more, per month, in total sales taxes for the previous fiscal year shall remit the tax due and shall participate in the Tax Commission's electronic funds transfer and electronic data interchange program, according to the following schedule:

(1) For sales from the first (1st) day through the fifteenth (15th) day of each month, the tax shall be due and payable on the twentieth (20th) day of the month, and remitted to the Tax Commission by electronic funds transfer. A taxpayer will be considered to have complied with the requirements of this paragraph if, on or before the twentieth (20th) day of each month, the taxpayer paid at least ninety (90) percent of the liability for that fifteen-day period, or at least fifty (50) percent of the liability incurred during the immediate preceding calendar year for the same month.

(2) For sales from the sixteenth (16th) day through the end of each month, the tax shall be due and payable on the twentieth (20th) day of the following month, and remitted to the Tax Commission by electronic funds transfer; [See: 68 O.S. § 1365(D)(2)]

(d) Electronic reporting. Beginning June 1, 2007, all new sales tax registrants required to report and remit sales tax shall file their monthly sales tax report in accordance with the Tax Commission's electronic funds transfer and electronic data interchange program unless the vendor receives an exception to the electronic filing requirement pursuant to OAC 710:65-3-4(c).

(e) Electronic reporting; due dates; delinquency dates. Persons required to remit the tax due pursuant to subsection (c) and (d) shall file a monthly sales tax report in accordance with the Tax Commission's electronic data interchange program on the twentieth (20th) day of the month following that in which the sales occurred. Taxes not paid on or before the due dates specified in subsection (c) shall be delinquent from such dates.

(f) Payment. Remittances covering the sales tax liability reported shall accompany the sales tax return. Sales taxes will be considered delinquent and interest as provided by law will be charged, if payment is not received or postmarked by the date the return is due.

(g) Interest. Interest at the rate provided by law will be imposed on all liability not paid at the time when required to be paid. Said interest will be imposed and collected on the delinquent tax at the statutory rate from the date the tax is delinquent until paid.

(h) Audits; refund/credit for overpayment; assessment inclusive of interest due. When, in the course of an audit, it is found that the tax being audited was overpaid for any period included in the audit, and the taxpayer has not filed a verified claim for refund of the overpayment, the overpayment may be allowed as a credit against the total liability established during the audit. The overpayment shall be applied to the liability as of the date of the overpayment. Whenever an assessment is made for any delinquent tax, the amount of interest due thereon at the time the assessment is made shall be included in the assessment.

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(2) For sales from the sixteenth (16th) day through the end of each month, the tax shall be due and payable on the twentieth (20th) day of the following month, and remitted to the Tax Commission by electronic funds transfer; [See: 68 O.S. § 1365(D)(2)]

(d) Electronic reporting. Beginning June 1, 2007, all new sales tax registrants required to report and remit sales tax shall file their monthly sales tax report in accordance with the Tax Commission's electronic funds transfer and electronic data interchange program unless the vendor receives an exception to the electronic filing requirement pursuant to OAC 710:65-3-4(c).

(e) Electronic reporting; due dates; delinquency dates. Persons required to remit the tax due pursuant to subsection (c) and (d) shall file a monthly sales tax report in accordance with the Tax Commission's electronic data interchange program on the twentieth (20th) day of the month following that in which the sales occurred. Taxes not paid on or before the due dates specified in subsection (c) shall be delinquent from such dates.

(f) Payment. Remittances covering the sales tax liability reported shall accompany the sales tax return. Sales taxes will be considered delinquent and interest as provided by law will be charged, if payment is not received or postmarked by the date the return is due.

(g) Interest. Interest at the rate provided by law will be imposed on all liability not paid at the time when required to be paid. Said interest will be imposed and collected on the delinquent tax at the statutory rate from the date the tax is delinquent until paid.

(h) Audits; refund/credit for overpayment; assessment inclusive of interest due. When, in the course of an audit, it is found that the tax being audited was overpaid for any period included in the audit, and the taxpayer has not filed a verified claim for refund of the overpayment, the overpayment may be allowed as a credit against the total liability established during the audit. The overpayment shall be applied to the liability as of the date of the overpayment. Whenever an assessment is made for any delinquent tax, the amount of interest due thereon at the time the assessment is made shall be included in the assessment.

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(2) For sales from the sixteenth (16th) day through the end of each month, the tax shall be due and payable on the twentieth (20th) day of the following month, and remitted to the Tax Commission by electronic funds transfer; [See: 68 O.S. § 1365(D)(2)]

(d) Electronic reporting. Beginning June 1, 2007, all new sales tax registrants required to report and remit sales tax shall file their monthly sales tax report in accordance with the Tax Commission's electronic funds transfer and electronic data interchange program unless the vendor receives an exception to the electronic filing requirement pursuant to OAC 710:65-3-4(c).

(e) Electronic reporting; due dates; delinquency dates. Persons required to remit the tax due pursuant to subsection (c) and (d) shall file a monthly sales tax report in accordance with the Tax Commission's electronic data interchange program on the twentieth (20th) day of the month following that in which the sales occurred. Taxes not paid on or before the due dates specified in subsection (c) shall be delinquent from such dates.

(f) Payment. Remittances covering the sales tax liability reported shall accompany the sales tax return. Sales taxes will be considered delinquent and interest as provided by law will be charged, if payment is not received or postmarked by the date the return is due.

(g) Interest. Interest at the rate provided by law will be imposed on all liability not paid at the time when required to be paid. Said interest will be imposed and collected on the delinquent tax at the statutory rate from the date the tax is delinquent until paid.

(h) Audits; refund/credit for overpayment; assessment inclusive of interest due. When, in the course of an audit, it is found that the tax being audited was overpaid for any period included in the audit, and the taxpayer has not filed a verified claim for refund of the overpayment, the overpayment may be allowed as a credit against the total liability established during the audit. The overpayment shall be applied to the liability as of the date of the overpayment. Whenever an assessment is made for any delinquent tax, the amount of interest due thereon at the time the assessment is made shall be included in the assessment.

(i) Liability for tax, penalty, interest; interest computation. Any taxpayer responsible for the payment of any tax levied by any state tax law shall be liable for payment of interest at the rate set by statute on any amount of tax not paid before it becomes delinquent. Interest shall be computed for each day of delinquency from the date the tax becomes delinquent until it is paid.

(j) Penalty for failure to file and remit. Penalties - A vendor who fails to file a return and remit the full amount of the tax
within fifteen (15) days after the tax is due shall be subject to a penalty of ten (10) percent of the amount of tax due.

(k) **Penalty for failure or refusal to file after demand.** In the case of failure or refusal to file within ten (10) days after written demand has been served upon the taxpayer by the Commission, a penalty of twenty-five (25) percent may be assessed and collected.

(l) **Penalty for fraud.** If any portion of the deficiency is due to fraud with intent to evade tax, a penalty of fifty (50) percent shall be added, collected, and paid.

(m) **Waiver of penalty; interest.** At the discretion of the Commission, the interest or penalty, or both, may be waived provided the taxpayer can demonstrate that the failure to pay the tax when due is satisfactorily explained, or that the failure resulted from a mistake by the taxpayer of either law or fact, or that the taxpayer is unable to pay the interest or penalty due to insolvency. Requests for waiver or remission must be made in writing and must include all pertinent facts to support the request. [See: 68 O.S. §§ 217, 1365, 1405]

**710:65-3-4. Contents of monthly sales report**

(a) **General provisions.** Every vendor shall file a monthly report for sales made the preceding month stating the name of the seller, address, telephone number, and, sales tax number as it appears on the sales tax permit of the business and the period (month and year) covered by the report. In instances where a business does not provide a sales tax number, the federal employer identification number (FEIN) or social security number (SSN) of the business is required to be included on the sales tax report. In addition, the report shall disclose the following:

1. Total gross receipts for the preceding month from sales, both taxable and non-taxable.
2. The "sales value" of all withdrawals from inventory of goods initially purchased exempt from sales tax, including all items withdrawn for gifts, donations, prizes or business or personal use. Included is the cost of all withdrawals from inventory of goods initially purchased on a tax deferred basis pursuant to a direct pay permit which are subsequently withdrawn for a taxable use.
3. Deductions allowed by law. Deductions not specifically delineated on the face of the return must be fully explained in the space provided.
4. The amount of tax due, including any city or county tax, or both, as described in (c) of this Section.
   (A) The return should show the amount of interest (if any) that is due.
   (B) The return should show the amount of penalty (if any) that is due.
5. Such other reasonable information as the Commission may require. [See: 68 O.S. §§1365]

(b) **Exception to the requirement to file electronically.** The vendor may apply in writing to the Business Tax Electronic Filing Coordinator, Oklahoma Tax Commission, Taxpayer Assistance Business Tax Services Division, 2501 N. Lincoln Blvd 123 Robert S. Kerr Ave, Oklahoma City, OK 73104-73102, for a determination that the vendor is unable to participate in the electronic funds transfer and electronic data interchange program, and if the application is approved, the vendor will be permitted to report on paper.

1. To determine whether a vendor is "unable" to file electronically, the following guidelines shall be utilized:
   (A) The taxpayer does not have access to a computer or internet access at home or place of business;
   (B) The taxpayer does not use a tax preparer that has a computer or one that does not have internet access.
2. Any exception to the electronic filing requirement will be granted for only twelve (12) months. At the end of the exception period the taxpayer's electronic filing capability may be reviewed.
3. An aggrieved taxpayer may protest the determination of the Commission as provided by 68 O.S. § 207 pursuant to OAC 710:1-5-20 through 710:1-5-49, the Rules of Practice and Procedure before the Office of the Administrative Law Judges.

(c) **Reporting for city and county taxes.**

1. The state tax is determined by applying the state rate to the amount of net taxable sales (all sales less deductions allowed by law).
2. The amount of city sales tax is determined by multiplying the amount of net taxable sales for each city by the rate for that city.
3. The amount of county sales tax is determined by multiplying the amount of net taxable sales for each county by the rate for that county.

(d) **Excess tax collected.** If the vendor has collected, in the aggregate, an amount of sales tax from its customers, larger than the amount which would result from multiplying the taxable sales by the tax rate, whether due to the use of the bracket charts supplied by the Commission, the use of an electronic cash register that rounds up the tax, or any other reason, the vendor is responsible for remitting the total tax collected. The statement "Excess Tax Collected" should be written on the face of the report, under the line captioned "Total Due."

**SUBCHAPTER 7. DUTIES AND LIABILITIES**

**710:65-7-9. Vendors' responsibility - sales to a manufacturer**

(a) In the case of sales to purchasers claiming exemption for manufacturing, the vendor must obtain a copy of the purchaser's manufacturer's exemption permit issued pursuant to 68 O.S. § 1359.2 (hereafter referred to as "Sales/Manufacturers Permit"), or if unavailable, the name, address, and Sales/Manufacturers Permit Number of the purchaser or, a statement that contains the information that would appear on the Sales/Manufacturers Permit. If a copy of the Sales/Manufacturers Permit is unavailable and if the information provided has not been previously verified, it must be verified by either calling the Taxpayer Assistance - Division Resource Center or by reference to the sales tax permit list obtained pursuant to OAC 710:65-9-6.
(b) In the case of sales to purchasers claiming exemption pursuant to a contractual relationship with a manufacturer for the construction and improvement of manufacturing goods, wares, merchandise, property, machinery and equipment for use in a manufacturing operation which is classified NAICS 324110 (Petroleum Refineries) the vendor must obtain the following:

1. A copy of the Manufacturer's Sales Tax Exemption card issued to the entity described in (b) of this Section;
2. Documentation indicating the contractual relationship between the contractor and the manufacturer; and,
3. Certification by the purchaser, on the face of each invoice or sales receipt, setting out the name of the exempt entity, that the purchases are being made on behalf of the entity, and that they are necessary for the completion of the contract.

710:65-7-10. Vendors' responsibility - sales made pursuant to direct payment permit

In the case of sales made to purchasers claiming deferral pursuant to a direct payment permit, the vendor must obtain the items of information described in this Section:

1. A copy of the purchaser's Direct Payment Permit (DPP), or if unavailable, the purchaser's name, address, DPP number, and its date of expiration. If a copy of the Direct Payment Permit is unavailable and if the information provided has not been previously verified, it must be verified by either calling the Taxpayer Assistance Division Resource Center or by reference to the sales tax permit list obtained pursuant to OAC 710:65-9-6;
2. A statement that the permit-holder claims deferral of the payment of any applicable state and local sales or use taxes upon its purchases of taxable tangible personal property or services;
3. A statement that the articles purchased are for use in the purchaser's Oklahoma enterprises, and not for resale; and,
4. The signature of the purchaser or a person authorized to legally bind the purchaser, and date signed.

710:65-7-12. Vendors' responsibility - sales to persons raising animals for resale

In the case of persons regularly engaged in the business of raising animals for resale, the vendor must obtain the items of information set out in this paragraph:

1. A copy of the purchaser's sales tax permit, or if unavailable, the purchaser's name, address, sales tax permit number, and its expiration date. If a copy of the Sales Tax Permit is unavailable and if the information provided has not been previously verified, it must be verified by either calling the Taxpayer Assistance Division Resource Center or by reference to the sales tax permit list obtained pursuant to OAC 710:65-9-6;
2. A statement that the articles purchased are for use in raising animals;
3. The signature of the purchaser or a person authorized to legally bind the purchaser; and,
4. Certification on the face of the invoice, bill or sales receipt that states that the purchaser is "regularly engaged in the business of raising animal life for resale and that the items being purchased exempt from sales tax are solely for business use".

SUBCHAPTER 9. PERMITS

710:65-9-1. Obtaining a sales tax permit to do business

(a) General provisions. Every person desiring to engage in a business within this state who will regularly and continuously make sales subject to taxation from an established place of business, will make taxable seasonal sales, or make taxable sales through peddlers, solicitors or other salesmen who have no established place of business in Oklahoma must secure from the Commission every three (3) years a written sales tax permit for a fee of Twenty Dollars ($20.00) prior to engaging in such business in this state. Each such person shall file with the Commission an application for a permit to engage in or transact business in this state, setting forth such information as the Commission may require. The application shall be signed by an owner or authorized representative of the business, and, in the case of a corporation, by an officer thereof.

(b) Probationary permits. Every vendor who is making an "initial application" for a sales tax permit and who otherwise qualifies based on a review of the information contained in the application for a sales tax permit and who does not currently hold a sales tax permit, or does not qualify to receive a non-probationary permit as those qualifications are described in this Section, will be issued a probationary permit as allowed by 68 O.S. §1364(B) and implemented by the procedures set out in this Section. When issued, the probationary permit will be effective for six (6) months and will be automatically renewed for an additional thirty (30) months, unless the applicant is given written notice of Tax Commission's refusal to renew the permit.

(c) Issuance upon receipt of an "initial application." An "initial application" means the first application by an entity for a sales tax permit. Upon receipt of an initial application for a sales tax permit by a person required to obtain a sales tax permit, the Commission may issue a probationary sales tax permit, based on its records, after determining that the applicant appears to be in compliance with all of the tax laws of this state and has, or will be, required to secure a sales tax permit based on the information contained in the application which was submitted.

(d) Post-issuance review of probationary permit-holder. Once a probationary permit has been issued, the Commission may conduct a compliance visit at the taxpayers place of business or at the location of the books and records of the applicant in Oklahoma, as those locations are set out in the initial application.

1. The compliance visit may be made by a telephone call to the offices of the applicant if the Compliance Collections Division Representative believes the information
contained in the application may be verified in that manner or in the case where the applicant does not have an established place of business in Oklahoma or has an office located outside of Oklahoma.

(2) The purpose of the compliance visit is to determine if the applicant qualifies for a sales tax permit and will include:

(A) Establishing that the taxpayer is engaged in business as a group one or group three vendor, and that the applicant's business activities are not solely those of a consumer-user and therefore the probationary permit should be automatically renewed.

(B) Determining that the applicant has maintained compliance with all tax laws of the state, rules of the Commission and recordkeeping requirements and offering assistance to aid the applicant in complying with the tax laws of the state, rules of the Commission and recordkeeping requirements where necessary.

(e) Refusal of the Commission to renew the permit; notice, options available upon refusal.

(1) If the compliance visit indicates that the applicant is ineligible; if the applicant fails to contact the Commission regarding a compliance visit, after attempted contact; if other circumstances indicate that the applicant does not qualify; or if the applicant is not complying with the tax laws of this State, rules of the Commission and recordkeeping requirements, the Commission shall, prior to the end of the sixth month of the probationary period, give notice that the applicant's probationary permit will not be renewed.

(2) The notice shall be in writing and shall allow the applicant to request a hearing to show why the permit should be issued.

(3) Upon receipt of a request for a hearing, the Tax Commission shall set the matter for a hearing and provide notice of the date, time and place of the hearing to the applicant, along with a statement of the reason for refusal. At the hearing the applicant shall appear, state its qualifications for a permit, and provide proof of compliance with all state tax laws. The hearing will not be held sooner than 10 days from the date the notice is mailed.

(4) Proceedings related to the refusal to issue a sales tax permit shall be governed by OAC 710:1-5-100.

(f) Compliance reviews not limited to probationary permits. Nothing in this Section shall be construed so as to prevent, or circumscribe in any fashion, the authority of the Oklahoma Tax Commission and its appointed agents and representatives, to examine and review the books and records of every taxpayer and business operation for compliance with the tax laws of this State, rules of the Commission and recordkeeping requirements. In all cases where a review results in a determination that the business may not be in compliance with the tax laws of this state, rules of the Commission and recordkeeping requirements a hearing to revoke or suspend any license or permit may be held pursuant to OAC 710:1-5-100, and any other action available by law to the Tax Commission to remedy the deficiency may be pursued.

(g) Sales / Manufacturers Permit. Each applicant who is engaged in manufacturing at a manufacturing site located in Oklahoma will be issued a Sales/Manufacturers Permit.

(h) Special event permits. Promoters or organizers of special events must apply for a special events permit at least twenty (20) days prior to the event, provide forms to special event vendors for reporting sales tax collections, collect the sales taxes from the vendors, and remit them, along with daily sales tax reports to the Tax Commission within fifteen (15) days following the conclusion of the special event, pursuant to 710:65-9-8. [See: 68 O.S.Supp.2003, Section 1364.2]
(D) an event sponsored by a city or town that includes less than ten special event vendors or

(E) a registered farmers market which is a designated area where farmers, growers, or producers from a defined region gather on a regularly scheduled basis to sell at retail nonpotentially hazardous farm food products and whole-shell eggs to the public. [68 O.S. Supp. 2013 § 1364.2]

(5) "Special event vendor" means a person making sales of tangible personal property or services taxable under Section 1350 et seq. of Title 68 of the Oklahoma Statutes at a special event within this state and who is not permitted under Section 1364 of Title 68 of the Oklahoma Statutes. [68 O.S. § 1364.2]

(b) Application for special event permit. Every promoter or organizer of a special event shall file an application for a special event permit with the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission at least twenty (20) days before the beginning of the special event. If more than one special event is to be held at the same location during a single calendar year, all may be included in one application, and a separate permit will be issued for each event. Each permit will include the dates of the event to be held, and must be prominently displayed at the site of the event for its duration. If an applicant wishes to have permits issued for additional events after an application has been previously submitted, another supplemental application must be filed for the additional events. The application form for a special event permit may be obtained from the Compliance Division, Oklahoma Tax Commission, 409 N.E. 28th Street, Oklahoma City, OK 73119, or online at www.tax.ok.gov.

(c) Fee. There is a fee of fifty dollars ($50.00) for each application filed, which must be remitted with the application.

(d) Promoter or organizer to distribute vendors’ reporting forms. Special event promoters and organizations are required to provide sales tax report forms to special event vendors that will be selling tangible personal property and taxable services at the event.

(e) Promoter or organizer to collect reports and tax from special event vendors. At the end of the event, special event promoters are required to collect the sales tax reports, along with the sales tax due from each special event vendor.

(f) Promoter or organizer to report and remit sales tax. Promoters or organizers of special events must file sales tax reports and remit taxes collected from special events, as follows:

1. Promoters and organizers are required to file the sales tax reports within fifteen (15) days following the last day of a special event.

2. Payment of the total tax due is required at the time the sales tax report is filed. If not filed on or before the fifteenth (15th) day, the tax shall be delinquent from such date. Reports timely mailed shall be considered timely filed. If a report is not timely filed, interest shall be charged from the date the report should have been filed until the report is actually filed; and

3. The organizer or promoter shall also submit a list of vendors at each event that hold a valid sales tax permit issued under 68 O.S. § 1364. The list shall include the vendor's name, address, telephone number, and sales tax permit number.

(g) Limitation of responsibilities of promoters or organizers. Promoters or organizers of a special event that is held on an annual basis during the same thirty-day period each year may request that the Tax Commission limit their responsibilities to the following:

1. Submitting an application for a special event permit as provided in (b) of this Section;

2. Providing report forms to special event vendors as provided in (d) of this Section; and

3. Within fifteen (15) days following the conclusion of the special event, submitting a list of special event vendors at each event, including the vendor's name, address, and telephone number.

(h) Denial of limitation. Requests submitted pursuant to (g) of this Section may be denied by the Tax Commission for reasons including, but not limited to, failure by the promoter to comply with the requirements of this Section or failure by vendors of the promoter's previous special events to comply with the provisions of (i) of this Section.

(i) Vendor reporting and remitting pursuant to subsection (g). A special event vendor who has participated in a special event approved under subsection (g) shall remit the tax along with a sales tax report directly to the Tax Commission within fifteen (15) days following the conclusion of the special event. Sales taxes shall be considered delinquent and interest as provided by law will be charged if payment is not received or postmarked by the fifteenth (15th) day following the event.

(j) Reporting and remitting tax when event lasts thirty (30) days or longer. When the special event will last thirty (30) days or longer, a sales tax report is required to be filed for each calendar month by the fifteenth (15th) day of the following month.

710:65-9-10. Direct payment permits (DPP)

(a) General provisions. The holder of a valid Oklahoma direct payment permit may make purchases of taxable items, for use in its Oklahoma enterprises and not for resale, and defer the taxes imposed by the Oklahoma Sales and Use Tax Codes until such time as the items are first used or consumed in a taxable manner, if all requirements described in this Section are met. [See: 68 O.S. § 1364.1]

(b) Qualification for direct payment permit. To qualify for a direct payment permit, valid for three (3) years, an applicant must meet the requirement set forth in paragraph 1, 2, or 3.

1. Documentation for established businesses. The applicant must be making purchases of $800,000.00 annually in taxable items for the use in its Oklahoma enterprises, and not for resale and annual purchases of $800,000.00 must be verifiable from the applicant's sales or use tax records.

2. Documentation for new or expanding businesses. An applicant without any qualifying sales and use tax reporting history in Oklahoma must submit to the
Commission along with its application, a sworn statement that "applicant shall purchase $800,000.00 of taxable items and services annually for use in its Oklahoma enterprises and not for resale." Adequate records or documentation must be available to support the statement of projected purchases.

(3) Documentation for healthcare providers. The applicant must be making purchases of drugs for the treatment of human beings, medical appliances, medical devices and other medical equipment including but not limited to corrective eyeglasses, contact lenses, hearing aids, prosthetic devices, durable medical equipment, and mobility-enhancing equipment for administration or distribution by a practitioner, as defined in 68 O.S. § 1357.6(B), who is authorized by law to administer or distribute the referenced items and the cost of such items will be reimbursed under the Medicare or Medicaid programs.

(c) Other qualifications. In addition to any other conditions mandated by statute, all applicants for a direct payment permit must comply with all conditions, prerequisites and qualifications described in (1) through (4) of this subsection:

(1) Overall compliance with tax provisions. The applicant must be in compliance with all pertinent tax laws of the State of Oklahoma and with the respective rules of the Commission.

(2) Applicant must establish reliability and accuracy of accounting methods. All applicant(s) must be able to establish to the satisfaction of the Commission that the applicant is or will be using an accounting method which clearly distinguishes between taxable and nontaxable purchases. An explanation of the accounting procedures which will be used to determine the taxability of any purchase and to ensure that any tax due is correctly accrued and remitted must accompany the application for a direct payment permit. Additional to substantiate the exempt purchase of medical equipment pursuant to subsection (a) of 710:65-13-173, a healthcare provider holding a direct pay permit must maintain separate from confidential patient records the following information:

(A) Patient case number or account number;
(B) Type of insurance and
(C) Item description or product number.

(3) Compliance with reporting and remitting requirements. The applicant must agree to accrue and pay all taxes imposed by the Sales or Use Tax Codes, on the applicable direct payment sales or use tax return, for items not specifically exempted. The applicant must agree to make the payments to the State on or before the 20th day of the month following the applicable reporting period in which the items become subject to the tax by reason of their consumption in this State. A written agreement to this effect, signed by an officer or other person authorized to legally bind the applicant must be furnished to the Commission along with the application for a direct payment permit.

(4) Compliance with restrictions on purchases for resale. The applicant must agree to give a resale certificate, rather than a direct payment permit, for any item that will be resold, as provided by the Sales or Use Tax Codes.

(d) Application for direct payment permit. Application for a direct payment permit may be made to the Taxpayer Assistance—Business Tax Services Division, Oklahoma Tax Commission, 2501 Lincoln Blvd., 123 Robert S. Kerr Ave, Oklahoma City, OK 73194 73102.

(e) Granting of permit discretionary; options available upon denial. The Oklahoma Tax Commission shall be the sole judge of an applicant's qualifications and may deny an application or refuse to issue a direct payment permit. However, an applicant is not precluded from submitting an amended application or may submit a new application after a reasonable period of time from the date of the original application. For purposes of this subsection "reasonable period of time" means a period of time of not less than twelve (12) calendar months duration from the date of the Commission denial or refusal to issue the permit.

(f) Issuance, scope, limitations of direct payment permit. When a direct payment permit is issued to a particular legal entity, it will include all branches and divisions of that entity which are purchasing taxable items. A direct payment permit issued to a supplier by one branch or division shall apply to purchases made by all branches or divisions from the same supplier. For purposes of this Section, "branches and divisions" shall be limited to those subunits or groups associated with a single unique federal employer identification number. A direct payment permit-holder may not authorize any other person or entity to purchase any taxable items under the permit. Use by unauthorized persons may result in revocation of the permit.

(g) Use of direct payment certification procedure with vendors. A direct payment permit-holder must provide its vendors with the direct payment certification defined in this Section and a copy of its direct payment permit in order to make those purchases which to the permit is applicable.

(h) "Direct payment certification" described. "Direct payment certification" means the procedure by which a direct payment permit-holder provides a vendor with properly completed documentation and certification as to its deferred status. Properly completed documentation may consist of a copy of the direct payment permit, multi-state exemption certificate, or other document, so long as it contains the information described in (1) through (4) of this subsection.

(1) A copy of the purchaser's Direct Payment Permit (DPP), or if unavailable, the name, address, and DPP number of the purchaser;
(2) A statement that the permit-holder claims deferral of the payment of state, city and county sales or use taxes upon its purchases of taxable tangible personal property or services;
(3) A statement that the articles purchased are for use in the purchaser's Oklahoma enterprises, and not for resale;
(4) The signature of the purchaser or a person authorized to legally bind the purchaser, and date signed.
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(i) **Limitations on use of direct payment procedure.** Direct payment certification procedures are not applicable to the purchase of materials or supplies used, transferred, or consumed by a third party in performing services for the direct payment permit-holder, regardless of whether the third party is a contractor, service provider, or other person.

(j) **Incidence of tax for purchases made pursuant to direct payment permit and stored in Oklahoma.** For taxable items purchased under a direct payment permit, the incidence of Oklahoma sales and use taxes to be accrued and remitted on items stored in Oklahoma is to be determined by reference to this subsection, as well as to the provisions of the Oklahoma Sales and Use Tax Codes. [See: 68 O.S. § 1361(C)]

1. **Use tax to be accrued on items and goods purchased outside Oklahoma.** Items and goods purchased outside Oklahoma pursuant to an Oklahoma direct payment permit, which are intended solely for use in other states, but which are stored in the State pending shipment to such other states, or which are temporarily retained for the purpose of fabrication, repair, testing, alteration, maintenance, or other service, are not subject to Oklahoma use tax. However, if the items purchased out-of-state are first used or consumed in Oklahoma, then Oklahoma use tax and any applicable city use tax shall be accrued and remitted to the Commission by the direct payment permit-holder.

2. **Sales tax to be accrued on items and goods purchased in Oklahoma.** Items and goods purchased in Oklahoma pursuant to a valid Oklahoma direct payment permit are subject to Oklahoma sales and applicable city and county sales taxes at the time they are first used or consumed in a taxable manner. Sales made to direct payment permit holders of tangible personal property intended solely for use in other states, but which is stored in Oklahoma pending shipment to other states or which is temporarily retained in Oklahoma for the purpose of fabrication, repair, testing, alteration, maintenance, or other service are not subject to Oklahoma sales tax.

(k) **Monthly reports required.** All direct payment permit-holders must file sales and use tax returns, in the manner set out in this subsection, whether or not they have either sales tax or use tax to report.

1. Purchases made in Oklahoma, using the taxpayer's DPP, such that the Sales Tax sales tax otherwise due has been deferred, are to be reported monthly on the Sales Tax Report Form which bears taxpayer's Direct Payment Permit Number. This report is in addition to any Sales Tax Report which is required to be filed using taxpayer's Sales Tax Permit Number.

2. Purchases made outside Oklahoma, using the taxpayer's DPP, such that the Use Tax use tax otherwise due has been deferred, are to be reported monthly on the taxpayer's Use Tax Report Form, using the Use Tax Account Number.

(l) **Cancellation, suspension, revocation of permit.** A direct payment permit may be cancelled by the Commission if the annual purchases fall below the qualifying threshold. Further, the Commission may revoke a permit upon information that the permit has been used by persons other than to whom it was issued. Finally, the Commission may suspend, cancel, or revoke a direct payment permit, at any time, for non-compliance with the provisions of this Section, with applicable Oklahoma tax statutes, or for other good cause shown. Proceedings related to the cancellation or refusal to issue a license or permit pursuant to this Section shall be governed by 710:1-5-100 and 710:1-5-21 through 710:1-5-49 of the permanent rules of the Commission.

(m) **Procedure upon cancellation, revocation, or forfeiture.** Any entity whose direct payment permit is either voluntarily forfeited, or is cancelled or revoked by action of the Commission, must immediately notify all vendors from whom purchases of taxable items are made advising them that any certification provided to them pursuant to the forfeited, cancelled or revoked direct payment permit is no longer valid.

**SUBCHAPTER 11. CREDITS AND REFUNDS**

710:65-11-1. **Sales tax credits and refunds**

(a) Credits, other than for bad debts discussed below, may not be taken on the sales tax reporting form until or unless a valid letter of credit has been received from the Commission. The burden of establishing the right to, and the validity of, a credit or refund is on the vendor or purchaser claiming the credit or refund.

(b) Credit/refund requests submitted by a vendor shall include the information set out in paragraphs (1) though (8) of this subsection (if applicable). The application for credit may be obtained from the Oklahoma Tax Commission, 2001 N. Lincoln Boulevard, 123 Robert S. Kerr Ave, Oklahoma City, OK 73102, or online at www.tax.ok.gov.

1. A written detailed explanation of why the credit/refund is due. (Include exemption numbers and/or an explanation on exempt customers.)

2. Amended reports detailing the correct figures that should have been reported. (A worksheet may be used in lieu of an amended report for each month involving an extended period.)

3. Copies or a list of the sales tax reports on which the sales were originally reported.

4. Copies of cancelled checks used to remit the tax paid.

5. Copies of the original invoices on which the tax was originally charged. If the number of invoices exceeds twenty-five (25), the invoices must be accompanied by an electronic spreadsheet of the invoices associated with the refund claim that relates back to the tax amount requested on the application for credit. The required fields should accurately list the customer name, invoice date, invoice number, description of the items, the taxable amount, the sales/use tax requested, period the tax was remitted, permit number the tax was remitted under, and the jurisdiction(s) for which the tax was paid.
(6) Copies of the credit invoices or checks showing the tax collected or charged in error has been refunded to your customer.
(7) A recap of the credit/refunds by tax type, tax period, and taxing jurisdiction.
(8) Other documentation which may be pertinent to the requested credit/refund.
(c) Credit/refund requests submitted by a purchaser shall include the information set out in paragraphs (1) through (5) of this subsection (if applicable). The application for credit may be obtained from the Oklahoma Tax Commission, 2501 N. Lincoln Boulevard, 123 Robert S. Kerr Ave, Oklahoma City, OK 73104, or online at www.tax.ok.gov.

(1) The name, address, telephone number of the contact person along with the name, address, telephone number and at least the last four digits of the purchaser's identification number.
(2) A written detailed explanation of why the credit/refund is due. Such explanation must contain sufficient factual information about the transaction and reason why the transaction is not subject to tax. (Include exemption number, if applicable)
(3) Copies of the original invoices included in the refund request, in chronological order, from the oldest to the most current. If the number of invoices exceeds twenty-five (25), the invoices must be accompanied by an electronic spreadsheet of the invoices associated with the refund claim that relates back to the tax amount requested on the application for credit. The required fields should accurately list the vendor name, invoice date, invoice number, description of the items, the taxable amount, the sales/use tax requested, period the tax was remitted, permit number the tax was remitted under, and the jurisdiction(s) for which the tax was paid.
(4) Additional documents which support the refund claim, for example: executed contracts, shipping documents or bills of lading, or documentation reflecting usage of tangible personal property, if not evident from the invoice description.
(5) If the amount of the credit/refund request exceeds $10,000.00, the purchaser must also provide the following:
   (A) A statement from each vendor to whom the purchaser paid the tax setting forth each invoice included in the claim,
   (B) The amount of state, city and/or county tax collected from the purchaser and reported by the vendor and the local jurisdiction(s) for which the tax was paid,
   (C) The date on which the tax was remitted to the Tax Commission, and
   (D) A statement that the vendor has not, and will not, refund the tax to the purchaser.

SUBCHAPTER 13. SALES AND USE TAX EXEMPTIONS

PART 7. CHURCHES

710:65-13-33. Children's homes and youth camps
(a) Qualification for the exemption for children's homes located on church-owned property. The sale of tangible personal property or services to children's homes located on church-owned property and operated by a qualified organization is exempt from sales tax. "Qualified organization" means, for purposes of this Section, an organization which is exempt from taxation pursuant to the provisions of the Internal Revenue Code, 26 U.S.C. Section 501(c)(3). [See: 68 O.S. § 1357(15)]
(b) Qualification for the exemption for certain children's homes supported by one or more churches. The sale of tangible personal property or services to children's homes supported or sponsored by one or more churches, whose members serve as trustees of the children's home, is exempt from sales tax. [See: 68 O.S. § 1356(27)]
(c) Qualification for the exemption for certain youth camps. The sale of tangible personal property or services to youth camps supported or sponsored by one or more churches, whose members serve as trustees of the youth camp, is exempt from sales tax. [See: 68 O.S. § 1356(29)]
(d) Application process. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., 123 Robert S. Kerr Ave, Oklahoma City, OK 73104, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with the applicable documentation set forth in (e) of this Section.
(e) Supporting documentation required.
   (1) Children's homes on church property. Children's homes on church property must submit the following documentation:
      (A) A letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income taxation pursuant to 26 U.S.C. § 501(c)(3); and
      (B) Documentation evidencing church ownership of the property where the children's home is located.
   (2) Children's homes supported by churches. Children's homes supported or sponsored by churches must submit the following documentation:
      (A) The name(s) of the church(es) which support the home; and
      (B) The amount that each church contributes each year.
   (3) Youth camps. Youth camps must submit the following documentation:
      (A) The name(s) of the church(es) which sponsor the camp; and
      (B) The names of the church members who serve as trustees of the camp.
710:65-13-40. Sales by churches; sales to churches
(a) Sales "by" churches. Sales by churches are not subject to sales tax when it can be said that such selling is noncompetitive with business establishments.

(1) The following are tests for determining that such selling is noncompetitive:

(A) The transactions are conducted by members of the church and not by any franchisee or licensee.
(B) All of the proceeds must go to the church organization.
(C) The transaction must not be a continuing one but rather should be held whether annually or a reasonably small number of times within a year. The test of reasonableness would be an administrative decision, to be made by the Commission.

(D) The reasonably ascertainable dominant motive of most transfeerees of the items sold must be the making of a contribution, with the transfer of property being merely incidental and secondary to the dominant purpose of making a gift to the church.

(2) In addition, there are these further considerations as guides to the resolution of questions raised by each individual situation:

(A) The nature of the particular item sold. All other things being equal, the decision as to candy might well be different from the decision as to refrigerators.
(B) The character of the particular sale, and the real practical effect upon putative competition. [See: 68 O.S. § 1356(7)]

(b) Sales "to" churches. Generally, sales made directly to a church are exempt from sales and use tax. Only sales purchased by the church, invoiced to the church, and paid for by funds or check directly from the church, will qualify for the exemption. A vendor wishing to be relieved of liability to collect the tax should follow the requirements of OAC 710:65-7-6 and 710:65-7-15.

(c) Purchases by contractors. Purchases of taxable personal property or services by a contractor with whom a church has duly entered into a construction contract, or to any subcontractor to such construction contract, are exempt provided they are necessary for carrying out the contract. A vendor wishing to be relieved of liability to collect the tax should follow the requirements of subsection (c) of OAC 710:65-7-13.

(d) Application process. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N Lincoln Blvd., Oklahoma City, OK 73104, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with supporting documentation which shows that the church consists of a body of believers which holds religious services and public notification of the place and time of those services such as a copy of a newspaper or yellow pages ad, newsletter or bulletin sent to regular attendees or distributed during a service.

710:65-13-55. Exemption for coal mining
(a) Qualification in general. Sales of machinery, electricity, fuels, explosives and materials, excluding chemicals, used in the mining of coal in this state are exempt from sales or use tax.

(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N Lincoln Blvd., Oklahoma City, OK 73104, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 and online at www.tax.ok.gov along with supporting documentation as follows:

(1) The applicant's name, mailing address and federal taxpayer's identification number; and
(2) A statement that the entity is engaged in mining coal in Oklahoma and setting out any coal mining permit numbers issued to the entity or, if the applicant is a contractor to a mine owner, the coal mining permit numbers issued to the mine owner, by the Oklahoma Department of Mines or other applicable regulatory agency.

(c) Exemption limited to eligible, properly-documented transactions. Only those purchases actually purchased by the qualifying entity, invoiced to that entity and paid for by funds or check directly from the qualifying entity will be eligible for the exemption described in this Section.

PART 15. HAZARDOUS WASTES

710:65-13-80. Exemption for purchases to reduce hazardous waste
(a) Definitions. The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) "Directly used or consumed in the process of treatment" means either the tangible personal property is:

(A) "Directly used" in the step-by-step processes by which hazardous waste is treated. Any tangible personal property or any services which are only indirectly related to the process of treatment are not included; or
(B) "Consumed" as in destroyed, used up, or worn out to the degree or extent that such property cannot be repaired, reconditioned, or rendered fit for further use. "Consumed" does not mean or include mere obsolescence.

(2) "Equipment" means the implements used in the direct process of treatment.

(3) "Hazardous waste" means waste materials and by-products, either solid or liquid, which are to be discarded by the generator, and which are toxic to human, animal, aquatic or plant life and which are generated in such quantity that they cannot be safely disposed of in properly operated, state-approved sanitary landfills, waste or sewage treatment facilities. Hazardous waste may
include, but is not limited to, explosives, flammable liq-
uids, spent acids, caustic solutions, poisons, containerized
gases, sludge, tank bottoms containing heavy metallic
ions, toxic organic chemicals, infectious materials, and
materials such as paper, metal, cloth or wood which are
contaminated with hazardous waste, and excludes do-
mestic sewage. For purposes of the sales and use tax
exemption, the term "hazardous waste" may include
low-level radioactive waste.

(4) "Incorporated into" means directly used or con-
sumed in the process of treatment.

(5) "Machinery" means mechanically, electrically, or
electronically operated devices used for performing the
tasks of remediation of hazardous waste.

(6) "Other materials" means other items of tangible
personal property which are used in the direct process
of treatment of hazardous waste, but which are not ma-
achinery, equipment, fuel, or chemicals. For purposes of
this Section, electricity is included in the category "other
materials".

(b) Exemption limited to eligible, properly documented
transactions. Only purchases of machinery, equipment, fuel,
and chemicals or other materials incorporated into and directly
used or consumed in the process of treatment to substantially
reduce the volume of harmful properties of hazardous waste
at treatment facilities specifically permitted pursuant to the
Hazardous Waste Management Act and operated at the place
of waste generation, or facilities approved by the Department
of Environmental Quality for the clean-up of a site of
contamination are exempt. Only purchases made by persons
engaged in the process of treatment, invoiced to those persons,
and paid for by such persons are exempt.

(c) Application process. Application for exemption is
made by submitting to the Taxpayer Assistance-Business Tax
Services Division, Oklahoma Tax Commission, 2501 Lincoln
Bldg., Suite 123 Robert S Kerr Ave, Oklahoma City, OK 73102,
a completed Form 13-16-A, contained in Packet E available
telephonically at (405) 521-3160 or online at www.tax.ok.gov
along with supporting documentation as follows:

(1) A written description of the process in which the
person will be engaged;

(2) Information regarding the permit or approval under
which the person is operating;

(3) Documentation that any nonresident contractor
or subcontractor is in compliance with the registration
requirements found at 68 O.S. § 1701 et. seq.; and

(4) Such additional information as the Commission
may require to confirm eligibility.

(d) Review and determination. Upon receipt of the appli-
cation, the Commission will review and make a determina-
tion as to the applicant's eligibility. Upon approval, a letter certify-
ing the exemption allowed will be forwarded to the applicant.

(e) Denial of certification; cancellation, suspension,
revocation of certification. Certification may be denied,
cancelled, suspended, or revoked by the Commission for
non-compliance with the provisions of this Section, with
applicable Oklahoma tax statutes, or for other good cause
shown. Proceedings related to the cancellation or refusal to
issue a certification pursuant to this Section shall be governed
by 710:1-5-100 and 710:1-5-21 through 710:1-5-49 of the
permanent rules of the Commission.

(f) Use of letter certifying eligibility for the exemption.
Persons claiming exemption under this Section shall provide
their vendors with a copy of the certification letter issued by the
Commission and a signed statement that the purchase is being
made exempt from sales tax. If purchases will be made from
a vendor on a regular basis, the vendor may make subsequent
sales without requiring proof of eligibility for each sale, pro-
viding the person to whom the exempt sales are being made has
agreed in writing to notify the vendor of any and all purchases
which may be made to which the exemption would not apply.
Vendors may accept the certification set out in this subsection
in the same manner as any other letter certifying to a specific
statutory exemption as set out in 710:65-7-6 and 710:65-7-15.

(g) Limitations. Any letter certifying an exemption issued
under this Section is valid only for use by the addressee and is
not transferable. The exemption may not be used by any other
entity, even if that entity claims to be an agent, administrator,
party to a contract or other relationship. Each entity desiring to
obtain a letter certifying an exemption must make application
in its own name.

PART 16. ELECTRONIC GOODS - REFITTING,
REFURBISHING OR REPAIRING

710:65-13-85. Exemption for refitting, refurbishing, or
repairing of consumer electronic goods

(a) Definitions. The following words and terms, when used
in this Section shall have the following meaning, unless the
context clearly indicates otherwise:

(1) "Qualified devices" means certain electronic
consumer goods including but not limited to cell phones,
compact disc players, personal computers, MP3 players,
digital devices for the storage and retrieval of information
through hard-wired or wireless computer or Internet con-
nexions.

(2) "Qualified purchaser" means an entity primarily
engaged in the repair of consumer electronic goods which
purchases from the original manufacturers qualified
devices for refitting, refurbishing or repairing and subse-
quently sells these devices to either retail customers or to
businesses primarily engaged in the sale of the enumerated
qualified devices.

(3) "Qualified purchases" means only tangible per-
sonal property and services directly related to the activity
of refitting, refurbishing, and repairing consumer elec-
tronic goods purchased from the original manufacturer of
the qualified items for subsequent sale or resale. Quali-
fied purchasers may not make exempt purchases for their
regular consumer repair business, for other facets of their
business or for the refitting, repairing, or refurbishing of
consumer electronic goods purchased or acquired from
sources other than the original manufacturer of the quali-
"
(b) **General provisions.** Effective July 1, 2007, Section 1357(40) of Title 68 provides for a sales tax exemption for sales of tangible personal property or services to a business primarily engaged in the repair of consumer electronic goods if the devices are sold to the business by the original manufacturer of such devices and the devices are repaired, refitted, or refurbished for sale by the entity qualifying for the exemption directly to retail customers or if the devices are sold to another business entity for sale to retail customers.

(c) **Application.** Application for exemption may be made by filing a signed, sworn statement with the Taxpayer Assistance Business Tax Services Division of the Oklahoma Tax Commission, which includes:

1. The name, address, and federal employer identification number of the applicant and the name and title of the person signing for the applicant;
2. A complete description of the repair, refitting or refurbishing activities that will take place at the business location;
3. A statement that applicant is primarily engaged in the repair of consumer electronic goods;
4. Identification of the original manufacturers of the consumer electronic goods from which the applicant purchases qualified devices;
5. A statement that applicant, once the consumer electronic goods are refitted, repaired or refurbished, will hold these devices for sale either directly to retail customers or to businesses regularly engaged in selling the qualified devices;
6. The signature of a person authorized to bind the applicant, signed under penalty of perjury before a notary;
7. Copies of written documentation substantiating the purchase of the consumer electronic goods from the original manufacturers of those items along with such additional information as the Taxpayer Assistance Business Tax Services Division may require to confirm eligibility.

(d) **Review and determination.** Upon receipt of the application, the Taxpayer Assistance Business Tax Services Division will review and make a determination as to the applicant's eligibility. Upon approval, certification in the form of a letter or card, of the exemption allowed will be forwarded to the applicant.

(e) **Issuance, scope, limitations of exemption certification.** The certification issued by the Taxpayer Assistance Business Tax Services Division will be effective for a period of twelve (12) months, and may be renewed, subject to annual review and recertification of the applicant's eligibility by the Taxpayer Assistance Business Tax Services Division.

(f) **Denial of certification; cancellation, suspension, revocation of certification.** Certification may be denied, cancelled, suspended, or revoked by the Commission for non-compliance with the provisions of this Section, with applicable Oklahoma tax statutes, or for other good cause shown. Proceedings related to the cancellation or refusal to issue a certification pursuant to this Section shall be governed by 710:1-5-100 and 710:1-5-21 through 710:1-5-49 of the permanent rules of the Commission.

**PART 23. GAS AND ELECTRICITY**

710:65-13-122. **Exemption for sales of electricity for use in a reservoir dewatering project**

(a) **General provisions.** Beginning January 1, 2004, sales of electricity and associated delivery and transmission services, when sold exclusively for use by an oil and gas operator for approved reservoir dewatering projects and associated operations shall be exempt from the levy of sales tax.

(b) **Where to apply.** To qualify for the exemption, the operator of the reservoir dewatering project must apply in writing to the Director's Office, Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Boulevard, Oklahoma City, OK 73107, requesting an exemption letter.

(c) **Contents of the application letter.** The letter of application must set out the name of the operator, the physical location of the project, the Federal Identification Number of the operator, the date the project commenced, and the electric service account number associated with services provided to the project. A copy of the Oklahoma Corporation Commission Order approving the designation of the area and reservoir as a "reservoir dewatering project" or a "reservoir dewatering unit" must accompany the application letter.

(d) **Review and approval procedure.** Upon review and approval, a letter of exemption shall be issued to the operator, who must forward the exemption letter to the electricity utility, to document the sales tax exemption on their purchases of electricity. The letter, when provided to the utility along with a statement by the operator that the purchases of electricity are exempt, shall constitute "properly completed documentation certified by the Oklahoma Tax Commission" as that phrase is used in 710:65-7-6.

(e) **Limitations.** The exemption shall apply to the electricity used in reservoir dewatering projects and associated operations which commenced after June 30, 2003. The exemption shall not apply to the transportation or distribution of the oil or gas once it has been produced.

710:65-13-123. **Exemption for sales of electricity for use in enhanced recovery methods of oil production**

(a) **General provisions.** Beginning July 1, 2006, sales of electricity to the operator of a spacing unit or lease where oil is produced or is attempted to be produced using enhanced recovery methods shall be exempt from the levy of sales tax. Enhanced recovery methods include but are not limited to increased pressure in a producing formation through the use of water or saltwater if the electrical usage is associated with and necessary for the operation of equipment required to inject or circulate fluids in a producing formation for the purpose of forcing oil or petroleum into a wellbore for eventual recovery and production from the wellhead.
(b) **Where to file for exemption.** To qualify for the exemption, the operator of the enhanced recovery methods on a spacing unit or lease must apply in writing to the Director’s Office, Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Boulevard, 123 Robert S Kerr Ave, Oklahoma City, OK 73104-73102, requesting an exemption letter.

c) **Supporting documentation required.** The request must set out the name of the operator, the physical location of the project, the Federal Identification Number, the Federal identification number of the operator, the project number, and the electric service account number associated with services provided to the project and the Production Unit Number and Merge Number of the project. A copy of the application [Form 1535] filed with and approved by the Oklahoma Corporation Commission must accompany the request.

(d) **Review and approval procedure.** Upon review and approval, a letter of exemption shall be issued to the operator, who must forward the exemption letter to the electric utility to document the sales tax exemption on their purchases of electricity. The letter, when provided to the utility along with a statement by the operator that the purchases of electricity are exempt, shall constitute "properly completed documentation certified by the Oklahoma Tax Commission" as that phrase is used in 710:65-7-6.

e) **Eligibility.** In order to be eligible for the exemption set forth in this section, the total content of oil recovered after the use of the enhanced recovery methods must not exceed one percent (1%) by volume.

(f) **Limitations.** The exemption shall apply only to the state sales tax rate and not to any county or municipal sales tax rate.

**PART 25. GOVERNMENTAL ENTITIES**

710:65-13-133. State parks

(a) **General provisions.** Sales of tangible personal property or services, directly used in or for the benefit of a state park, and made to an organization which is exempt from taxation pursuant to the provisions of the Internal Revenue Code, 26 U.S.C., § 501(c)(3) and organized primarily for the purpose of supporting one or more state parks located in this state, are exempt from sales tax.

(b) **Application process.** Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 Lincoln Blvd., Robert S Kerr Ave, Oklahoma City, OK 73104-73102, a completed Form 13-16-A, contained in Packet E, available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with supporting documentation as follows:

1. A letter from the Internal Revenue Service recognizing the organization as exempt from federal income taxation pursuant to 26 U.S.C. § 501(c)(3); and
2. A written description stating the activities of the organization, as evidenced by copies of:
   A. Articles of Incorporation;
   B. By-laws;
   C. Brochure; or

(D) Notarized letter from the President or Chairman of the organization.

**PART 29. MANUFACTURING**

710:65-13-154. Limitation on credits

No qualified establishment, nor its contractors or subcontractors, receiving an incentive payment pursuant to the Oklahoma Quality Jobs Program Act, 68 O.S.§ 3601 et seq., shall be eligible to receive the credit described in 710:65-13-153 or 710:65-13-155, or 710:65-13-156. See: 68 O.S. § 3607.

710:65-13-156. Exemption for "qualified distributor" [REVOKED]

(a) **Qualification.** Sales of construction materials to a qualified distributor to be consumed or incorporated in a new distribution facility or to expand an existing facility are exempt from sales and use tax. For purposes of this exemption, sales made to or for a subcontractor who has previously entered into a contractual relationship with a qualified distributor for construction or expansion of a distribution facility shall be considered sales made to the qualified distributor.

1. "Distribution facility." For purposes of this exemption, means buildings and land improvements used in the general wholesale distribution of groceries as defined or classified in the North American Industry Classification System (NAICS) under Industry No. 4244 and 4245, except that up to ten percent (10%) of the square feet of such building may be devoted to office to provide clerical support for the distribution operation.

2. "Qualified distributor." For purposes of this exemption, means an enterprise:

   A. Whose total cost of construction of a new or expanded facility exceeds the sum of Forty Million Dollars ($40,000,000) and the new or expanded facility adds at least fifty (50) new full-time equivalent employees, as certified by the Employment Security Commission, and such employees are maintained for a period of at least thirty-six (36) months, upon completion of the facility.

   B. Which has at least seventy-five percent (75%) of its total sales to in-state customers or buyers.

   C. Which starts construction of its new or expanded facility on or after July 1, 2005 and before December 31, 2005.

   D. The exemption authorized pursuant to subsection (a) of this Section shall only become effective when the governing body of the municipality in which the enterprises is located approves a resolution expressing the municipality's support for the construction for such new or expanded facility. Upon approval by the municipality, the municipality shall forward a copy of such resolution to the Oklahoma Tax Commission.

3. "Total cost of construction" defined. For purposes of this Section, "total cost of construction" means...
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and includes building and construction materials, and engineering and architectural fees or charges directly associated with the construction of a new or expanded facility, but shall not include attorney fees. It shall also include the cost of all parking, security and dock structures or facilities necessary to manage, process or secure vehicles used to receive and/or distribute groceries through such a facility. For purposes of (a)(2)(A) of this Section the "total cost of construction" shall also include the cost of qualified depreciable property, as defined by Section 2357.4 of Title 68 of the Oklahoma Statutes, and labor services performed in the construction of a new or expanded facility.

(4) The employment requirement. The employment requirement described in this Section can be satisfied by a portion of the required new full-time equivalent employees being employed at a distribution facility related to or supported by the new or expanded distribution facility, so long as both or all facilities are owned by the same person.

(b) Limitations.

(1) The exemption pertains only to sales of tangible personal property consumed or incorporated in the construction of a new manufacturing facility or the expansion of an existing facility made after June 1, 1988. The exemption applies to sales made to a contractor or sub-contractor to be consumed or incorporated in the construction of a new or expanded manufacturing facility pursuant to a contract with a qualified manufacturer as well as to sales made to a qualified manufacturer.

(2) The exemption applies only to tangible personal property that becomes a part of the facility or that is directly consumed in the construction process.

(3) No exemption shall be granted if a qualified distributor fails to file both the documentation required in (a)(1) of this Section and the required certification issued by the Employment Security Commission with the Commission.

(c) Administration. Pursuant to statute, the exemption for sales to a qualified distributor outlined in this Section will be administered as a refund for state and local taxes paid by the qualified distributor to the vendor or, in the case of use tax, remitted to the state of Oklahoma.

(d) Application process.

(1) Application. All persons who believe that they fall within the exemption provided shall file an Application/Intent to Qualify with the Commission. The Application/Intent to Qualify shall be in forms provided by the Commission and shall include, as attachments, specification of the new or expanded manufacturing facility a complete description of the facility to be expanded or newly built, and other information requested by the Commission.

(2) Review. Upon receipt of the Application, the Application will be reviewed by the Commission for completeness and compliance with the exemption. A copy of the application will be forwarded to the Employment Security Commission for establishment of the entities base line employment. The applicant will be notified of any action taken regarding the Application by the Commission.

(e) Claims process.

(1) Records required for claim.

(A) For each purchase made, the entity who believes that it will be certified as a qualified distributor shall file the following documentation with the Commission on forms provided for that purpose by the Commission:

(i) Invoice indicating the amount of state and local taxes billed to the qualified distributor;

(ii) Affidavit of the vendor of the construction materials reflected on the invoice that state and local sales tax reflected on that invoice has not been audited, rebated, or refunded to the qualified manufacturer or the sales tax charge has been collected to the vendor and remitted to the Commission. Any number of invoices from the same vendor may be attached to one affidavit so long as the affidavit covers all invoices attached;

(iii) All additional documentation required to be submitted by the Commission.

(B) In cases where the state and local sales tax was paid by a contractor or sub-contractor who has previously entered into a contract with a qualified distributor, the qualified distributor shall file with the Commission the following:

(i) Invoices indicating the amount of state and local sales taxes billed;

(ii) An affidavit from the contractor or sub-contractor who made the purchase of construction materials reflected on the invoice stating that the sales tax reflected on the attached invoice and claimed by the qualified distributor is based on state and local sales tax paid by the contractor or sub-contractor on construction materials to be consumed or incorporated in a construction of new or expanded construction facility and that the amount of state and local sales tax claimed was paid by the contractor or sub-contractor to the vendor and no credit, refund or rebate has been claimed by the contractor or sub-contractor. Any number of invoices can be attached to an affidavit of a contractor or sub-contractor provided that all invoices attached reflect purchases made by that contractor or sub-contractor and are reflected in the affidavit;

(iii) Additional documentation required by the Commission.

(2) Filing claims. At the option of the entity who believes it will be certified as a qualified manufacturer, the documentation can be filed monthly, quarterly, semi-annually, or annually. Certification issued by the Employment Security Commission must be filed within thirty-six (36) months of the date of first purchase.

(3) Review. The Commission will review the documentation submitted and determine within thirty (30) days whether the refund claimed will be allowed. In the event that the claim is denied, the person who submitted the documentation will be notified by the Commission as to the
reason for denial. The person who submitted the document will similarly be notified that a claim has been approved.

(f) Fiscal procedure. Each month, the Commission shall transfer from sales tax collected the estimated amount of claims approved by the Commission the previous month.

(g) Certification process.

(1) Application review. Upon completion of the new or expanded distribution facility and the addition of the employees as required by statute, the person who believes he falls within the exemption shall apply for certification on forms provided by the Commission. Each application for certification shall be reviewed by the Commission for the purpose of determining that the thresholds required by law have been met. During such time that the Commission is reviewing the application for certification, the Commission will forward a copy of the application for certification to the Employment Security Commission who will review employees hired. Upon completion of the review by the Tax Commission and the Employment Security Commission, the Tax Commission will notify the applicant of the approval or denial of the certification requested.

(2) Approval. The applicant whose certification has been approved shall receive a refund in the amount not to exceed the total amount of state and local sales taxes paid and previously approved by the Tax Commission. The applicant will also receive accrued interest upon the principal amount of the refund made. Provided, no claim for refund shall be filed by a qualified distributor before July 1, 2006. [See: 68 O.S. § 1359.1(C)]

(3) Assessment. If at any time within thirty-six (36) months of the date certification is issued by the Oklahoma Employment Security Commission the number of full-time equivalent employees drops below fifty (50) such employees, any use or sales tax and interest previously refunded to the taxpayer will be assessed against the taxpayer receiving such refund and interest.

(4) Denial of certification: protest procedure.

(A) Any applicant whose request for certification is denied may, within sixty (60) days after the mailing of the denial by the Commission, file with the Commission a protest under oath, signed by the applicant or his duly authorized agent setting out:

(i) a statement of denial as determined by the Commission;

(ii) a statement of the applicant's disagreement with such denial; and

(iii) supporting documentation relied on by the taxpayer in support of certification.

(B) If an applicant fails to file a written protest within the sixty (60) days, then the denial, without further action of the Commission shall become final and no appeal will be entertained.

(C) Applicants filing a protest to the denial of certification by the Commission shall be scheduled for a hearing on or before the Commission for a date, time and place set by the Commission. Notice of the date, time and place will be given by mail at least ten (10) days prior to the hearing.

(D) The burden of proving that the denial of certification was erroneous is on the applicants. The applicant can present testimony, evidence and argument in support of the requested certification.

(E) The Commission will issue an order in each case. That order is directly appealable to the Supreme Court. [See: 68 O.S. § 225]

(F) For further information the applicant should refer to the Rules of Practice and Procedure before the Office of the Administrative Law Judges (710:1-5-1 through 710:1-5-40). [See: 68 O.S. §§ 1359.1, 1404.1]

PART 31. MEDICINE, MEDICAL APPLIANCES, AND HEALTH CARE ENTITIES AND ACTIVITIES

710:65-13-172. Exemption for health centers, indigent health care clinics, certain community-based health care centers, and community mental health centers

(a) Qualification for the exemption for health centers, indigent health care clinics, certain community-based health care centers and community mental health centers. Sales tax does not apply to the sale of tangible personal property or taxable services when sold to:

(1) Any health center as defined in Section 254(b) of Title 42 of the United States Code;

(2) Any clinic receiving disbursements of state monies from the Indigent Health Care Revolving Fund pursuant to the provisions of Section 66 of Title 56 of the Oklahoma Statutes;

(3) Any community-based health center which provides primary care services at no cost to the recipients, and is exempt from taxation pursuant to the provisions of Section 501(c)(3) of the Internal Revenue Code, 26 U.S.C., Section 501(c)(3). For purposes of this Section, "primary care services" means health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians, and where appropriate, physician assistants, nurse practitioners, or other licensed medical professionals; or

(4) Any community mental health center as defined in Section 3-302 of Title 43A of the Oklahoma Statutes. For purposes of this Section, "community mental health center" means a facility offering:

(A) A comprehensive array of community-based mental health services, including, but not limited to, outpatient treatment, emergency evaluation and care, consultation, education, rehabilitation services, and aftercare, and

(B) Certain services at the option of the center, including, but not limited to, inpatient treatment, training programs, and research and evaluation programs.
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(b) **Application process.** Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 123 Robert S Kerr Ave, Oklahoma City, OK 73102, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with the applicable documentation set forth in (c) of this Section:

(c) **Supporting documentation required.**

(1) **Health centers.** Health centers must submit the letter of notification from the U.S. Department of Health and Human Services, recognizing that the center qualifies under Section 254b(a) of Title 42 of the United States Code.

(2) **Clinics receiving disbursements of state monies from the Oklahoma Indigent Health Care Revolving Fund.** Clinics receiving disbursements of state monies from the Oklahoma Indigent Health Care Revolving Fund must submit a copy of the letter or disbursement voucher from the Fund, showing the date the funds were disbursed.

(3) **Community-based health centers.** Community-based health centers must submit the documentation described in (A) through (C) of this paragraph:

(A) A letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income taxation pursuant to 26 U.S.C. § 501(c)(3);

(B) A written description of the primary care services provided must be submitted, stating the activities of the organization, and evidenced by copies of the following, as applicable:

(i) By-laws;

(ii) An audit or other financial statement, showing the types and amounts of revenue received; and

(iii) Intake documents or other forms used to obtain information from clients and which specifically reflect that the primary care services were being provided at no cost to the recipients.

(C) For the purposes of this paragraph, "at no cost to the recipient" means at no cost to either the recipient or any unit of government, or any insurance company, or any other person or entity. Centers which provide primary care services on a "sliding scale" fee schedule do not qualify for the exemption.

(4) **Community mental health centers.** Community mental health centers must submit to the Commission, as part of its application, proof of recognition by the Oklahoma Department of Mental Health and Substance Abuse Services that applicant qualifies as a Community Mental Health Center, along with a written description of the comprehensive array of community-based mental health and other optional services the facility offers, as may be evidenced by copies of:

(A) Articles of incorporation;

(B) By-laws;

(C) Brochure; or

(D) Notarized letter from the President or Chairman of the organization.

(d) **Exemption limited to eligible, properly documented transactions.** Only sales of tangible personal property and services purchased by the organization, invoiced to the organization, and paid for by funds or check directly from the organization will qualify for the exemption described in this Section.

(e) **Purchases by contractors.** Purchases of taxable personal property or services by a contractor, as defined by 68 O.S. § 1352, are taxable to the contractor. A contractor may not purchase tangible personal property or services to perform contracts with qualifying health care organizations exempt from sales tax.

710:65-13-174. Exemption for tax-exempt, independent, nonprofit biomedical research foundations

(a) **Qualification for tax-exempt, independent, nonprofit biomedical research foundations.** Sales of tangible personal property or taxable services to independent, nonprofit biomedical research foundations who are entities qualified pursuant to 26 U.S.C. § 501(c)(3) and who provide educational programs for Oklahoma science students and teachers will be exempt from sales tax.

(b) **Application process.** Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 Lincoln Blvd 123 Robert S Kerr Ave, Oklahoma City, OK 73104 73102, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with supporting documentation as follows:

(1) A letter from the Internal Revenue Service (IRS) recognizing the foundation as exempt from federal income taxation pursuant to 26 U.S.C. § 501(c)(3); and

(2) A written description of the qualifying activities of the foundation, as may be evidenced by copies of:

(A) Articles of incorporation;

(B) By-laws;

(C) Brochure; and

(D) Notarized letter from the President or Chairman of the foundation.

(c) **Exemption limited to eligible, properly-documented transactions.** Only those purchases actually purchased by the foundation, and paid for by funds or check directly from the foundation, will qualify for the exemption described in this Section.

(d) **Purchases by contractors.** Purchases of taxable personal property or services by a contractor, as defined by 68 O.S. § 1352, are taxable to the contractor. A contractor who performs improvements to real property for foundations which qualify for the exemption from sales tax on their purchases described in this Section may not purchase tangible personal property or services to perform the contract exempt from sales tax under the exemption provided by statute to the qualified foundations.
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710:65-13-175. Exemption for tax-exempt, independent, nonprofit community blood banks headquartered in this state

(a) Qualification in general. Sales of tangible personal property or taxable services to tax-exempt, independent, nonprofit community blood banks headquartered in this state are exempt from sales tax.

(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 Lincoln Blvd, 123 Robert S Kerr Ave, Oklahoma City, OK 73104, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with supporting documentation as follows:

1. A letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income taxation pursuant to 26 U.S.C. § 501(c)(3); and
2. A written description of the qualifying criteria that the organization meets, as may be evidenced by copies of:
   (A) Articles of incorporation;
   (B) By-laws;
   (C) Brochure; and
   (D) Notarized letter from the President or Chairman of the organization.

(c) Exemption limited to eligible, properly-documented transactions. Only those purchases actually purchased by the organization, invoiced to the organization, and paid for by funds or check directly from the organization, will qualify for the exemption described in this Section. A vendor wishing to be relieved of liability to collect the tax should follow the requirements of OAC 710:65-7-6 and 710:65-7-15.

(d) Sales under contract. Sales to any person, including contractors and subcontractors, with whom a qualifying organization has duly entered into a construction contract necessary for carrying out such contract are exempt from sales tax.

(e) Documentation and certification required. In the case of sales to a person including contractors and subcontractors claiming exemption pursuant to this Section, the vendor must obtain:

1. A copy of the exemption letter or card issued to the qualified organization;
2. Documentation indicating the contractual relationship between the purchaser and the qualified organization; and
3. Certification by the purchaser, on the face of each invoice or sales ticket, setting out the name of the exempt organization that the purchases are being made for and on behalf of the organization, and that they are necessary for the completion of the contract.

710:65-13-177. Construction projects for organizations providing end-of-life care and hospice service

(a) Qualification for exemption. Sales of tangible personal property and services for use solely on construction projects for organizations exempt from taxation pursuant to the Internal Revenue Code, 26 U.S.C. § 501(c)(3) whose purpose is to provide low income individuals who live in a facility owned by the organization end-of-life care and access to hospice services.

(b) Application process. Application is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd, 123 Robert S Kerr Ave, Oklahoma City, OK 73104, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 or online at www.tax.ok.gov, along with the following information:

1. Letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income taxation pursuant to 26 U.S.C. § 501(c)(3); and
2. A written description stating the activities of the organization, as evidenced by copies of:
   (A) Articles of incorporation;
   (B) By-laws;
   (C) Brochure; or,
   (D) Notarized letter from the President or Chairman of the organization.

(c) Sales to qualified organization limited to eligible, properly-documented transactions. Only sales of goods or services for use solely on construction projects actually purchased by the organization, invoiced to the organization, and paid for by funds or check directly from the organization, will qualify for the exemption described in this Section. A vendor wishing to be relieved of liability to collect the tax should follow the requirements of OAC 710:65-7-6 and 710:65-7-15.

(d) Sales under contract. Sales to any person, including contractors and subcontractors, with whom a qualifying organization has duly entered into a construction contract necessary for carrying out such contract are exempt from sales tax.

(e) Documentation and certification required. In the case of sales to a person including contractors and subcontractors claiming exemption pursuant to this Section, the vendor must obtain:

1. A copy of the exemption letter or card issued to the qualified organization;
2. Documentation indicating the contractual relationship between the purchaser and the qualified organization; and
3. Certification by the purchaser, on the face of each invoice or sales ticket, setting out the name of the exempt organization that the purchases are being made for and on behalf of the organization, and that they are necessary for the completion of the contract.

710:65-13-194. Exemption for sales of tangible personal property and services to a motion picture or television production company to be used or consumed in connection with an eligible production

(a) General provisions. The sale of tangible personal property and services to a motion picture or television production company are exempt from sales and use taxes in Oklahoma, if used or consumed in connection with an eligible production.

(b) Definitions. Pursuant to 68 O.S. §1357(23), "Eligible production" means "a documentary, special, music video, or a television commercial or television program that will serve as a pilot for or be a segment of an ongoing dramatic or situation comedy series, filmed or taped for network or national or regional syndication; or a feature-length motion picture intended for theatrical release or for network or national or regional syndication or broadcast."Qualified purchaser" means a motion picture or television production company making purchases of tangible personal property and services for use in producing an eligible production, which has received an exemption letter for its eligible production.
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710:65-13-210. Exemption for public and private schools and institutions of higher education

(a) Sales to schools. Sales of tangible personal property or services to the following entities are exempt from taxation:

1) Private institutions of higher education.
2) Private elementary and secondary schools.
3) Members of the Oklahoma system of higher education.
4) Public school districts.

(b) Scope of exemption. The exemption in this subsection shall apply only if said institution or school is accredited by the State Department of Education, registered by the State Board of Education for purposes of participating in federal programs or accredited as defined by the Oklahoma State Regents for Higher Education which are exempt from taxation pursuant to 26 U.S.C. § 501(c)(3) of the Internal Revenue Code. Included in sales which are exempt are materials, supplies and equipment used in construction and improvement of buildings owned by said entities and operated for educational services.

(c) Sales by a lease or lease-purchase agreement with a school district. Sales of tangible personal property or services pursuant to a lease or lease-purchase agreement executed between a vendor and a school district are exempt from sales tax.

(d) Sales under public contract. Sales to any public school, institution of the Oklahoma system of higher education and to any person, including subcontractor, whom a public school or institution of the Oklahoma system of higher education has duly entered into a contract pursuant to law necessary for carrying out said contract are exempt from taxation.

(e) Certification required. Certification on the face of the invoice is required of persons making purchases on behalf of an entity listed in (a) of this Section. The invoice containing the certification must be retained by the vendor. Wrongful or erroneous certification may result in criminal punishment.

(f) Campus or school construction. Sales for use on campus or school construction projects for the benefit of either the institutions of the Oklahoma system of higher education, private institutions of higher education accredited by the Oklahoma State Regents for Higher Education, or for public schools or school-districts, are exempt when the projects are financed by or through the use of nonprofit entities exempt from taxation pursuant to the provisions of the Internal Revenue Code 26 U.S.C., § 501(c)(3).

(g) Obtaining exemption for campus or school construction projects. The general contractor shall request a letter of confirmation that the project qualifies for the exemption from the Taxpayer Assistance Business Tax Services Division. Along with the request, the following must be supplied:

1) A letter from the institution confirming that the not-for-profit entity is financing the project and that the requestor is the general contractor for the project.
2) A copy of the IRS letter to the not-for-profit entity showing its exemption status.

(h) Private schools tuition. Tuition and educational fees paid to private institutions of higher education, private elementary and secondary institutions of education duly accredited by the State Board of Education or registered to participate in federal programs are exempt from sales tax. The institution must

PART 39. SCHOOLS AND HIGHER EDUCATION

(c) Examples of exempt items. Items that may be purchased exempt from sales tax by a qualified purchaser include, but are not limited to:

1) Accommodations and meals.
2) Production equipment purchases and rentals.
3) Set construction and rigging materials.
4) Production office equipment and supplies.
5) Prop and wardrobe purchases and rentals.
6) Utilities used by the production company on location and in the production office.

(d) Application process. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2504 Lincoln Blvd, 123 Robert S Kerr Ave, Oklahoma City, OK 73104, a completed Form 13-88, contained in Packet E available telephonically at (405) 521-3160 or online at www.tax.ok.gov.

(e) Review and determination. Upon receipt of the application, the Commission will review and make a determination as to the applicant's eligibility. Upon approval, a letter certifying that the exemption is allowed will be forwarded to the applicant.

(f) Denial of certification; cancellation, suspension, revocation of certification. Certification may be denied, cancelled, suspended, or revoked by the Commission for non-compliance with the provisions of this Section, with applicable Oklahoma tax statutes, or for other good cause shown. Proceedings related to the cancellation or refusal to issue an exemption letter pursuant to this Section shall be governed by 710:1-5-100 and 710:1-5-21 through 710:1-5-49 of the permanent rules of the Commission.

(g) Use of letter certifying eligibility for the exemption. Persons claiming exemption under this Section should provide their vendors with a copy of the certification letter issued by the Commission and a signed statement that the purchase is being made exempt from sales tax. If purchases will be made from a vendor on a regular basis, the vendor may make subsequent sales without requiring proof of eligibility for each sale, providing the person to whom the exempt sales are being made has agreed in writing to notify the vendor of any and all purchases which may be made to which the exemption would not apply. Vendors may accept the certification set out in this subsection in the same manner as any other letter or card certifying to a specific statutory exemption as set out in 710:65-7-6 and 710:65-7-15.

(h) Limitations. Any letter certifying an exemption issued under this Section is valid only for use by the addressee and is not transferable. The exemption may not be used by any other entity, even if that entity claims to be an agent, administrator, party to a contract or other relationship. Each entity desiring to obtain a letter certifying an exemption must make application in its own name.
be exempt from income taxation pursuant to the provisions of 26 U.S.C.A. § 501(c)(3) for this exemption to apply.

(i) **Sales in school cafeterias.** Sales of food in cafeterias or lunchrooms of elementary schools, high schools, colleges or universities which are operated primarily for teachers and pupils are exempt from taxation so long as the cafeteria or lunch room is not operated primarily for the public or for profit. Management companies operating for a profit who contract with a school, college or university to operate a lunchroom or cafeteria will be denied the exemption. Also, sales of food made on school premises but not in a cafeteria or lunchroom do not fall within the exemption provided by statute.

(j) **Sales of admission tickets.** That portion of the gross receipts received from the sale of admission tickets which is for the repayment of money borrowed by an accredited state-supported college or university for the purposes outlined in the statute is exempt from taxation if said amount is:

(1) separately stated on the admission ticket; and

(2) imposed, collected and used for the sole purpose of servicing the debt incurred by the college or university for capital improvements described in the statute.

(k) **Sales by school, student, parent-teacher organizations or associations.** Private schools, public schools, public or private school boards, public school districts, public or private school student organizations and parent-teacher organizations or associations can make sales of tangible personal property exempt from sales tax. Public or private school personnel can make sales for fund-raising projects to benefit the school, school district, school board or student group or organization without collecting and remitting sales tax. For purposes of subsections (k) and (l) tangible personal property includes the sale of admission tickets and concessions at athletic events. [See: 68 O.S. § 1356(13)]

(l) **Sales to, or by, parent-teacher organizations.** Parent-teacher associations and parent-teacher organizations that are exempt from federal income tax pursuant to Section 501(c)(3) of the Internal Revenue Code may make purchases and sales free from the levy of Oklahoma sales taxes.

(m) **Sales to, or by, nonprofit local public or private school foundations.** Nonprofit local public or private school foundations which solicit money or property in the name of any public or private school or public school district may make purchases and sales of tangible personal property exempt from sales tax.

(n) **Sales to career technology student organizations.** Career technology student organizations under the direction and supervision of the Oklahoma Department of Career and Technology Education may make purchases exempt from Oklahoma sales and use taxes and local sales and use taxes.

(o) **Application process.** The entities set forth in (l) through (n) of this Section may make application for exemption by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd, 123 Robert S. Kerr Ave, Oklahoma City, OK 73102, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 and online at www.tax.ok.gov along with the applicable documentation outlined in (p) of this Section.

(p) **Supporting documentation required.**

(1) **Parent-Teacher Associations or Organizations.** Parent-Teacher Associations or Organization Organizations must submit the Internal Revenue Service determination letter recognizing the organization as exempt from federal income taxation pursuant to 26 U.S.C. § 501(c)(3).

(2) **School foundations.** School foundations must submit the documentation described in (A) and (B) of paragraph (2).

(A) A letter from the Internal Revenue Service recognizing the foundation as exempt from federal income taxation pursuant to 26 U.S.C. § 501(c)(3);

(B) A written description of the qualifying activities of the foundation or organization, as may be evidenced by copies of:

(i) Articles of Incorporation;

(ii) By-laws;

(iii) Brochure; and

(iv) Notarized letter from the President or Chairman of the foundation.

(3) **Career Technology School Organizations.** Career Technology School Organizations must submit documentation that the organization is under the direction and supervision of the Oklahoma Department of Career and Technology Education.

710:65-13-220. Exemption for child care facilities which provide on-site universal pre-kindergarten education

(a) **Qualification for child care facilities which provide on-site universal pre-kindergarten education exemption.** Sales of tangible personal property and services to a child care facility, licensed pursuant to the Oklahoma Child Care Facilities Licensing Act which possesses either a 3-star rating from the Department of Human Services Reaching for the Stars Program or a national accreditation and provides on-site universal pre-kindergarten education to four-year-old children through a contractual agreement with any public school or school district are exempt from sales tax.

(b) **Application process.** Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd, 123 Robert S. Kerr Ave, Oklahoma City, OK 73104-73102, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with supporting documentation as follows:

(1) A copy of the Oklahoma Child Care Facility License;

(2) A copy of the 3-star rating Certificate from the Department of Human Services Reaching for the Stars Program or documentation which shows that the entity has a national accreditation; and

(3) A copy of a current year contractual agreement with a public school or school district for provision, by the child care facility, of on-site universal pre-kindergarten education to four-year-old children.

(c) **Sales to child care center limited to eligible, properly-documented transactions.** Only sales of goods or
services actually purchased by the organization, invoiced to the organization, and paid for by funds or check directly from the organization, will qualify for the exemption described in this Section. A vendor wishing to be relieved of liability to collect the tax should follow the requirements of OAC 710:65-7-6 and 710:65-7-15.

(d) **Sales under contract.** Sales to any person, including contractors and subcontractors, with whom a child care center has duly entered into a contract for construction and improvement of buildings and other structures owned by the child care center and operated for education purposes are exempt from sales tax.

(e) **Documentation and certification required.** In the case of sales to a person including contractors and subcontractors claiming exemption pursuant to this Section, the vendor must obtain:

1. A copy of the exemption letter or card issued to the qualified child care center;
2. Documentation indicating the contractual relationship between the purchaser and the qualified child care center; and
3. Certification by the purchaser, on the face of each invoice or sales receipt, setting out the name of the exempt entity, that the purchases are being made on behalf of the entity, and that they are necessary for the completion of the contract.

PART 42. DISABLED VETERANS IN RECEIPT OF COMPENSATION AT THE ONE HUNDRED PERCENT RATE

710:65-13-275. **Exemption for disabled veterans in receipt of compensation at the one hundred percent rate and unremarried surviving spouses of qualifying veterans**

(a) **General provisions for exemption afforded certain veterans.** Sales of tangible personal property or services are exempt from sales tax when made to persons who have been honorably discharged from active service in any branch of the Armed Forces of the United States or Oklahoma National Guard, and who have been certified by the United States Department of Veterans Affairs, or its successor, to be in receipt of compensation at the one hundred percent (100%) rate for a permanent disability sustained through military action or accident or resulting from a disease contracted while in such service. The exemption includes sales to the spouse of such veteran or to a household member where the veteran resides and who is authorized to make purchases on behalf of the veteran in the veteran's absence, so long as the purchase is for the benefit of the qualified veteran.

(b) **General provisions for exemption afforded unremarried surviving spouse of deceased qualifying veteran.** Sales of tangible personal property or services are exempt from sales tax when made to a surviving spouse of a deceased veteran qualifying for the exemption set out in subsection (a) of this Section if the spouse has not remarried. The exemption includes sales to a household member where the surviving spouse of the deceased qualifying veteran resides who is authorized to make purchases on behalf of the spouse in his or her absence, so long as the purchase is for the benefit of the spouse.

(c) **Qualification to receive an exemption card.** To qualify for exemption under this Section and receive an exemption card a veteran or surviving spouse of the qualifying veteran must be an Oklahoma "resident" as defined in 68 O.S. §2353 and submit to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 Lincoln Blvd 123 Robert S. Kerr Ave, Oklahoma City Ok 7310473102 the following information:

1. **Qualifying Veteran.** A letter from the United States Department of Veterans Affairs certifying that the veteran is receiving disability compensation at the 100% rate.
2. **Unremarried surviving spouse.** A letter from the United States Department of Veterans Affairs, Muskogee, OK certifying that the applicant is the unremarried spouse of the qualifying veteran.

(d) **Exemption limitations.** The authorized exemption in this Section is subject to the following limitations:

1. **Disabled veterans in receipt of compensation at the one hundred percent rate.** The authorized exemption for a qualified veteran is limited to Twenty-five Thousand Dollars ($25,000.00) per year of qualifying purchases made by the qualified veteran, spouse or household member authorized to make purchases on behalf of the qualified veteran in the veteran's absence. The Tax Commission may request persons asserting or claiming exemption under this Section to provide a statement executed under oath, that the total sales amounts for which the exemption is applicable have not exceeded the yearly limitation of Twenty-five Thousand Dollars ($25,000.00).

If an exempt sale exceeds the exemption limitation, the sales tax in excess of the limitation shall be treated as a direct sales tax liability and the Tax Commission may recover the tax including penalty and interest by the use of any method authorized by law.

2. **Unremarried surviving spouse of qualifying disabled veteran.** The authorized exemption for the unremarried surviving spouse is limited to One Thousand Dollars ($1,000.00) per year of qualifying purchases made by the qualified surviving spouse. The Tax Commission may request persons asserting or claiming exemption under this Section to provide a statement executed under oath, that the total sales amounts for which the exemption is applicable has not exceeded the yearly limitation of One Thousand Dollars ($1,000.00).

If an exempt sale exceeds the exemption limitation, the sales tax in excess of the limitation shall be treated as a direct sales tax liability and the Tax Commission may recover the tax including penalty and interest by the use of any method authorized by law.

(e) **Qualifying sales.** Sales are exempt if the qualified veteran or surviving spouse has an interest in the funds presented and the purchase is made on his or her behalf, and the qualified veteran's spouse or household member or the surviving spouse's household member authorized to make purchases on behalf of the veteran or surviving spouse in their absence has...
presented the exemption card issued by the Oklahoma Tax Commission.

(f) Denial of exemption by vendor. All vendors shall honor the proof of eligibility for the sales tax exemption to both the qualified veteran, qualified unremarried surviving spouse and persons making purchases for the benefit of the disabled veteran or surviving spouse. Qualifying 100% disabled veterans and qualifying unremarried surviving spouses who have had claims for sales tax exemption denied by vendors may notify the Tax Commission of such denial by submitting to the Compliance Audit Services Division a signed and completed OTC Form 13-37, which is available telephonically at (405) 521-3281 or online at www.tax.ok.gov.

(g) Purchases by contractors. Purchases of tangible personal property or services by a contractor, as defined by 68 O.S. Section 1352 are taxable to the contractor. A contractor who performs improvements to real property for a disabled veteran in receipt of compensation at the one hundred percent (100%) rate or an unremarried surviving spouse of the qualifying veteran who qualifies for the exemption from sales tax on their purchases described in this Section may not purchase tangible personal property or services to perform the contract exempt from sales tax under the exemption provided by statute to disabled veterans in receipt of compensation at the one hundred percent rate.

PART 43. SOCIAL, CHARITABLE, AND CIVIC ORGANIZATIONS AND ACTIVITIES

(a) General provisions. Museums or other entities accredited by the American Alliance of Museums formally the American Association of Museums are exempt from the levy of sales tax on their purchases of tangible personal property and services, and provided that the museum is in compliance with (d)(2) of this Section, on the sales of tickets for admission.

(b) Certification required for purchases. Certification, in which the name of the museum or other accredited entity is set out on the face of the invoice or sales receipt to be obtained and retained by the vendor, is required of persons making purchases on behalf of a qualifying museum or other accredited entity, in order to support the exemption pursuant to OAC 710:65-3-30 and 710:65-3-33.

(c) Application procedure. Application for the exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 Lincoln Blvd, 123 Robert S Kerr Ave, Oklahoma City, OK 73104, 73102, a completed Form 13-16A, contained in Packet E available from the Division at (405) 521-3160, or online at www.tax.ok.gov along with written confirmation that the applicant is currently accredited by the American Alliance of Museums formally the American Association of Museums.

(d) Exemption limited to eligible, properly-documented transactions.

(1) Only those purchases actually purchased by the museum or other accredited entity, invoiced to the museum or entity, and paid for by funds or check directly from the museum or other accredited entity, will qualify for the exemption on purchases.

(2) To qualify for the exemption on sales of admission tickets, the museum must separately state an amount equivalent to the tax which would otherwise have been required to be collected on the face of the admission ticket and must use the amount so stated and so collected solely for the purpose of servicing debt incurred by the museum in the construction, enlargement, or renovation of facilities used or to be used for the entertainment, edification, or cultural cultivation of persons admitted to the museum or facility. The museum or other accredited entity must maintain records adequate to show that the proper amount was collected in lieu of the tax and that those funds were used for purposes of servicing qualifying projects.

(e) Purchases by contractors. Purchases of taxable personal property or services by a contractor, as defined by 68 O.S. § 1352, are taxable to the contractor. A contractor who performs improvements to real property for organizations which qualify for the exemption from sales tax on their purchases described in this Section may not purchase tangible personal property or services to perform the contract exempt from sales tax under the exemption provided by statute to museums and other accredited entities.

710:65-13-335. Limited exemption for organizations which sponsor and promote educational, charitable, and cultural events for disadvantaged children
(a) Qualification for educational, charitable, and cultural events for disadvantaged children exemption. The first $15,000.00 of each calendar year's sales, to or by, organizations which were established to sponsor or promote educational, charitable, or cultural events for disadvantaged children, are exempt from sales tax.

(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 Lincoln Blvd, 123 Robert S Kerr Ave, Oklahoma City, OK 73104, 73102, a completed Form 13-16A, contained in Packet E available telephonically at (405) 521-3160, or online at www.tax.ok.gov and the supporting documentation described in (c) of this Section.

(c) Supporting documentation required. To support the exemption claimed under this Section, the applicant must submit to the Commission, along with the application:

(1) A letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income tax pursuant to 26 U.S.C. § 501(c)(3); and

(2) Documentation showing that the organization was established to sponsor and provide educational, charitable, and cultural events for disadvantaged children, along with a written description of the activities of the organization, as may be evidenced by copies of one or more of the following:

(A) Articles of incorporation;

(B) By-laws;
710:65-13-336. Exemption for Disabled American Veterans, Department of Oklahoma, Inc. and subordinate chapters

(a) General provisions. Disabled American Veterans, Department of Oklahoma, Inc. and its subordinate chapters are exempt from the levy of sales tax on purchases of tangible personal property and services.

(b) Application procedure. Application for exemption is made by submitting to the Taxpayer Assistance—Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., 123 Robert S Kerr Ave, Oklahoma City, OK 73102, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 and online at www.tax.ok.gov along with supporting documentation as follows:

1. A written description stating the activities of the organization, as evidenced by copies of:
   (A) Articles of incorporation;
   (B) By-laws;
   (C) Brochure; or,
   (D) Notarized letter from the President or Chairman of the organization.

(c) Exemption limited to eligible, properly-documented transactions. Only sales of food, food products, or any equipment or supplies used in the preparation of the food or food products purchased by the organization, invoiced to the organization, and paid for by funds or check directly from the organization will qualify for the exemption described in this Section.

(d) Purchases by contractors. Purchase of taxable personal property or services by a contractor, as defined by 68 O.S. § 1352, are taxable to the contractor. A contractor may not purchase tangible personal property or services to perform contracts with qualifying "Meals on Wheels," "Mobile Meals," and similar programs enumerated in 68 O.S. § 1357(13)(a) exempt from sales tax.

710:65-13-338. Qualifications for "Older Americans Act" exemption

(a) Qualification for the Older Americans Act exemption. Sales tax does not apply to the sale of food or food products, or any equipment or supplies used in the preparation of the food or food products, to or by organizations enumerated in 68 O.S. § 1357(13)(b), and which receive federal funding pursuant to the Older Americans Act of 1965, for purposes of providing nutrition programs for the care and benefit of elderly persons.

(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance—Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., 123 Robert S Kerr Ave, Oklahoma City, OK 73104-73102, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 and online at www.tax.ok.gov along with supporting documentation as follows:

1. Letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income taxation pursuant to 26 U.S.C. § 501(c)(3); and,
2. A written description stating the activities of the organization, as evidenced by copies of:
   (A) Articles of incorporation;
   (B) By-laws;
   (C) Brochure;
   (D) Notarized letter from the President or Chairman of the organization.

(c) Exemption limited to eligible, properly-documented transactions. Only sales of food or food products, purchased by the organization, invoiced to the organization, and paid for by funds or check directly from the organization will qualify for the exemption described in this Section.
(a) Sales to volunteer fire departments which are organized under 18 O.S. § 592 are exempt from sales tax. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd. _123 Robert S Kerr Ave, Oklahoma City, OK 73104 73102, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with supporting documentation that the department is registered with the Oklahoma Secretary of State.
(b) A vendor shall obtain the documentation set out in OAC 710:65-7-15 in order to be relieved of liability for sales tax on such sales.
(c) Additionally, volunteer fire departments which are organized under 18 O.S. Section 592 are exempt from having to charge sales tax on the first Fifteen Thousand Dollars ($15,000.00) of sales per year which are made for the purpose of raising funds for the benefit of the department, provided the sales are made on no more than six days per year. [68 O.S. § 1356(19)]

710:65-13-341. Exemption for Council organizations or similar state supervisory organizations of Boy Scouts of America, Girl Scouts of U.S.A., and Camp Fire USA
(a) General provisions. Council and state supervisory organizations of the Boy Scouts of America, Girl Scouts of U.S.A., and Camp Fire USA are exempt from the levy of sales tax on purchases of tangible personal property and services. Dens, packs, troops, or similar groups affiliated with a council or state supervisory organization of the Boy Scouts of America, Girl Scouts of U.S.A., or Camp Fire USA are not included within the scope of the exemption described in this Section.
(b) Application procedure. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd. _123 Robert S Kerr Ave, Oklahoma City, OK 73104 73102, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with a determination letter or group ruling from the Internal Revenue Service.

710:65-13-342. Qualifications for "Juvenile Rehabilitation" exemption
(a) Qualification for the Juvenile Rehabilitation exemption. Sales tax does not apply to the sale of goods or services to organizations which take court-adjudicated juveniles for purposes of rehabilitation and which are exempt from taxation pursuant to the provisions of the Internal Revenue Code, 26 U.S.C., Section 501(c)(3). However, at least fifty percent (50%) of the juveniles served by the organization must be court-adjudicated and the organization must receive state funds in an amount which is less than ten percent (10%) of the annual budget of the organization.

(d) Purchases by contractors. Purchases of taxable personal property or services by a contractor, as defined by 68 O.S. § 1352, are taxable to the contractor. A contractor may not purchase tangible personal property or services to perform contracts with qualifying "Older Americans Act" organizations exempt from sales tax.

(a) Qualification for Collection and Distribution Organization exemption. Sales tax does not apply to the sale of tangible personal property or services to or by organizations exempt from taxation pursuant to 26 U.S.C. § 501(c)(3) and:
1. are primarily involved in the collection and distribution of food and household products to other organizations that facilitate the distribution of such products to the needy and such distributee organizations are exempt from taxation pursuant to 26 U.S.C. § 501(c)(3) or
2. facilitate the distribution of such products to the needy.
(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd. _123 Robert S Kerr Ave, Oklahoma City, OK 73104 73102, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with supporting documentation as follows:
1. Letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income taxation pursuant to 26 U.S.C. § 501(c)(3);
2. A written description stating the activities of the organization, as evidenced by copies of:
   (A) Articles of incorporation;
   (B) By-laws;
   (C) Brochure; or,
   (D) Notarized letter from the President or Chairman of the organization; and,
3. For organizations described in (a)(1) a list of organizations, including federal employer identification numbers, to which items were distributed for the previous calendar year must also be provided.
(c) Exemption limited to eligible, properly documented transactions. Only sales of food, food products, and household products, purchased by the organization, invoiced to the organization, and paid for by funds or check directly from the organization will qualify for the exemption described in this Section.
(d) Other limitations. The exemption set out in this Section does not apply to sales made in the course of business for profit or savings, competing with other persons engaged in the same or similar business.
(e) Purchases by contractors. Purchases of taxable personal property or services by a contractor, as defined by 68 O.S. § 1352 are taxable to the contractor. A contractor may not purchase tangible personal property or services to perform contracts with qualifying "Collection and Distribution Organizations" exempt from sales tax.
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(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., Oklahoma City, OK 73102, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with the following information:

(1) Letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income tax pursuant to 26 U.S.C. § 501(c)(4); and,
(2) A written description stating the activities of the organization, as evidenced by copies of:
   (A) Articles of incorporation;
   (B) By-laws;
   (C) Brochure; or,
   (D) Notarized letter from the President or Chairman of the organization.

(c) Exemption limited to eligible, properly-documented transactions. Only the first $15,000 of either sales or purchases of the organization are exempt. The organization must keep accurate records to enable it to properly document the exemption on its purchases and to know when it is required to charge sales tax on its sales. If sales tax is collected by the organization on sales which could have been exempt under the provisions of this Section, the sales tax must be remitted to the Oklahoma Tax Commission. Only those purchases actually purchased by the organization, invoiced to the organization, and paid for by funds or check directly from the organization, will qualify for the exemption described in this Section.

(d) Purchases by contractors. Purchases of taxable personal property or services by a contractor, as defined by 68 O.S. § 1352, are taxable to the contractor. A contractor may not purchase tangible personal property or services to perform contracts with qualifying organizations exempt from sales tax.

710:65-13-344. Exemption for tax exempt, nonprofit organizations, which provide services during the day to homeless persons.

(a) Qualification for tax-exempt, nonprofit organizations which provide services during the day to homeless person exemption. Sales of tangible personal property to a nonprofit organization exempt from income tax pursuant to the provisions of the Internal Revenue Code, 26 U.S.C. Section 501(c)(3), which is organized primarily for the purpose of providing services to homeless persons during the day and located in a metropolitan area with a population in excess of five hundred thousand (500,000) persons according to the latest Federal Decennial Census are exempt from sales tax.

(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., Oklahoma City, OK 73102, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with the following information:

(1) A letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income tax pursuant to 26 U.S.C. Section 501(c)(3); and,
(2) Documentation showing that the organization was established to provide services to homeless persons during the day and is located in a metropolitan area with a population in excess of five hundred thousand (500,000) persons according to the latest Federal Decennial Census. Also, a
written description of the services of the organization, as may be evidenced by copies of:

(A) Articles of incorporation;
(B) By-laws;
(C) Brochure; or
(D) Notarized letter from the President or Chairman of the organization.

(c) Exemption limited to eligible, properly-documented transactions. Only those purchases actually purchased by the organization, invoiced to the organization, and paid for by funds or check directly from the organization, will qualify for the exemption described in this Section.

(d) Purchases by contractors. Purchases of tangible personal property by a contractor, as defined by 68 O.S. Section 1352, are taxable to the contractor. A contractor who performs improvements to real property for organizations which qualify for the exemption from sales tax on their purchases described in this Section may not purchase tangible personal property or services to perform the contract exempt from sales tax under the exemption provided by statute to the qualified organizations.

710:65-13-345. Exemption for tax exempt organizations, which provide funding for the preservation of wetlands or habitats for wild ducks or preservation and conservation of wild turkeys

(a) Qualifications for exemption. Sales of tangible personal property or services are exempt from sales tax when made to or by an organization exempt from income taxation pursuant to the provisions of the Internal Revenue Code, 26 U.S.C. Section 501(c)(3), for events the principal purpose of which is to provide funding for the preservation of wetlands and habitats for wild ducks or preservation and conservation of wild turkeys.

(b) Exemption limited to eligible, properly-documented transactions. Only those purchases or sales which are made for an event, the principal purpose of which is to provide funding for the preservation of wetlands and habitats for wild ducks and/or the preservation and conservation of wild turkeys will qualify for the exemption described in this Section.

(c) Application process. Application is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., 123 Robert S. Kerr Ave., Oklahoma City, OK 73104-73102, a completed Form 13-16-A, contained in Packet E available telephonically at 405-521-3160 or online at www.tax.ok.gov, along with the following information:

1. Letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income taxation pursuant to 26 U.S.C. § 501(c)(3); and,
2. A written description stating the activities of the organization, as evidenced by copies of:
   (A) Articles of incorporation;
   (B) By-laws;
   (C) Brochure; or
   (D) Notarized letter from the President or Chairman of the organization.

(d) Purchases by contractors. Purchase of taxable personal property or services by a contractor, as defined by 68 O.S. § 1352, are taxable to the contractor. A contractor may not purchase tangible personal property or services to perform contracts with qualifying organizations enumerated in 68 O.S. §1356(55) & (56) exempt from sales tax.

710:65-13-346. Exemption for tax exempt organizations which are a part of a network of community-based, autonomous member organizations providing job training and employment services

(a) Qualifications for exemption. Sales of tangible personal property or services are exempt from sales tax when made to an organization, exempt from income taxation pursuant to Section 501(c)(3) of the Internal Revenue Code, which is a part of a network of community-based, autonomous member organizations provided that the organization meets the following criteria;

1. Serves people with workplace disadvantages and disabilities by providing job training and employment services, as well as job placement opportunities and post-employment support,
2. Has locations in the United States and at least twenty other countries,
3. Collects donated clothing and household goods to sell in retail stores and provides contract labor services to business and government, and
4. Provides documentation to the Oklahoma Tax Commission that over seventy-five percent (75%) of its revenues are channeled into employment, job training and placement programs and other critical community services.

(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., 123 Robert S. Kerr Ave., Oklahoma City, OK 73104-73102, a completed Form 13-16-A, contained in Packet E available telephonically at 405-521-3160 or online at www.tax.ok.gov along with supporting documentation as follows:

1. Letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income taxation pursuant to 26 U.S.C. Section 501(c)(3);
2. A written description stating the activities of the organization which shows that the applicant meets the criteria set out in subsection (a) above as evidenced by copies of:
   (A) Articles of incorporation;
   (B) By-laws;
   (C) Brochure; or
   (D) Notarized letter from the President or Chairman of the organization.

(c) Exemption limited to eligible, properly documented transactions. Only sales of tangible personal property or services, purchased by the organization, invoiced to the organization, and paid for by funds or checks directly from the organization, invoiced to the organization, and paid for by funds or checks directly from the organization.
organization, will qualify for the exemption described in this Section.

(d) Purchases by contractors. Purchases of tangible personal property or services by a contractor, as defined by 68 O.S. § 1352, are taxable to the contractor. A contractor who performs improvements to real property for organizations which qualify for the exemption from sales tax on their purchases described in this Section may not purchase the tangible personal property or services to perform the contract exempt from sales tax under the exemption provided by statute to the qualified organizations.

710:65-13-348. Limited exemption for qualified neighborhood watch organizations

(a) Qualification for exemption. Effective July 1, 2005, the first $2,000 of each calendar year's sales of tangible personal property or services, to, by, or for the benefit of a qualified neighborhood watch organization that is endorsed or supported by or working directly with a law enforcement agency with jurisdiction in the area in which the neighborhood watch organization is located are exempt from sales tax. For purposes of this exemption "qualified neighborhood watch organization" means an organization that is a not-for-profit corporation under the laws of the State of Oklahoma that was created to help prevent criminal activity in an area through community involvement and interaction with local law enforcement and which is one of the first two thousand organizations which makes application to the Oklahoma Tax Commission for the exemption after the effective date of the act.

(b) Application process. Only the first two thousand applications received by the Oklahoma Tax Commission are eligible for exemption. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., 123 Robert S Kerr Ave, Oklahoma City, OK 73114-73102, a completed Form 13-16-A, contained in Packet E, available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with supporting documentation as follows:

(1) Documentation showing that the organization is a not-for-profit corporation under the laws of Oklahoma established to help prevent criminal activity in a specific area through community involvement and interaction with local law enforcement, as may be evidenced by copies of one or more of the following:

   (A) Articles of incorporation;
   (B) By-laws;
   (C) Other documents that show the intent of the incorporators at the time of incorporation.

(2) Documentation showing that the organization is either endorsed, supported by or working directly with a law enforcement agency that has jurisdiction in the area where the neighborhood watch is located. Documentation may consist of membership lists, notices or minutes of meetings or letters from the applicable law enforcement agencies concerning their support, endorsement or involvement with the organization.

(3) A description of the boundaries of the area in which the neighborhood watch organization is located.

(4) The name and address of the person representing the organization to whom the exemption card will be mailed and who will be responsible for keeping track of the sales made to, by, or for the benefit of the organization so that the annual limit of $2,000 will not be exceeded by the organization.

(c) Exemption limited to eligible, properly-documented transactions. Only the first $2,000 of either sales to, by or on behalf of the organization are exempt. The organization must keep accurate records to enable it to properly document the exemption. The exemption documentation that vendors are required to obtain on purchases to, or for the benefit of the organization is set out in 710:65-7-17.

(d) Purchases by contractors. Purchases of tangible personal property or services by a contractor, as defined by 68 O.S. § 1352, are taxable to the contractor. A contractor who performs improvements to real property for organizations which qualify for the exemption from sales tax on their purchases described in this Section may not purchase tangible personal property or services to perform the contract exempt from sales tax under the exemption provided by statute to the qualified organizations.

(e) Review and determination. Upon receipt of the application, the Commission will review and make a determination as to the applicant's eligibility. Upon approval, an exemption card will be sent to the applicant.

(f) Denial of exemption; cancellation, suspension, revocation of exemption card. The exemption may be denied, and the exemption card cancelled, suspended, or revoked by the Commission for non-compliance with the provisions of this Section, with applicable Oklahoma tax statutes, or for other good cause shown. Proceedings related to the cancellation or refusal to issue a certification pursuant to this Section shall be governed by 710:1-5-100 and 710:1-5-21 through 710:1-5-49 of the permanent rules of the Commission.


(a) General provisions. Sales of tangible personal property or services to or by the Daughters of the American Revolution are exempt from sales tax.

(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., 123 Robert S Kerr Ave, Oklahoma City, OK 73114-73102, a completed Form 13-16-A, contained in Packet E, available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with supporting documentation as follows:

(1) Written confirmation that the applicant is currently recognized as an Oklahoma chapter of the Daughters of the American Revolution; and

(2) A written description stating the activities of the organization, as evidenced by copies of:

   (A) Articles of incorporation;
   (B) By-laws;
   (C) Brochure; or
(D) Notarized letter from the President or Chairman of the organization.

(c) Exemption limited to eligible, properly-documented transactions. Only property or services actually purchased by the organization, invoiced to the organization, and paid for by funds or check directly from the organization, will qualify for the exemption described in this Section.

(d) Purchases by contractors. Purchases of taxable personal property or services by a contractor, as defined by 68 O.S. Section 1352, are taxable to the contractor. A contractor who performs improvements to real property for organizations which qualify for the exemption from sales tax on their purchases described in this Section may not purchase tangible personal property or services to perform the contract exempt from sales tax under the exemption provided by statute to the qualified organizations.

710:65-13-351. Exemption for Veterans of Foreign Wars, Department of Oklahoma, Inc. and subordinate posts

(a) General provisions. Sales of tangible personal property or services to or by the Veterans of Foreign Wars, Department of Oklahoma, Inc. and its subordinate posts are exempt from sales tax.

(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance—Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., Oklahoma City, OK 73102, a completed Form 13-16-A, contained in Packet E, available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with supporting documentation as follows:

(1) A letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income tax pursuant to 26 U.S.C. § 501(c)(19);

(2) Written confirmation that the applicant is currently recognized as a post of the Veterans of Foreign Wars, Department of Oklahoma, Inc.; and

(3) A written description stating the activities of the organization, as evidenced by copies of:

(A) Articles of incorporation;

(B) By-laws;

(C) Brochure; or

(D) Notarized letter from the President or Chairman of the organization.

(c) Exemption limited to eligible, properly-documented transactions. Only property or services actually purchased by the organization, invoiced to the organization, and paid for by funds or check directly from the organization, will qualify for the exemption described in this Section.

(d) Purchases by contractors. Purchases of taxable personal property or services by a contractor, as defined by 68 O.S. Section 1352, are taxable to the contractor. A contractor who performs improvements to real property for organizations which qualify for the exemption from sales tax on their purchases described in this Section may not purchase tangible personal property or services to perform the contract exempt from sales tax under the exemption provided by statute to the qualified organizations.

710:65-13-352. Exemption for YWCA or YMCA organizations

(a) General provisions. Sales of tangible personal property or services to or by YWCA or YMCA organizations are exempt from sales tax.

(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance—Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., Oklahoma City, OK 73102, a completed Form 13-16-A, contained in Packet E, available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with supporting documentation as follows:

(1) Written confirmation that the applicant is currently recognized as part of a national nonprofit community service organization meeting the health and social service needs of its members; and

(2) A written description stating the activities of the organization, as evidenced by copies of:

(A) Articles of incorporation;

(B) By-laws;

(C) Brochure; or

(D) Notarized letter from the President or Chairman of the organization.

(c) Exemption limited to eligible, properly-documented transactions. Only property or services actually purchased by the organization, invoiced to the organization, and paid for by funds or check directly from the organization, will qualify for the exemption described in this Section.

(d) Purchases by contractors. Purchases of taxable personal property or services by a contractor, as defined by 68 O.S. Section 1352, are taxable to the contractor. A contractor who performs improvements to real property for organizations which qualify for the exemption from sales tax on their purchases described in this Section may not purchase tangible personal property or services to perform the contract exempt from sales tax under the exemption provided by statute to the qualified organizations.

710:65-13-353. Exemption for organizations primarily engaged in providing educational services and programs concerning health-related diseases and conditions

(a) Qualification for organizations primarily engaged in providing educational services and programs concerning health-related diseases and conditions exemption. Sales of tangible personal property or services to an organization primarily engaged in providing educational services and programs concerning health-related diseases and conditions to individuals suffering from such health-related diseases and conditions, their caregivers and family members, or in health-related research of such diseases and conditions, or both, are exempt from sales tax. However, in order to qualify, such organization must itself be a member of a tax-exempt organization that is primarily engaged in advancing the purposes
of its member organizations through fundraising, public awareness or other efforts for the benefit of its member organizations.

(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance—Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., 123 Robert S Kerr Ave, Oklahoma City, OK 73102, a completed Form 13-16-A, contained in Packet E, available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with supporting documentation as follows:

(1) A letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income taxation pursuant to 26 U. S. C. § 501(c)(3);
(2) Proof of membership in a tax-exempt organization primarily engaged in advancing the purposes of its member organization, including a description of the activities of the membership organization; and
(3) Documentation showing that the organization is primarily engaged either in providing educational services, programs or support concerning health-related diseases and conditions to individuals suffering from such diseases or their caregivers and family members and or health-related research of such diseases or conditions, along with a written description of the activities of the organization, as may be evidenced by copies of one or more of the following:

   (A) Articles of incorporation;
   (B) By-laws;
   (C) Brochure; or
   (D) Notarized letter from the President or Chairman of the organization.

(c) Exemption limited to eligible, properly-documented transactions. Only property or services actually purchased by the organization, invoiced to the organization, and paid for by funds or check directly from the organization, will qualify for the exemption described in this Section.

(d) Purchases by contractors. Purchases of taxable personal property or services by a contractor, as defined by 68 O.S. Section 1352, are taxable to the contractor. A contractor may not purchase tangible personal property or services to perform contracts with qualifying organizations exempt from sales tax.

710:65-13-354. Exemption for organizations whose purpose is to provide training and education to developmentally disabled persons

(a) Qualification for organizations whose purpose is to provide training and education to developmentally disabled persons. Sales to or by qualifying organizations of tangible personal property and services to be used exclusively for charitable or educational purposes are exempt from sales tax. To qualify an organization must be exempt from taxation pursuant to Section 501(c)(3) of the Internal Revenue Code and must be organized for the purpose of providing training and education to developmentally disabled individuals; educating the community about the rights, abilities and strengths of developmentally disabled individuals; promoting unity among developmentally disabled individuals in their community and geographic area.

(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance—Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., 123 Robert S Kerr Ave, Oklahoma City, OK 73102, a completed Form 13-16-A, contained in Packet E, available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with supporting documentation as follows:

(1) A letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income taxation pursuant to 26 U. S. C. § 501(c)(3);
(2) Proof of Not-for-Profit Certificate of Incorporation in Oklahoma; and
(3) Documentation showing that the organization is organized for the purpose of providing training and education to developmentally disabled individuals, educating the community about the rights, abilities and strengths of developmentally disabled individuals and promoting unity among developmentally disabled individuals in their community and geographic area, along with a written description of the activities of the organization, as may be evidenced by copies of one or more of the following:

   (A) Articles of incorporation;
   (B) By-laws;
   (C) Brochure; or
   (D) Notarized letter from the President or Chairman of the organization which states the services provided by the organization.

(c) Purchases by contractors. Purchases of taxable personal property or services by a contractor, as defined by 68 O.S. Section 1352, are taxable to the contractor. A contractor may not purchase tangible personal property or services to perform contracts with qualifying organizations exempt from sales tax.

710:65-13-355. Exemption for shelters for abused, neglected, or abandoned children from birth to age eighteen

(a) Qualification for shelters for abused, neglected, or abandoned children from birth to age eighteen. Sales of tangible personal property and services to an organization exempt from taxation pursuant to Section 501(c)(3) of the Internal Revenue Code, which is a shelter for abused, neglected, or abandoned children from birth to age eighteen, are exempt from sales tax and after July 1, 2008, the exemption shall apply to eligible shelters for children from birth to age eighteen.

(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance—Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., 123 Robert S Kerr Ave, Oklahoma City, OK 73102, a completed Form 13-16-A, contained in Packet E, available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with supporting documentation as follows:
(1) A letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income taxation pursuant to 26 U.S.C. § 501(c)(3); and

(2) Documentation showing that the organization is a shelter for abused, neglected, or abandoned children from birth to twelve or beginning July 1, 2008 is a shelter for children from birth to age eighteen.

(3) A written description of the activities of the organization, as may be evidenced by copies of one or more of the following:
   (A) Articles of incorporation;
   (B) By-laws;
   (C) Brochure;
   (D) Intake documents or other forms used to obtain information from clients which specifically reflect age of children and reason for being sheltered; or
   (E) Notarized letter from the President or Chairman of the organization which states the services provided by the organization.

(c) **Exemption limited to eligible, properly-documented transactions.** Only sales of goods or services actually purchased by the organization, invoiced to the organization, and paid for by funds or check directly from the organization, will qualify for the exemption described in this Section.

(d) **Purchases by contractors.** Purchases of taxable personal property or services by a contractor, as defined by 68 O.S. Section 1352, are taxable to the contractor. A contractor may not purchase tangible personal property or services to perform contracts with qualifying organizations exempt from sales tax.

710:65-13-357. Organizations providing funding for scholarships in the medical field

(a) **Qualification for exemption.** Sales tax does not apply to the sale of food and snacks items to or by organizations exempt from taxation pursuant to Internal Revenue Code, 26 U.S.C., Section 501(c)(3) who primary and principal purpose is providing funding for scholarships in the medical field.

(b) **Application process.** Application is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., Oklahoma City, OK 73121-473102, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 or online at www.tax.ok.gov, along with the following information:

   (1) Letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income taxation pursuant to 26 U.S.C. § 501(c)(3); and,

   (2) A written description stating the activities of the organization, as evidenced by copies of:
      (A) Articles of incorporation;
      (B) By-laws;
      (C) Brochure; or
      (D) Notarized letter from the President or Chairman of the organization.

(c) **Exemption limited to eligible, properly documented transactions.** Only sales of food or snack items, purchased by the organization, invoiced to the organization, and paid for by funds or check directly from the organization, will qualify for the exemption described in this Section.

(d) **Purchases by contractors.** Purchase of taxable personal property or services by a contractor, as defined by 68 O.S. § 1352, are taxable to the contractor. A contractor may not purchase tangible personal property or services to perform contracts with qualifying organizations exempt from sales tax.

710:65-13-359. Nonprofit foundations supporting NRA and other like organizations

(a) **Qualifications for exemption.** Sales of property to a nonprofit foundation which raises tax deductible contributions in support of a wide range of firearms related public interest activities of the National Rifle Association of America and other...
organizations that defend and foster the Second Amendment are exempt from sales tax.

(b) Application process. Application is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., 123 Robert S. Kerr Ave., Oklahoma City, OK 73104 73102, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 or online at www.tax.ok.gov, along with the following information:

(1) A letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income taxation pursuant to 26 U.S.C. § 501(c)(3); and

(2) A written description of the qualifying activities of the foundation or organization, as may be evidenced by copies of:

(A) Articles of incorporation;
(B) By-laws;
(C) Brochure; and
(D) Notarized letter from the President or Chairman of the foundation or organization.

c) Exemption limited to eligible, properly documented transactions. Only property purchased by the foundation/organization, invoiced to the foundation/organization, and paid for by funds or check directly from the foundation/organization will qualify for the exemption described in this Section.

d) Purchases by contractors. Purchase of taxable personal property or services by a contractor, as defined by 68 O.S. § 1352, are taxable to the contractor. A contractor may not purchase tangible personal property or services to perform contracts with qualifying foundations/organizations enumerated in 68 O.S. §1356(74)(a) exempt from sales tax.

710:65-13-360. Grassroots fundraising programs supporting the NRA

(a) Qualification for exemption. Sales of property to or by grassroots fund raising programs related to events to raise funds for nonprofit foundations which raise tax deductible contributions in support of firearms related public interest activities of the National Rifle Association are exempt from sales tax.

(b) Exemption limited to eligible, properly documented transactions. Only those purchases or sales which are made in relation to events to raise funds for nonprofit foundations which raise tax deductible contributions in support of firearms related public interest activities of the National Rifle Association will qualify for the exemption described in this Section.

c) Application process. Application is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., 123 Robert S. Kerr Ave., Oklahoma City, OK 73104 73102, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 or online at www.tax.ok.gov, along with a written description stating the activities of the organization, as evidenced by copies of:

(1) Articles of incorporation;
(2) By-laws;
(3) Brochure; or,

(4) Notarized letter from the President or Chairman of the organization.

710:65-13-362. Exemption for Boys & Girls Clubs of America affiliates

(a) General provisions. Sales of tangible personal property or services to any Boys & Girls Clubs of America affiliate in Oklahoma which is not affiliated with the Salvation Army and which is exempt from taxation pursuant to the Internal Revenue Code, 26 U.S.C. § 501(c)(3) are exempt from sales tax.

(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., 123 Robert S. Kerr Ave., Oklahoma City, OK 73104 73102, a completed Form 13-16-A, contained in Packet E, available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with supporting documentation as follows:

(1) Letter from the Internal Revenue Service recognizing the organization as exempt from federal income taxation pursuant to 26 U.S.C. § 501(c)(3); and

(2) Documentation verifying that the applicant club is not affiliated with the Salvation Army.

710:65-13-363. Exemption for the National Guard Association of Oklahoma

(a) General provisions. Effective July 1, 2018, sales of tangible personal property or services to or by an association which is exempt from taxation pursuant to 26 U.S.C. § 501(c)(19) and which is known as the National Guard Association of Oklahoma are exempt from sales tax.

(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., 123 Robert S. Kerr Ave., Oklahoma City, OK 73104 73102, a completed Form 13-16-A, contained in Packet E, available online at www.tax.ok.gov along with supporting documentation as follows:

(1) A letter from the Internal Revenue Service recognizing the organization as exempt from federal income taxation pursuant to 26 U.S.C. § 501(c)(19); and

(2) Written confirmation that the applicant is currently recognized as the National Guard Association of Oklahoma.

c) Exemption limited to eligible, properly-documented transactions. Only property or services actually purchased by the organization, invoiced to the organization, and paid for by funds or check directly from the organization, will qualify for the exemption described in this Section.

d) Purchases by contractors. Purchases of tangible personal property or services by a contractor, as defined by 68 O.S. § 1352, are taxable to the contractor. A contractor who performs improvements to real property for organizations which qualify for the exemption from sales tax on their purchases described in this Section may not purchase tangible personal property or services to perform the contract exempt from sales tax.
tax under the exemption provided by statute to the qualified organizations.


(a) General provisions. Effective July 1, 2018, sales of tangible personal property or services to or by an association which is exempt from taxation pursuant to 26 U.S.C. § 501(c)(4) and which is known as the Marine Corps League of Oklahoma are exempt from sales tax.

(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., 123 Robert S Kerr Ave., Oklahoma City, OK 73104 73102, a completed Form 13-16-A, contained in Packet E available online at www.tax.ok.gov along with supporting documentation as follows:

(1) Letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income taxation pursuant to Section 501(c)(3);
(2) Written confirmation that the applicant is currently recognized as the Marine Corps League of Oklahoma.

(c) Exemption limited to eligible, properly-documented transactions. Only sales of tangible personal property or services, purchased by the organization, invoiced to the organization, and paid for by funds or checks directly from the organization, will qualify for the exemption described in this Section.

(d) Purchases by contractors. Purchases of tangible personal property or services by a contractor, as defined by 68 O.S. § 1352, are taxable to the contractor. A contractor who performs improvements to real property for organizations which qualify for the exemption from sales tax on their purchases described in this Section may not purchase tangible personal property or services to perform the contract exempt from sales tax under the exemption provided by statute to the qualified organizations.

710:65-13-365. Exemption for tax exempt organizations which operate as a collaborative model which connects community agencies to serve individuals and families affected by violence

(a) Qualifications for exemption. Effective November 1, 2017, sales of tangible personal property or services are exempt from sales tax when made to an organization exempt from income taxation pursuant to Section 501(c)(3) of the Internal Revenue Code that operates as a collaborative model which connects community agencies in one location to serve individuals and families affected by violence and where victims have access to services and advocacy at no cost to the victim. For the purposes of this paragraph, "at no cost to the recipient" means at no cost to either the recipient or any unit of government, or any insurance company, or any other person or entity. Organizations which provide services on a "sliding scale" fee schedule do not qualify for the exemption.

(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., 123 Robert S Kerr Ave., Oklahoma City, OK 73104 73102, a completed Form 13-16-A, contained in Packet E available online at www.tax.ok.gov along with supporting documentation as follows:

(1) Letter from the Internal Revenue Service (IRS) recognizing the organization as exempt from federal income taxation pursuant to Section 501(c)(3).
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(2) A written description stating the activities of the organization which shows the applicant meets the criteria set out in subsection (a) above as evidenced by copies of:
   (A) Articles of incorporation;
   (B) By-laws;
   (C) Brochure;
   (D) Letter from the MIT Fab Foundation verifying the organization is an official member of the Fab Lab Network and in compliance with the Fab Charter.

(c) Exemption limited to eligible, properly documented transactions. Only sales of tangible personal property or services, purchased by the organization, invoiced to the organization, and paid for by funds or checks directly from the organization, will qualify for the exemption described in this Section.

(d) Purchases by contractors. Purchases of tangible personal property or services by a contractor, as defined by 68 O.S. § 1352, are taxable to the contractor. A contractor who performs improvements to real property for organizations which qualify for the exemption from sales tax on their purchases described in this Section may not purchase the tangible personal property or services to perform the contract exempt from sales tax under the exemption provided by statute to the qualified organizations.

710:65-13-367. Exemption for the American Legion
(a) Qualifications for exemption. Sales of tangible personal property or services are exempt from sales tax when made to the American Legion, whether the purchase is made by the entity chartered by the United States Congress or is an entity organized under the laws of this or another state pursuant to the authority of the national American Legion organization.
(b) Application process. Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., Robert S Kerr Ave, Oklahoma City, OK 73104, a completed Form 13-16-A, contained in Packet E available online at www.tax.ok.gov along with supporting documentation as follows:
   (1) Documentation that the applicant is the entity chartered as the American Legion by the U.S. Congress;
   (2) Proof the applicant is organized under the laws of Oklahoma or another state pursuant to the authority of the national American Legion organization;
   (3) Written confirmation the applicant is currently recognized as an organization of the American Legion.
(c) Exemption limited to eligible, properly documented transactions. Only sales of tangible personal property or services, purchased by the organization, invoiced to the organization, and paid for by funds or checks directly from the organization, will qualify for the exemption described in this Section.
(d) Purchases by contractors. Purchases of tangible personal property or services by a contractor, as defined by 68 O.S. § 1352, are taxable to the contractor. A contractor who performs improvements to real property for organizations which qualify for the exemption from sales tax on their purchases described in this Section may not purchase the tangible personal property or services to perform the contract exempt from sales tax under the exemption provided by statute to the qualified organizations.

PART 55. TRUST AUTHORIES

710:65-13-550. Trust authority transactions
(a) Trust authorities organized pursuant to 60 O.S. § 176 et seq. may purchase material exempt from sales tax, but may not appoint an agent to do so. In order for the transaction to be exempt from sales tax, the purchase must be invoiced to and paid for by the authority, using authority funds or revenue received from bonds let by the authority.
(b) Purchases made with flow-thru funds are taxable. Flow-thru funds are defined as monies deposited in a trust authority account, by private industry, with the authority to dispense the funds under the trust's own name. [See: 68 O.S. § 1356]
(c) The amount of proceeds received from the sale of admission tickets which is separately-stated on the ticket of admission, for the repayment of money borrowed by any public trust of which a county in this state is the beneficiary, for purposes set out in 60 O.S. § 1356(8), is not taxable.
(d) The amount of any surcharge, separately stated on an admission ticket, which is imposed, collected, and used for the sole purpose of constructing, remodeling, or enlarging facilities of a public trust having a municipality or county as its sole beneficiary is exempt from sales tax.
(e) Application for exemption is made by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 Lincoln Blvd, 123 Robert S Kerr Ave, Oklahoma City, OK 73104, a completed Form 13-16-A, contained in Packet E available telephonically at (405) 521-3160 or online at www.tax.ok.gov along with the enabling document for the Trust or Authority showing organization under 60 O.S. § 176 et seq.

PART 65. WEB PORTALS

710:65-13-650. Exemption for sales of tangible personal property and services to a web search portal
(a) General provisions. Exempted from sales tax are sales of goods, wares, merchandise, tangible personal property, machinery and equipment to a web search portal located in this state which derives at least eighty percent (80%) of its annual gross revenue from the sale of a product or service to an out-of-state buyer or consumer. For purposes of this paragraph, "web search portal" means an establishment classified under NAICS code 519130 which operates websites that use a search engine to generate and maintain extensive databases of Internet addresses and content in an easily searchable format.
(b) Where to apply. To qualify for the exemption, the entity operating the web search portal must apply in writing to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 North Lincoln Boulevard, Oklahoma City, OK 73104.
710:65-19-55. Taxability of sales to contractors [REVOKED]

Unless specifically exempt by statute, a contractor shall pay the sales or use tax as a consumer on the purchase of all materials, supplies, tools and equipment, including rentals thereof and all replacement parts used by him in fulfilling either a lump-sum contract, a cost plus contract, a time and material contract with an upset or guaranteed price which may not be exceeded, or any other kind of construction contract for the development and/or improvement of real property. [See: 68 O.S. §§ 1354(21); 1356(10)]


(a) Definition. The term "contractor," as used in this Section means both contractors and subcontractors and includes, but is not limited to, building, grading and excavating, electrical, plumbing, heating, painting, drilling, decorating, paper hanging, air conditioning, ventilating, insulating, sheet metal, steel, masonry, carpentry, plastering, cement, road, bridge, landscape, and roofing contractors. The term contractor also includes any person engaged in a contractual arrangement for the repair, alteration, improvement, remodeling or construction of real property. A person working for a salary or wage is not considered a contractor.

(b) General provisions. As consumers/users, contractors must pay sales tax on all taxable services and tangible personal property, including materials, supplies, and equipment, purchased to develop, repair, alter, remodel, and improve real property.

(c) Exempt transactions. A contractor may make purchases based upon the exempt status of another entity only in the statutorily limited circumstances described in this Section:

(1) A contractor who has a public contract, or a subcontract to that public contract, with an Oklahoma municipality, county, school district, institution of the Oklahoma System of Higher Education, a rural water district, the Grand River Dam Authority, the Northeast Oklahoma Public Facilities Authority, the Oklahoma Municipal Power Authority, the City of Tulsa, Rogers County Port Authority, the Broken Bow Economic Development Authority, the Muskogee City County Port Authority, the Oklahoma Ordnance Works Authority, the Durant Industrial Authority, the Ardmore Development Authority, the Oklahoma Department of Veterans Affairs, the Central Oklahoma Master Conservancy District, or Department of Central Services only when carrying out a public construction contract on behalf of the Oklahoma Department of Veterans Affairs may make purchases of tangible personal property or services, which are necessary for carrying out the public contract, exempt from sales tax.

(2) A contractor who has entered into a contract with a private institution of higher education or with a private elementary or secondary institution, may make purchases of tangible personal property or services, including materials, supplies and equipment used in the construction of buildings owned and used by the institution for educational purposes exempt from sales tax.
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(3) A contractor who has contracted with an agricultural permit holder to construct a facility which will be used directly in the production of any livestock, including facilities used in the production and storage of feed for livestock owned by the agricultural permit holder, may make purchases of materials, supplies and equipment necessary to fulfill the contract, exempt from sales tax. [See: 710:65-7.6 and 710:65-7.11]

(4) A contractor may make purchases exempt from sales tax for use on campus construction projects for the benefit of institutions of the Oklahoma State System of Higher Education or private institutions of higher education accredited by the Oklahoma State Regents for Higher Education. The projects must be financed by or through the use of nonprofit entities which are exempt from taxation pursuant to Section 501(c)(3) of the Internal Revenue Code.

(5) A contractor may make purchases of machinery, equipment, fuels, and chemicals or other materials, exempt from sales tax, which will be incorporated into and directly used or consumed in the process of treatment of hazardous waste, pursuant to OAC 710:65-13-80. Contractors claiming exemption for purchases to be used to remediate hazardous waste should obtain a letter certifying the exemption status from the Tax Commission by following the procedures set out in 710:65-13-80, and provide a copy of the letter to vendors pursuant to subsection (f) of that rule.

(6) A contractor or a subcontractor to a construction contract, which has been duly entered into between a contractor and a church, may make purchases, exempt from sales tax of tangible personal property or services necessary for carrying out the construction contract. A vendor wishing to be relieved of liability to collect the tax should follow the requirements of subsection (e) of OAC 710:65-7.13.

(7) A contractor, or a subcontractor to such contractor, may make purchases of tangible personal property which is to be consumed or incorporated in the construction or expansion of a facility for a corporation organized under Section 437 et seq. of Title 18 of the Oklahoma Statutes as a rural electric cooperative exempt from sales tax.

(8) A contractor, or a subcontractor to such contractor, may make purchases of tangible personal property or services pursuant to a contractual relationship with a child care center, qualified for exemption pursuant 68 O.S. § 1356(d), for construction and improvement of buildings and other structures owned by the child care center and operated for educational purposes exempt from sales tax.

(9) A contractor, or a subcontractor to such contractor, may make purchases of tangible personal property or services pursuant to a contractual relationship with a manufacturer for the construction and improvement of manufacturing goods, ware, merchandise, property, machinery and equipment for use in a manufacturing operation classified under NAICS No. 324110 (Petroleum Refineries).

(d) Fabrication by contractors. A contractor may fabricate part or all of the articles to be used in construction work. For example, a sheet metal contractor may partly or wholly manufacture roofing, cornices, gutter pipe, furnace pipe, furnaces, ventilation or air conditioning ducts or other items from sheet metal purchased and used pursuant to a contract for the construction or improvement of real property. In such a contract the purchase by the contractor is a purchase by a consumer or user and the contractor is required to pay the sales or use tax at the time of purchase. This is so, whether the articles fabricated are used in the alteration, repair or reconstruction of an old building, or in new construction.


(a) Since a store is reimbursed by the manufacturer for the amount of a manufacturer’s coupon, the sales tax is computed on the gross sales price without any deduction for the coupon. To illustrate: A container of laundry detergent sells for $2.50 and the purchaser has a manufacturer’s coupon with $0.50. The sales tax is computed on the gross sales price of $2.50.

(b) In the case of coupons issued by a store for its own product, the amount of the coupon is not subject to sales tax. To illustrate: A container of laundry detergent sells for $2.50 and the purchaser has a coupon issued by that store worth $0.50. The sales tax is computed on the net sales amount of $2.00. This is considered to be a discount given by the store. [See: 68 O.S. § 1352]

(c) The sale of a booklet or brochure containing certificates which entitle the recipient to order and receive specific manufacturers’ coupons, that are then redeemable at a retail store, is not subject to sales tax.

PART 7. "D"


Discounts, whether cash, term, or coupons which are not reimbursed by a third party that are allowed by a seller and taken by a purchaser on a sale are excluded from the calculation of sales price for basing sales tax computation. [See: 68 O.S. §§ 1352(12)(b)(1)] “Term Discount” for purposes of this Chapter means a predetermined discount offered by a seller to customers conditioned upon the invoice being paid within a specific period of time.

PART 11. "F"


Effective August 26, 2011, no exemption shall apply to the sale of fireworks other than for resale purposes and all retail fireworks locations must possess a current sales tax permit which is to be conspicuously posted and immediately available for examination. Fireworks retailers shall make application for a sales tax permit by submitting to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission, 2501 N. Lincoln Blvd., 123 Robert S Kerr Ave, Oklahoma City, OK 7310473102, a completed Form
40003 available telephonically at (405) 521-3160 or online at www.tax.ok.gov.

PART 13. "G"

710:65-19-125. Premiums and gifts [REVOKED]

A sale of tangible personal property is taxable when made to a person who will use the property as a prize or a premium or will give the property away as a gift.


When the merchant gift wraps an item upon request of the customer, the merchant becomes the consumer or user of the gift wrapping materials. A charge for gift wrapping, separately stated on the invoice or sales ticket is not subject to sales tax.

PART 17. "I"

710:65-19-155. Ice plants [REVOKED]

The following machinery and equipment used by ice manufacturers may be purchased exempt: Pumps, motors, compressors, pipes, valves, gauges, water filters, ice crushing and shaving machines and other machines and the machinery used directly in the ice making process beginning with the point where the water enters into the process through the point where the ice is removed from the cans in which it is made or, if the ice is to be sold as crushed or shaved ice, through the point where the ice is crushed or chipped. Refrigerants used in the manufacturing process are also exempt.

PART 23. "L"


(a) Sales to a consumer or user are taxable. Sales for resale are exempt but the seller is required to establish that the purchaser has a valid sales tax permit and is regularly engaged in reselling the items purchased.

(b) Sales to a person regularly engaged in "agricultural production" may be either taxable or exempt, depending upon the specific use of the material sold.

(c) Sales to contractors for the purposes of developing or improving real estate are taxable unless specifically exempt regardless of the fact that the real estate is intended for resale.

PART 25. "M"


(a) Vendors operating a multi-level distribution system will collect tax on the gross receipts of the retail value of the products sold. This tax is to be passed through the multi-level distributors, who will not be required to hold an Oklahoma sales tax permit, to the consumers/users.

(b) For example, the vendor who sells to distributors, who in turn sell to consumers/users at home parties, is required to collect, report, and remit sales tax on the total amount of gross receipts received by the vendor's distributors from the sales of tangible personal property or taxable services. The distributors will collect the tax from the consumer.

(c) Shipping and handling charges associated with the shipment of multi-level sales merchandise to the distributor or the distributor's customers are not subject to sales tax, if separately stated.

(d) If the products are not sold by the distributor in the original form or packaging created by the multi-level vendor, but instead used as an ingredient in or component to a separate product, the distributor must collect sales tax on the total sales price of the final product to the consumer.

[OAR Docket #21-482; filed 6-15-21]

TITLE 710. OKLAHOMA TAX COMMISSION

CHAPTER 70. TOBACCO, TOBACCO PRODUCTS, AND CIGARETTES

[OAR Docket #21-483]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 2. Cigarette Stamp Tax
710:70-2-11 [AMENDED]
Subchapter 3. Unfair Cigarette and Tobacco Products Sales
710:70-3-2 through 710:70-3-5 [AMENDED]
Subchapter 5. Excise on Tobacco Products
710:70-5-4 [AMENDED]
710:70-5-13 [AMENDED]

AUTHORITY:
68 O.S. § 203; Oklahoma Tax Commission

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n/a

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n/a

GIST/ANALYSIS:
The amendments clarify policy, improve readability, correct scrivener's errors, remove obsolete language, update or correct citations, update contact information, and ensure accurate internal cross-references.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(S) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 2. CIGARETTE STAMP TAX

PART 1. GENERAL PROVISIONS

710:70-2-11. Requirements placed on distributors, wholesalers and retailers to maintain copies of invoices
(a) Wholesalers shall keep copies of invoices or equivalent documentation for each of its facilities for every transaction in which the wholesaler is the seller, purchaser, consignor, consignee, or recipient of cigarettes. The invoices or documentation must show the name, address, phone number and wholesale license number of the consignor, seller, purchaser, or consignee, and the quantity by brand style of the cigarettes involved in the transaction. [68 O.S. § 312.1(E)].
(b) Retailers shall keep copies of invoices or equivalent documentation for every transaction in which the retailer receives or purchases cigarettes at each of its facilities. The invoices or documentation must show the name and address of the wholesaler from whom, or the address of another facility of the same retailer from which, the cigarettes were received, the quantity of each brand style received in such transaction and the retail cigarette license number or sales tax license number. [68 O.S. § 312.1(F)].
(c) The invoices or equivalent documentation must be kept on the premises described in the license in such a manner as to ensure permanency and accessibility for inspection at reasonable hours by authorized personnel of the Oklahoma Tax Commission. With the permission of the Tax Commission, manufacturers, wholesalers, and retailers with multiple places of business may retain centralized records, but must transmit duplicates of the invoices or the equivalent documentation to each place of business within twenty-four (24) hours upon the request of the Tax Commission. Written requests for permission to keep centralized records should be submitted to the Business Tax Services Division of the Oklahoma Tax Commission by mail at 2501 Lincoln Blvd, 123 Robert S. Kerr Ave, Oklahoma City, Ok 73102, or by FAX at (405) 522-4450. [68 O.S. § 312.1(H)].
(d) The invoices or equivalent documentation must be retained for a period of three (3) years from the date of the transaction. [68 O.S. § 312.1(I)].

SUBCHAPTER 3. UNFAIR CIGARETTE AND TOBACCO PRODUCTS SALES

710:70-3-2. Filing of a complaint
Any person or entity who has been injured or would suffer injury from any violation or threatened violation of the provisions of the Unfair Cigarette and Tobacco Products Sales Act (68 O.S. §§326 et seq.) (the Act) shall file a written signed complaint of the complaining party with the Alcohol and Tobacco Section, Business Tax Services Division of the Oklahoma Tax Commission setting forth details and all evidence then available, together with the name and address of the person or entity that has allegedly violated and/or failed to comply with the provisions of the Act. [See: 68 O.S. §§340, 343]

710:70-3-3. Investigation and referral procedure
The Business Tax Services Division of the Oklahoma Tax Commission, upon receipt of the complaint described in 710:70-3-2, shall make a determination as to whether or not there is a probable violation of the provisions of the Unfair Cigarette and Tobacco Products Sales Act (68 O.S. §§326 et seq.) (the Act) appears to have occurred and shall forward such to the office of the General Counsel of the Oklahoma Tax Commission together with evidence of the relevant basic cost of cigarette and tobacco products and other relevant information in its possession. The General Counsel shall review the complaint and determine whether there exists a prima facie case of violation or failure to comply, and, if so, shall issue a notice to the alleged violator to attend a hearing where the alleged violator's license may be cancelled or suspended. A hearing shall be set after giving the complaining party and the person or entity who has allegedly violated the Act at least ten (10) days' notice and a copy of this Subchapter shall be available at the Oklahoma Tax Commission for all affected parties and may be mailed to such parties with the notice. If the General Counsel determines that there exists a prima facie case of violation, an action may be instituted in any court of competent jurisdiction and the rules of the court shall apply. [See: 68 O.S. §344]

710:70-3-4. Complaining party must appear
When an administrative hearing is set, the Business Tax Services Division of the Oklahoma Tax Commission and the complaining party shall be notified of the show cause hearing and it shall be mandatory for the complaining party to appear and submit evidence and/or testimony at the hearing to substantiate the alleged violation and/or failure by the alleged violating party to comply with the provisions of the Unfair Cigarette and Tobacco Products Sales Act (68 O.S. §§326 et seq.).

710:70-3-5. Evidence admissible to establish cost
The Business Tax Services Division shall appear at the hearing on an alleged violation of the Act and give testimony and evidence establishing the relevant basic cost of cigarettes and tobacco products and the minimum wholesale/retail price of such products based upon the provisions of the Unfair Cigarette and Tobacco Products Sales Act (68 O.S. §§326 et seq.), and such other evidence as may relate to the complaint. It shall be a rebuttable presumption that the basic cost to the wholesaler and to the retailer is that defined in the Act, unless a
SUBCHAPTER 5. EXCISE ON TOBACCO PRODUCTS

710:70-5-4. Incomplete monthly tobacco tax reports of licensed manufacturers, or wholesalers; forfeiture of discount

Any Monthly Tobacco Products Tax Report form filed with the Business Tax Services Division of the Oklahoma Tax Commission shall include, and have attached thereto, the minimum information specified in 68 O.S. §413 and 710:70-5-3. Any such monthly report form that does not include these minimum requirements shall not constitute the mandatory report. And, in the event a proper, complete monthly report is not filed on or before the due dates in accordance with 710:70-5-5, the discount of two percent (2%) of the tax due for maintaining and collecting such tax, shall not be allowed, and the report shall be delinquent.

710:70-5-13. Requirements placed on wholesalers and retailers to maintain copies of invoices with certain information that must be shown on each invoice

(a) Wholesalers of tobacco products, as defined in 68 O.S. § 401, shall keep copies of invoices or equivalent documentation for each of its facilities for every transaction in which the wholesaler is the seller, purchaser, consignor, consignee, or recipient of tobacco products. The invoices or documentation must contain the wholesaler's tobacco license number and the quantity by brand style of the tobacco products involved in the transaction. [68 O.S. Section 420.1(A)]

(b) Retailers of tobacco products, as defined in 68 O.S. § 401, shall keep copies of invoices or equivalent documentation for every transaction in which the retailer receives or purchases tobacco products at each of its facilities. The invoices or documentation must show the name and address of the wholesaler from whom, or the address of another facility of the same retailer from which, the tobacco products were received, the quantity of each brand style received in such transaction, and the retail tobacco license number. [68 O.S. § 420.1(B)]

(c) The invoices or equivalent documentation must be kept on the premises described in the license in such a manner as to ensure permanency and accessibility for inspection at reasonable hours by authorized personnel of the Oklahoma Tax Commission. With the permission of the Tax Commission, manufacturers, wholesalers, and retailers with multiple places of business may retain centralized records, but must transmit duplicates of the invoices or the equivalent documentation to each place of business within twenty-four (24) hours upon the request of the Tax Commission. Written requests for permission to keep centralized records should be submitted to the Business Tax Services Division of the Oklahoma Tax Commission by mail at 2501 Lincoln Blvd, 123 Robert S. Kerr Ave, Oklahoma City, Ok 73102 or by FAX at (405) 522-4450.

(d) The invoices or equivalent documentation must be retained for a period of three (3) years from the date of the transaction.
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710:90-1-10. Reporting to employees
(a) Every employer required to deduct and withhold Oklahoma tax from employee wages shall furnish the employee a written statement, each calendar year, showing:
   (1) The name of the employer;
   (2) The name of the employee;
   (3) The last four digits of the employee's social security number, shown in the format XXX-XX-1234 or ***-**-1234, if any, of the employee;
   (4) The total amount of wages subject to taxation that were paid during the year;
   (5) The total amount deducted and withheld as tax, and;
   (6) Any other such information as the Commission may require.
(b) The statement shall be furnished with the information in (a) of this Section as relating to the individual employee to whom taxable wages were paid, and each employee to whom taxable wages were paid shall be furnished such a statement containing his individual information. The statement shall be furnished to the employee on or before January 31st of the year following the year for which the information is provided.
(c) If an employee's employment is terminated before the close of a calendar year, said written statement must be furnished within thirty (30) days of the date of which the last payment of wages was made.
(d) Any employer who willfully fails to furnish an employee the required statement shall be guilty of a misdemeanor and upon conviction shall receive a fine not to exceed One Hundred Dollars ($100.00), or be imprisoned for not more than six (6) months in county jail, or both, for each offense.

SUBCHAPTER 3. RETURNS AND PAYMENTS

710:90-3-11. Income tax withholding for pass-through entities
(a) General provisions. Generally, any pass-through entity that makes a distribution to a non-resident member is required to deduct and withhold Oklahoma income tax from distributions of taxable income being made with respect to Oklahoma source income.
(b) Definitions. The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates otherwise:
   (1) "Member" means:
      (A) A shareholder of a corporation treated as an S Corporation Subchapter S Corporation;
      (B) A partner in a general partnership;
      (C) A partner in a limited partnership;
      (D) A partner in a limited liability partnership;
      (E) A member of a limited liability company; or,
      (F) A beneficiary of a trust.
   (2) "Non-resident" means an individual who is not a resident of, or domiciled in, this state; a business entity which does not have a commercial domicile in this state; or a trust which is not organized in this state.
   (3) "Pass-through entity" means:
      (A) A corporation that is treated as an S Corporation Subchapter S Corporation under the Internal Revenue Code;
      (B) A general partnership;
      (C) A limited partnership;
      (D) A limited liability partnership;
      (E) A trust; or,
      (F) A limited liability company that is not taxed as a corporation for federal income tax purposes. [68 O.S. § 2385.29]
   (4) "Pass-through entity" does not include an entity which is disregarded for income tax purposes under the Internal Revenue Code.
   (c) S Corporations Subchapter S Corporations: general, limited, or limited liability partnerships; limited liability companies. In the case of S Corporations Subchapter S Corporations: general, limited, or limited liability partnerships; and limited liability companies, withholding of five percent (5%) is required on the Oklahoma portion of the taxable income distributed to each non-resident member. In the case of S Corporations Subchapter S Corporations paying the tax on behalf of non-resident shareholders (68 O.S. § 2365) or partnerships filing composite returns on behalf of non-resident partners, the non-resident members withholding can be claimed on the return filed by the S Corporation Subchapter S Corporations or the partnership.
   (d) Trusts. For trusts, withholding of five percent (5%) is required on the Oklahoma portion of the taxable income distributed to each beneficiary of the trust.
   (e) Non-resident members not subject to withholding. The following persons and organizations are not subject to required withholding by a pass-through entity:
      (1) Persons, other than individuals, who are exempt from federal income tax;
      (2) Organizations granted an exemption under Section 501(c)(3) of the Internal Revenue Code;
      (3) Insurance companies subject to the Oklahoma Gross Premium Tax; gross premium income tax and therefor exempt from Oklahoma income tax pursuant to 68 O.S. § 2359(c); and
      (4) Non-resident members who have submitted a Non-resident Member Withholding Exemption Affidavit to the pass-through entity and which pass-through entity has submitted the affidavit information on behalf of the member to the Tax Commission. In the affidavit, the non-resident member agrees to be subject to the personal jurisdiction of the Tax Commission in the courts of this state for the purpose of determining and collecting any Oklahoma taxes, including estimated tax payments, together with any related interest and penalties. See (k) of this Section for the procedure to be followed in filing the affidavit.
      (A) For non-resident partners included in a composite partnership return under OAC 710:50-19-1 and filing a Nonresident Member Withholding Exemption Affidavit, the inclusion of the partner's income within the composite partnership return will satisfy the requirements contained in the affidavit.

Oklahoma Register (Volume 38, Number 23) 1576 August 16, 2021
(B) For non-resident shareholders filing a Non-
resident Member Withholding Exemption Affidavit
and electing not to file Oklahoma income tax returns
under 68 O.S. § 2365, inclusion of the non-resident
shareholder’s income in the Subchapter S corporate
income tax return will satisfy the requirements con-
tained in the affidavit.
(C) For non-resident beneficiaries included in a
trust return and filing a Nonresident Member With-
holding Exemption Affidavit, the inclusion of the
beneficiary’s income within the trust return will sat-
isfy the requirements contained in the affidavit.

(f) **When pass-through entities are not required to with-
hold.** Withholding is not required in the following instances:

1. When an entity is not required to file a federal in-
come tax return, or properly elects out of such duty;
2. When a pass-through entity is making distributions
of income not subject to Oklahoma income tax;
3. When a pass-through entity has withheld tax on roy-
alty interest income pursuant to 68 O.S. § 2385.25 et seq.;
4. When a pass-through entity is making distributions
to another pass-through entity. Provided however,
the exception set out in this paragraph does not relieve
the lower-tiered pass-through entity from the duty to withhold
on distributions it makes which are not otherwise exempt;
5. When a pass-through entity is a publicly traded
partnership, as defined by Section 7704(b) of the Internal
Revenue Code, and is treated as a partnership for purposes
of the Internal Revenue Code. Provided the publicly
traded partnership has agreed to file an annual information
return reporting the name, address, taxpayer identification
number, and other information requested by the Tax Com-
mision of each unit-holder with an income in the state in
excess of Five Hundred Dollars ($500.00); or,
6. When a distribution made by a pass-through entity
has been determined to be not subject to the provisions of
this Section by the Commission.

(g) **Due dates for payment of pass-through entity with-
holding.** Pass-through entities that withhold income tax
on distributions of taxable income to non-resident mem-
bers are required to remit the amount of tax withheld from
each non-resident member on or before the due date of the
pass-through entity’s income tax return, including extensions.
Any pass-through entity that can reasonably expect the total
amount of income tax withheld from all non-resident members
to exceed Five Hundred Dollars ($500.00) for the taxable year
**must** make quarterly estimated tax payments. The Oklahoma
Nonresident Distributed Income Estimated Withholding Tax
Report is to be used to remit the quarterly estimated tax pay-
ments. The required estimated tax payments are due on or
before the last day of the month after the end of the calendar
quarter and must be made in equal quarterly installments. The
total of the required quarterly estimated tax payments is the
lesser of seventy percent (70%) of the withholding tax that
must be withheld for the current taxable year, or one hundred
percent (100%) of the withholding tax withheld for the previ-
ous taxable year. Any pass-through entity that can reasonably
expect the total amount of tax withheld from all non-resident
members to be less than Five Hundred Dollars ($500.00) for
the taxable year may, at their option, make quarterly estimated
tax payments.

(h) **Required reports.** The pass-through entity is required
to provide non-resident members and the Oklahoma Tax Com-
mision an annual written statement showing the name of the
pass-through entity, to whom the distribution was paid, the
amount of taxable income distributed, and the amount of Ok-
lahoma income tax withheld. Further, the statement must also
furnish the non-resident member’s name, address, and social
security number or Federal Employer Identification Number.
To accomplish this:

1. Each pass-through entity must provide non-resident
members with Oklahoma Tax Commission Form 500-B
on or before the due date of the pass-through entity’s in-
come tax return, including extensions. Copies of OTC
Form 500-B, along with OTC Form 501, must be sent to
the Oklahoma Tax Commission by the same date.
2. Each pass-through entity must file with the Ok-
lahoma Tax Commission the appropriate income tax
withholding return on or before the due date of the
pass-through entity’s income tax return, including ex-
tensions.
3. Each non-resident member must enclose a copy of
OTC Form 500-B with the Oklahoma income tax return as
verification for this withholding.

(i) **Non-resident members entitled to credit, or refund,
from Oklahoma income taxes paid.** Any non-resident
member from whom an amount is withheld pursuant to the
provisions of this Section, and who files an Oklahoma income
tax return is entitled to a credit for the amount withheld. If the
amount withheld is greater than the tax due, the non-resident
member will be entitled to a refund of the amount of the over-
payment.

(j) **Pass-through entities must register.** Pass-through en-
tities that make distributions subject to Oklahoma withholding
must register with the Oklahoma Tax Commission.

(k) **Affidavit filing procedures.** Non-resident members
who elect to file a Nonresident Member Withholding Exemp-
tion Affidavit agreeing to be subject to the personal jurisdiction
of the Tax Commission in the courts of this state for the purpose
of determining and collecting any Oklahoma taxes, including
estimated tax payments, and any related interest and penalties,
**must** remit the affidavit to the appropriate pass-through entity.
The pass-through entity is to retain the affidavit and file the fol-
lowing information with the Oklahoma Tax Commission by the
due date of the required annual tax return of the pass-through
entity.

1. **Content.** The name, address, and social security
number or federal identification number of the non-resi-
dent member having signed an affidavit. All pass-through
entities are required to file the non-resident member affidavit information on a diskette or CD with the Oklahoma Tax Commission - Compliance Audit Services Division. (2) Format. The format for filing the diskette or CD will be in either a spreadsheet format (i.e. Lotus 1-2-3 or Excel) or a database format (i.e. dbf or Access). (3) Waiver. Pass-through entities may obtain a waiver from the diskette or CD filing requirement if the pass-through entity can demonstrate that a hardship would result if it were required to file on a diskette or CD. Direct waiver requests to the Oklahoma Tax Commission - Compliance Audit Services Division.

710:90-3-17. Penalty and interest (a) If an employer fails to file a return or to pay the Commission the Withholding Tax withholding tax when due, there shall be imposed on such employer a penalty of ten percent (10%) of the amount of tax, or ten percent (10%) of the amount of the underpayment of tax, if such failure is not corrected within fifteen (15) days after the tax becomes delinquent.

(1) There is also imposed upon the employer interest at the rate of one and one-quarter percent (1 1/4%) per month.

(2) If any portion of the deficiency is due to fraud with intent to evade tax, a penalty of fifty percent (50%) shall be assessed.

(b) At the discretion of the Commission, the interest or penalty may be waived, provided the taxpayer can demonstrate that the failure to pay the amount of tax, or ten percent (10%) of the amount of the un-derpayment of tax resulted from a mistake by the taxpayer of either law or fact or inability to pay such interest or penalty resulting from insolvency. Requests for waiver must be made in writing to the Account Maintenance Income Tax Accounts Division and must include all pertinent facts to support the request.

{OAR Docket #21-484; filed 6-15-21]

TITLE 710. OKLAHOMA TAX COMMISSION
CHAPTER 95. MISCELLANEOUS AREAS OF REGULATORY AND ADMINISTRATIVE AUTHORITY

{OAR Docket #21-485]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:
Subchapter 3. Telecommunication for the Hearing-Impaired Surcharge 710:95-3-3 [AMENDED]
Subchapter 21. Quality Events 710:95-21-4 [AMENDED]
710:95-21-6 [AMENDED]
Subchapter 22. Registration Requirements for Resident and Nonresident Contractors 710:95-22-5 [AMENDED]
710:95-22-7 [AMENDED]
710:95-22-8 [AMENDED]

AUTHORITY:
68 O.S. § 203; Oklahoma Tax Commission

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
December 22, 2020

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SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

GIST/ANALYSIS:
The amendments clarify policy, improve readability, correct scrivener's errors, remove obsolete language, update or correct citations, update contact information, and ensure accurate internal cross-references.

CONTACT PERSON:
Lisa Haws, Tax Policy and Research Division, Oklahoma Tax Commission, Oklahoma City, OK 73194; 405-521-3133; lhaws@tax.ok.gov.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF SEPTEMBER 1, 2021:

SUBCHAPTER 3. TELECOMMUNICATION FOR THE HEARING-IMPAIRED SURCHARGE

710:95-3-3. Telecommunications for the hearing-impaired surcharge

(a) The Telecommunications for the Hearing-Impaired Act levies a five cent per month surcharge on each access line provided by a local exchange telephone company. The surcharge must be added to the subscriber's telephone bill, unless the subscriber is exempt from sales tax.

(b) The local exchange telephone company shall remit the surcharge to the Oklahoma Tax Commission, on forms prescribed, on or before the 20th day of the month following the end of each quarter.

(c) When the balance of the Hearing Impaired Revolving Fund equals the three-year average of expenditures, collection of the surcharge by the local exchange telephone company will temporarily stop. Collection of the surcharge is to be resumed when the account balance has been reduced to one-half the original surplus.

(d) The Taxpayer Assistance Business Tax Services Division will notify, in writing, the local exchange telephone companies on the effective date of the moratorium on collections. Subscribers shall not be billed for the surcharge for any billing cycle that begins on or after the moratorium effective date.
(e) When the Fund balance requires the surcharge to be resumed, the Taxpayer Assistance Business Tax Services Division will notify the local exchange telephone companies, in writing, the effective date of resumption of the surcharge. Subscribers shall be billed and the surcharge on the next billing cycle that begins on or after the effective date the charge is to be resumed. [See: 63 O.S. §§2418-2419]

SUBCHAPTER 21. QUALITY EVENTS

710:95-21-4. Quality event approval and application requirements

(a) Application for approval. Within thirty (30) days of the adoption date of the ordinance or resolution designating a quality event, which must be adopted not later than six (6) months prior to the initial date of the designated quality event, the host community must submit a written request for recognition as a quality event to the Tax Policy Division of the Oklahoma Tax Commission at 2501 N. Lincoln Blvd 123 Robert S. Kerr Ave, Oklahoma City, Oklahoma 73102. The postmark date of the written request for recognition as a quality event is deemed to be its date of delivery.

(b) Application requirements. The application for recognition must include the following:

(1) Ordinance or resolution. A copy of the ordinance or resolution designating the quality event; and

(2) Event history. The event history must include the following information:

(A) Historical information on the event including past locations of the event,

(B) A description of previous attempts by the host community to secure the event,

(C) Information regarding attempts by other communities to recruit the event, and

(D) If applicable, the competitive bidding process for securing the event by the host community. [68 O.S. § 4303]

(c) Ineligibility for quality event recognition. The Tax Commission shall not consider any application for quality event recognition which is not submitted within the statutory timeframe outlined in this Section.

710:95-21-6. Determination of eligible local support amounts

(a) Outline and required documentation. Within thirty (30) days from the conclusion of the quality event the host community must submit to the Tax Policy Division of the Commission at 2501 N. Lincoln Blvd 123 Robert S. Kerr Ave, Oklahoma City, Oklahoma 73102. an outline with supporting billing and payment information detailing the total amount of eligible local support amounts for purposes of determining the amount of incremental state sales tax revenue that may be paid to the host community in which a quality event occurred.

(b) Payment verification. The Commission must verify the amount of eligible local support amounts prior to making any payment to the host community.

SUBCHAPTER 22. REGISTRATION REQUIREMENTS FOR RESIDENT AND NONRESIDENT CONTRACTORS

710:95-22-5. Complaints

(a) Complaints. Complaints of awarding public agencies that a contractor, upon written request, failed to provide the information as required by OAC 710:95-22-3 along with complaints that contractors are performing work in this state without properly registering for employer identification numbers with the Oklahoma Tax Commission, the Oklahoma Employment Security Commission, the Internal Revenue Service and the Social Security Administration should be forwarded to the Taxpayer Assistance Business Tax Services Division, Oklahoma Tax Commission.

(b) Complaint review. Taxpayer Assistance Business Tax Services Division will review the complaint and investigate whether the contractor, about which the complaint was made, is properly registered with the agencies referenced in subsection (a) of this Section.

(c) Determination of improper registration. Upon a determination by the Taxpayer Assistance Business Tax Services Division that a contractor is not properly registered with some or all of the required agencies, the Taxpayer Assistance Business Tax Services Division will provide a written advisement of the determination to the Compliance Audit Services Division along with a copy of the Complaint.

(d) Fine imposition. Upon receipt of the advisement, the Compliance Audit Services Division shall impose a fine in writing in accordance with OAC 710:95-22-4. The Fine Notification will be sent by the U.S. Postal Service to the contractor's address provided on the awarding agency's complaint or to the address of the contractor available to the Tax Commission.

710:95-22-7. Fine referral, imposition and notification

(a) Fine referrals. Referrals for imposition of the fine provided in OAC 710:95-22-6 may be made by the Oklahoma Employment Security Commission, Labor Department, or Compsource after an investigation and determination by the referring agency that a contractor has intentionally misclassified its employees. The referral along with all documentation supporting the referring agency's determination should be submitted to the Compliance Audit Services Division.

(b) Fine imposition. Upon receipt and review of the referral and supporting documentation the Compliance Audit Services Division shall impose the fine in accordance with 710:95-22-6. The Compliance Audit Services Division shall also impose the fine provided in 710:95-22-6 when determining upon its audit or investigation that a contractor has intentionally misclassified employees with intent to affect procedures and tax payments.

(c) Fine Notification. Fine Notifications will be sent by the U.S. Postal Service to the contractor's address provided on the
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agency's referrals or to the address of the contractor available to the Tax Commission.

710:95-22-8. Fine review procedures
(a) Review request. A contractor who disagrees with a fine imposed pursuant to 710:95-22-4 and 710:95-22-6 may request within thirty (30) days of mailing of the Fine Notification that the fine be reviewed by the Compliance—Audit Services Division.
(b) Contents of request. The request must be in writing, submitted to the Compliance—Audit Services Division at P.O. Box 269062, Oklahoma City, OK 73126-9062, and state the basis for the contractor's belief that the fine is issued in error. Documentation supporting the contractor's statement must accompany the request.
(c) Conditions of fine withdrawal. The fine(s) will be withdrawn under the stated circumstances:
(1) The Compliance—Audit Services Division determines that the fine(s) was issued in error.
(2) The Compliance—Audit Services Division finds that the contractor subsequentially to the imposition of the fine provided for in 710:95-22-4 obtained the required employer identification numbers.
(d) Contents of notification when fine not withdrawn.
If the Compliance—Audit Services Division does not agree that the fine should be withdrawn, the contractor shall be so notified in writing by the Compliance—Audit Services Division. The notification shall prominently state that if the contractor disagrees with the Compliance—Audit Services Division's final determination, the contractor must file, within thirty (30) days of mailing of the notification, a protest with the General Counsel's Office of the Oklahoma Tax Commission at 420 North Robinson, Suite 2000 W 123 Robert S. Kerr Ave, Oklahoma City, Oklahoma 73102-7801.
(e) Protest. Upon receipt, the General Counsel's Office shall forward the protest to the Office of the Administrative Law Judge to be set for hearing.

[OAR Docket #21-485; filed 6-15-21]

TITLE 715. TEACHERS' RETIREMENT SYSTEM
CHAPTER I. ADMINISTRATIVE OPERATIONS

[OAR Docket #21-468]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
715:1-1-4. Administrative office [REVOKED]
715:1-1-8. Payment of salaries, payrolls and claims [AMENDED]

AUTHORITY:
70 O.S. Section 17-101, et seq., especially Section 17-106(10); Board of Trustees

SUBMISSION OF PROPOSED RULES TO GOVERNOR AND CABINET SECRETARY:
November 23, 2020

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Approved June 11, 2021, by HJR 1046
FINAL ADOPTION:
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EFFECTIVE:
August 26, 2021

SUPERSEDED EMERGENCY ACTIONS:
Superseded rules:
715:1-1-4. Administrative Office [REVOKED]
715:1-1-8. Payment of salaries and claims [AMENDED]

Gubernatorial approval:
October 15, 2021
Registration publication:
38 Ok Reg 101
Docket number:
20-805

INCORPORATIONS BY REFERENCE:
715:
GIST/ANALYSIS:
715:1-1-4 is being revoked in its entirety due to the System's move to new headquarters on/about November 1, 2020, and as an unnecessary rule.
715:1-1-8 is being amended as the Board of Trustees is no longer charged with approving retirements of the System.
715:1-1-15 is being amended to update the age requirement for distributions for a member or member's beneficiary under Section 401(a)(9) of the Internal Revenue Code.

CONTACT PERSON:
Phyllis Bennett, Rules Liaison, Teachers' Retirement System of Oklahoma, 301 NW 63rd Street, Suite 500, Oklahoma City, OK, 73116, 405-521-4745.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTIONS 250.3(5) AND 308(E), WITH AN EFFECTIVE DATE OF AUGUST 26, 2021:

715:1-1-4. Administrative office [REVOKED]
The Teachers' Retirement System has office space located in the Oliver Hodge Education Building, 2500 N. Lincoln Boulevard, Oklahoma City, Oklahoma 73105. The mailing address for correspondence is TRS, P.O. Box 53524, Oklahoma City, OK, 73152. The main telephone number is (405) 521-2387. The toll-free telephone number for calls originating outside the Oklahoma City local calling area is 1-877-738-6365. Members are encouraged to visit the Retirement Office, or make written inquiries regarding any matter pertaining to their retirement accounts.

715:1-1-8. Payment of salaries, payrolls and claims
(a) The Executive Director is authorized to approve and pay all payrolls for the regular personnel and extra help of TRS, as provided in the budget approved by the Board of Trustees. In the absence of the Executive Director, the Deputy Executive Director of Operations may approve payrolls. The Executive Director, Chief Financial Officer, and Certified Procurement Officer must comply with the law in making purchases of
supplies, printing materials and equipment. In the event of the absence of the Executive Director, the Chief Financial Officer may also sign for approval of claims.

(b) The retired member payroll shall be paid when approved by the Chief Financial Officer and the Executive Director, or in the event of an absence, the General Counsel may approve for one. The Board of Trustees shall then make final approval at the next regular meeting following the date on which the checks were mailed to retired members. The Executive Director and TRS staff must comply with the Oklahoma Central Purchasing Act and associated policies and procedures in making purchases of supplies, printing materials and equipment. Internal approval of claims shall be made in compliance with the TRS Procurement Policy as approved by the State Purchasing Director from time to time.

(a) Notwithstanding any other provision of the administrative code, all benefits paid from the retirement system (other than the tax-sheltered annuity program) shall be distributed in accordance with the requirements of Section 401(a)(9) of the Internal Revenue Code and Treasury Regulations § 1.401(a)(9)-1 through § 1.401(a)(9)-9, even if the member has not submitted the appropriate notice. These provisions override any distribution options that are inconsistent with Internal Revenue Code Section 401(a)(9).

(b) In furtherance of this section, the Board of Trustees and its designee will apply the following provisions:

(1) The entire interest of each member:
   (A) will be distributed to such member not later than the required beginning date; or
   (B) will be distributed beginning not later than the required beginning date, in accordance with Treasury regulations over the life of such member or over the lives of such member and a designated beneficiary (or over a period not extending beyond the life expectancy of such member or the life expectancies of such member and a designated beneficiary).

(2) If distribution of the member's interest has begun in accordance with subparagraph (1)(B) and the member dies before his or her entire interest has been distributed to the member, the remaining amount shall be distributed at least as rapidly as under the method of distribution being used under subparagraph (1)(B) as of the date of the member's death.

(3) If a member dies before distribution of the member's benefits begins under subparagraph (1)(B), and if any portion of the member's interest is payable to or for the benefit of a designated beneficiary for the beneficiary's lifetime or for a period not to exceed the beneficiary's life expectancy, the distribution must begin no later than December 31 of the calendar year immediately following the calendar year in which the member died. However, if the designated beneficiary is the surviving spouse of the member:
   (A) the date on which the distribution is required to begin shall not be earlier than the date on which the member would have attained age 70 1/2 (age 72 for distributions required to be made after December 31, 2019, with respect to a member who would have attained age 70 1/2 after December 31, 2019), and
   (B) if the surviving spouse dies before the distribution to such spouse begins, subparagraph (1)(B) shall be applied as if the surviving spouse were the member.

(4) For benefit payments to beneficiaries that are not covered by paragraph (3), if the member dies before distribution of the member's interest has begun in accordance with subparagraph (1)(B), the member's entire interest must be distributed within 5 years after the member's death.

(5) For purposes of this section, the term "required beginning date" means April 1 of the calendar year following the later of:
   (A) the calendar year in which the employee reaches age 70 1/2 (age 72 for distributions required to be made after December 31, 2019, with respect to a member who would have attained age 70 1/2 after December 31, 2019), or
   (B) the calendar year in which the employee retires.

(6) For purposes of determining benefits, the life expectancy of a member, a member's spouse or a member's beneficiary shall not be recalculated after benefits commence.

(7) The amount of benefits payable to a member's beneficiary may not exceed the maximum determined under the incidental death benefit requirement of Internal Revenue Code Section 401(a)(9)(G).
Permanent Final Adoptions

715:10-9-1. Contributions from the Oklahoma Teachers' Deferred Savings Incentive Plan Fund into Program accounts of active contributing TRS members [REVOKED]

AUTHORITY:
70 O.S. Section 17-101, et seq., especially 17-106(10); Board of Trustees

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SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:
715:10-9-1. Return of contributions when death occurs before retirement [AMENDED]
Subchapter 11. Withdrawal from Membership and Refund of Deposits
715:10-11-1. Withdrawal from membership by an eligible person [AMENDED]

Gubernatorial approval:
October 15, 2020

Registration Publication:
38 Ok Reg 102

Docket number:
20-806

INCORPORATIONS BY REFERENCE:

n/a

GIST/ANALYSIS:
715:10-9-1 is being amended for consistency with the actuarially assumed rate of return adopted by the Board of Trustees of the Teachers' Retirement System of Oklahoma pursuant to 70 O.S. Section 17-106(18).
715:10-11-1 is being amended for consistency with the actuarially assumed rate of return adopted by the Board of Trustees of the Teachers' Retirement System of Oklahoma pursuant to 70 O.S. Section 17-106(18).
715:10-19-3 is being revoked due to the amendment to 70 O.S. Section 17-102.3 (2018) for the termination of the Tax-Sheltered Annuity Program administered under 26 U.S.C. Section 403(b) and the October 21, 2020, resolution of the Board of Trustees of the Teachers' Retirement System of Oklahoma to terminate the Program effective January 29, 2021.
715:10-19-5 is being revoked due to the amendment to 70 O.S. Section 17-102.3 (2018) for the termination of the Tax-Sheltered Annuity Program administered under 26 U.S.C. Section 403(b) and the October 21, 2020, resolution of the Board of Trustees of the Teachers' Retirement System of Oklahoma to terminate the Program effective January 29, 2021.

SUBCHAPTER 9. SURVIVOR BENEFITS

715:10-9-1. Return of contributions when death occurs before retirement

Upon the death of a member, who has not retired, the designated beneficiary on file with TRS prior to the member's death, or estate (if there is no designated beneficiary, or if the designated beneficiary predeceases the member) shall receive the member's total contributions, plus one hundred percent (100%) of all interest earned through the end of the fiscal year. Interest shall cease to accumulate with the payment of any portion of the member's contributions and interest to any beneficiary. Interest on death claims shall bear a rate equivalent to that of the actuarially assumed rate of return for the System as determined by the Board of Trustees from time to time, be calculated according to the following schedule:

1. July 1, 1968, through June 30, 1977, four and one-half percent (4 1/2%), compounded annually.
3. July 1, 1981, through June 30, 2019, eight percent (8%), compounded annually.
4. July 1, 2019 to present through June 30, 2020, seven and one-half percent (7 1/2%), compounded annually.
(5) July 1, 2020 to present (until changed by the Board of Trustees), seven percent (7%), compounded annually. See OAC 715:10-9-7, if the member and beneficiary were divorced before death.

SUBCHAPTER 11. WITHDRAWAL FROM MEMBERSHIP AND REFUND OF DEPOSITS

715:10-11-1. Withdrawal from membership by an eligible person

Any member who terminates employment in the public schools of Oklahoma may voluntarily withdraw from membership in TRS under the following conditions:

(1) 70 O.S. §17-105 provides that members who leave Oklahoma public education employment are eligible to withdraw the contributions made to their TRS account four (4) months after termination. A former employee may submit application for the proceeds of the account after the last day physically worked. There are no exceptions to this waiting period.

(2) Written verification from the school’s payroll department of a member’s termination of employment and/or non-resumption of teaching contract must be on file before processing the Application for Withdrawal.

(3) The years of membership shall be calculated as follows:

(A) For withdrawal purposes - from the date of the first contribution of the current membership to the date of withdrawal, except that member accounts closed in compliance with OAC 715:10-7-3 will be from the date of the first contribution to the date the account is closed.

(B) For payment of interest purposes - from the date of the first contribution of the current membership to the date of withdrawal, except that member accounts closed in compliance with OAC 715:10-7-3 will be from the date of the first contribution to the date the account is closed.

(4) Interest rate on withdrawals shall bear a rate equivalent to that of the actuarially assumed rate of return for the System as determined by the Board of Trustees from time to time, be paid as follows, calculated according to the following schedule:

(A) July 1, 1968 through June 30, 1977 - four and one-half percent (4 1/2%), compounded annually.

(B) July 1, 1977 through June 30, 1981 - seven percent (7%), compounded annually.

(C) As of July 1, 1981, through June 30, 2019 - eight percent (8%), compounded annually.

(D) As of July 1, 2019, to present - seven and one-half percent (7 1/2%), compounded annually.

(E) July 1, 2020 to present (until changed by the Board of Trustees), seven percent (7%), compounded annually.

(5) Interest payment on withdrawals shall be paid as follows:

(A) If termination occurs within sixteen (16) years from the date membership began, fifty (50) percent (50%) of the total accrued interest shall be paid.

(B) For members with at least sixteen (16) years but less than twenty-one (21) years of membership, sixty (60) percent (60%) of the total accrued interest shall be paid.

(C) For members with at least twenty-one (21) years but less than twenty-six (26) years of membership, seventy-five (75) percent (75%) of the total accrued interest shall be paid.

(D) For members with at least twenty-six (26) years of membership, ninety (90) percent (90%) of the total accrued interest shall be paid.

(6) A person whose membership has not terminated due to five (5) years of absence from Oklahoma public education employment, but who has applied to withdraw all accumulated contributions, shall not have membership terminated until the withdrawal payment has been processed.

(7) Effective July 1, 1990, no member is eligible to withdraw contributions made on a pre-tax basis, unless the employee has terminated employment in the public schools for a period of four months.

SUBCHAPTER 19. TAX-SHELTERED ANNUITY PROGRAM [REVOKED]

715:10-19-1. Authority for program [REVOKED]

The TRS Tax-Sheltered Annuity Program ("Program") is designed to meet the requirements of section 403(b) of the Internal Revenue Code ("Code") and the federal regulations that have been promulgated to implement Code Section 403(b), specifically including Treasury Regulations Sections 1.403(b)-1 through 1.403(b)-11. The Program is administered by the Board of Trustees. However, the Board can retain a third-party to administer the Program, including providing investment options. Code Section 403(b)authorizes tax-sheltered annuity programs, setting forth requirements that must be followed. Failure to follow these requirements may cause penalties to be imposed on the individual member or cause the tax sheltered status of the Oklahoma Teachers’ Retirement System program to be disallowed. Changes to Code Section 403(b) by Congress or changes to the federal regulations usually affect the Program’s administration, therefore, this Program will change as often as Congress amends or revises Code Section 403(b) and as changes are made to related federal regulations. Title 70 O.S. 17-108 allows members of Teachers’ Retirement System of Oklahoma ("TRS") to participate in the Program. However, in making deposits to this Program, the member and the employing school must comply with all applicable aspects of the Internal Revenue Code. The provisions of the Program described in this Subchapter 19 are effective as of January 1, 2009, except as otherwise noted in this Subchapter.
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715:10-19-2. General description [REVOKED]

The following is a general description of the Program available from TRS. (Where the term "TRS" is used in this subchapter, the term includes, where appropriate, a third-party administrator or other service provider selected by TRS to perform services with respect to the Program.) The member should be aware that tax-sheltered annuity plan investment options are also offered by many major insurance companies through the member's employing Oklahoma public school.

(1) The Program's primary purpose is to enable eligible members to contribute to a supplemental retirement program in preparation for retirement.

(2) An eligible employer makes salary reduction contributions on behalf of a member to the Program at the election of that member. Employers cannot require contributions to the Program as a condition of employment. However, an employer may establish an auto enrollment feature in accordance with federal law. The member's employer deducts tax-sheltered contributions from the member's salary and forwards the deductions to TRS. TRS places the monies in the member's Program account. The accounts are debited or credited with earnings according to the member's investment selection. Statements are mailed to the member's home address on a quarterly basis.

(3) Each participating member receives an immediate vested and nonforfeitable interest in the amounts credited to his or her Program account. The member is precluded from selling, assigning, or pledging his or her funds in the Program account to another person or party, except to designate a beneficiary in the event of death. However, TRS will honor qualified domestic relations orders within the meaning of 70 O.S. 17-109, OAC 715:10-25-1 et seq. and Code Section 414(p).

(4) Member accounts may be assessed investment management fees by TRS for services rendered by TRS.

(5) Monies in this Program are not insured in the same manner as deposits are insured with various privately operated financial institutions, (i.e. FDIC). TRS may establish a recordkeeping account for each member by TRS. Deposits are kept separate from the member's regular retirement account. TRS may select investment options, including a Tax Sheltered Annuity Program default fund, and may establish procedures related to the transfer of funds among investment options, including mapping instructions and black-out periods. TRS has in general delegated investment authority to each member to select among investment options determined by TRS.

(6) Money deposited in the Program will not be matched by the State of Oklahoma.

715:10-19-3. Eligible employees [REVOKED]

To participate in the Program, a member must be an active employee of a qualifying educational organization within the meaning of section 170(b)(1)(A)(ii) of the Internal Revenue Code which normally maintains a regular faculty, curriculum, and a regular organized body of students in attendance at the place where its educational activities are conducted. University regents or trustees and members of boards of education are not eligible to participate in the Program since they are elected or appointed. Employees of the Oklahoma Teachers' Retirement System are also not eligible to participate in the Program. Retired members who are employed full-time or part-time by a public school in Oklahoma are eligible to participate in the Program.

715:10-19-4. Program requisites [REVOKED]

The Internal Revenue Service has ruled that money deposited in the Program may be tax sheltered, provided the following steps are taken:

(1) A board of education or other governing board of an eligible employer adopts a resolution making the Program available to its employees. Once this action is taken, this subchapter and 70 O.S. 17-108 shall be deemed to be part of the employer's written plan document under Treasury Regulations § 1.403(b)-3(b)(3).

(2) The member signs an amended contract with the board of education or governing board for the express purpose of making elective deferrals to the Program. This is done by either taking a reduction in salary or waiving a salary increase. The salary reduction agreement must be entered into prior to the date contributions are to commence and may only apply to amounts earned by the member after the agreement is effective. Nothing in this section shall be construed to prohibit an employer from implementing auto enrollment pursuant to federal law.

(3) An eligible employer permitting any TRS member to contribute to the Program must permit all eligible TRS members to contribute to the Program in accordance with section 403(b)(12)(A)(ii) of the Internal Revenue Code and the Income Tax Regulations thereunder.

715:10-19-5. Contributions [REVOKED]

After a member enters into the salary reduction agreement (completing an amended contract and any other payroll requirement specified by the eligible employer), the eligible employer shall make payroll deductions in lieu of the member receiving cash compensation on a monthly basis in accordance with the agreement. The eligible employer shall submit the contributions for all members in the school district to the TRS service provider in the manner prescribed by the service provider.

(1) All contributions to the Program must be salary reductions. Members cannot make direct payments to the Program. If the contributions are not salary reductions, tax-deferral will not be possible. As a result, the Program will only accept employer payments of salary reduction contributions for members. Nothing in this provision prohibits a member from making a rollover contribution to the Program.

(2) Employers should forward salary reduction contributions in a timely manner, but in no event later than fifteen (15) business days following the end of the month in which the amount would have otherwise been paid to
the member. Employers are also responsible for ensuring that members do not contribute more than the maximum amount allowed by federal tax law. Salary reduction agreements are limited under the Internal Revenue Code, as described in the following:

(A) The amount of salary reduction contributions made in a member's taxable year under the Program, and any other plans, contracts, or arrangements of the employer, may not exceed the amount of the limitation in effect under Internal Revenue Code Section 402(g)(1), as increased by Internal Revenue Code Sections 402(g)(4), 402(g)(7) and 414(v), for such taxable year.

(B) Contributions to the Program and to any other section 403(b) plan (or, if required by Internal Revenue Code Section 415 and the Income Tax Regulations thereunder, to any other defined contribution plan) made in a calendar year (unless another twelve (12) month period ending within the calendar year is elected) with respect to an employee may not exceed limitations under Code Section 415(c) for such calendar year. The limitation on annual additions set forth in Internal Revenue Code 415(c) for any calendar year is the lesser of:

(i) Forty Thousand Dollars ($40,000), 

(ii) one hundred percent (100%) of the Participant's Includible Compensation.

(C) For purposes of this Section, "annual addition" has the meaning provided in section 415(c) of the Code, as modified by sections 415(j)(1) and 419At(d)(2) of the Code. In general, section 415(c) of the Code defines the annual addition as the sum of the following amounts credited to a member's accounts for any calendar year under this Program and to any section 403(b) plan (or, if required by section 415 of the Code and the Income Tax Regulations thereunder, to any other defined contribution plan): (1) employer contributions; (2) employee contributions; and (3) forfeitures. Annual additions shall not include: (1) any elective deferrals made by a member who is age fifty (50) or older in accordance with, and subject to, section 414(v) of the Code; (2) excess elective deferrals distributed in accordance with section 410(k)(1)(e)(2) of the Income Tax Regulations; or (3) rollover contributions.

(D) "Includible compensation" means a member's compensation received from the employer that is includible in the member's gross income for federal income tax purposes (computed without regard to Internal Revenue Code Section 911) for the most recent period that is a year of service. Includible compensation also includes any amount contributed or deferred by the employer at the election of the member that would be includible in the gross income of the member but for the rules of section 125, 132(f)(4), 402(a)(3), 402(h)(1)(B), 402(k), or 457(b) of the Code. The amount of Includible compensation is determined without regard to any community property laws. Includible compensation does not include any amounts "picked up" by the employer within the meaning of Internal Revenue Code 414(h).

Includible compensation includes differential pay as defined in Internal Revenue Code Section 414(u). Includible compensation includes any compensation described in paragraphs (E) or (F), provided the compensation is paid by the later of two and one-half (2 1/2) months after the member's severance from employment with the employer or the end of the calendar year in which the member has a severance from employment with the employer.

(E) Any payment that would have been paid to the member prior to a severance from employment if the member had continued in employment with the employer and that is regular compensation for services outside the member's regular working hours (such as overtime or other similar payments).

(F) A payment for unused accrued bona fide sick, vacation, or other leave, but only if the member would have been able to use the leave if employment had continued and the payment would have been included in the definition of compensation if it was paid prior to the member's severance from employment.

(3) Each member shall specify in the salary reduction agreement the dollar amount or percentage by which the member's salary is to be reduced by the employer. Each such agreement shall be legally binding and irrevocable as to the amounts earned while it is in effect. A member may change the salary reduction agreement during the member's taxable year. A member may terminate the agreement with respect to amounts not yet earned. Any member who wishes to change the amount contributed to the Program must complete a new amended contract. Contributions can be stopped at any time.

(4) Employers are required to report salary reduction contributions made to the Program on the federal Form W-2. Employers shall mark the "deferred compensation" block in the correct box of the W-2 and shall put the amount of the contribution and the appropriate code in the specified box of the Form W-2.

(5) Employers shall not withhold federal and state income taxes on salary reduction contributions made to the Program. No other withholdings, including regular contributions to TRS and FICA taxes, should be affected or decreased by salary reduction contributions to the Program.

(6) Any active or retired member may roll over to the Program an eligible rollover distribution as defined in section 402(c)(4) of the Internal Revenue Code from other section 403(b) plans or eligible retirement plans within the meaning of section 402(c)(3)(B) of the Internal Revenue Code subject to limitations in the Internal Revenue Code and/or pertinent sections of the Income Tax Regulations. An eligible rollover distribution means any distribution of
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all or any portion of a member's benefit under another eligible retirement plan, except that an eligible rollover distribution does not include (1) any installment payment for a period of 10 years or more, (2) a distribution made as a result of an unforeseeable emergency or other distribution which is made upon hardship of the employee, or (3) for any other distribution, the portion, if any, of the distribution that is a required minimum distribution under section 401(a)(9) of the Internal Revenue Code. An eligible retirement plan means an individual retirement account described in section 408(a) of the Code, an individual retirement annuity described in section 408(b) of the Code, a qualified trust described in section 401(a) of the Code, an annuity plan described in section 403(a) or 403(b) of the Code, or an eligible governmental plan described in section 457(b) of the Code, that accepts the eligible rollover distribution. Written verification that the rollover is an eligible rollover distribution from an eligible retirement plan must be received by TRS before any such monies will be accepted. Such rollover contributions shall be made in the form of cash only, not in-kind. A separate rollover account will be established for these rollovers.

7. The minimum allowable salary reduction contribution is Two Hundred Dollars ($200) per taxable year of the member.

8. The Internal Revenue Code has set limits on the amount a member can exclude from his or her income for tax purposes. It is each member's and his or her employer's responsibility to ensure that contributions do not exceed the maximum limitations set forth in the Internal Revenue Code. TRS does not compute the maximum allowable contribution for Program participants and TRS is prohibited from entering into holding harmless agreements with participating members or employers.

9. If TRS is notified of any excess deferral (within the meaning of Internal Revenue Code Section 402(g)), the excess deferral plus attributable income will be accounted for separately under Code Section 402(c) and if instructed will distribute the excess deferral plus interest to the member on or before April 15 of the following year after the year of deferral. In the event of such a distribution, TRS will furnish the member with a Form 1099R with respect to the distribution of the excess deferral and attributable income. If distributed by April 15, the member should include the excess deferral and refund in the member's gross income for the year the excess deferral was made and refund of the attributable income in the year distributed. The employee may have to file an amended income tax return for the year the excess contribution was made. If the excess contribution is not distributed by April 15, the distribution may not occur until a regular distribution would occur, and the employee must include the refund in the employee's gross income for the year of deferral and the year of distribution. In this case the excess deferral is taxed twice.

10. A plan-to-plan transfer from another section 403(b) plan to this Program may be made on behalf of an active member if the following conditions are satisfied:

(A) The member is an employee of the employer for the transferring plan;
(B) The transferor plan provides for transfers, and
(C) The member whose assets are being transferred has an accumulated benefit immediately after the transfer that is at least equal to the accumulated benefit of that member immediately before the transfer.

11. To the extent any amount transferred is subject to any distribution restrictions under section 1403(b)(6) of the Treasury Regulations, the Program shall impose restrictions on distributions to the member whose assets are being transferred that are not less stringent than those imposed on the transferor plan. In addition, if the transfer does not constitute a complete transfer of the member's interest in the section 403(b) plan, the Program shall treat the amount transferred as a continuation of a pro rata portion of the member's interest in the section 403(b) plan.

12. Notwithstanding any provisions of this subchapter, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and section 414(u) of the Internal Revenue Code. For this purpose, a member whose employment is interrupted by qualified military service under section 414(u) of the Internal Revenue Code or who is on a leave of absence for qualified military service under section 414(u) of the Internal Revenue Code may elect to make additional salary reduction contributions upon resumption of employment with the employer up to the maximum amount of salary reduction contributions that the member could have elected during that period if the member's employment with the employer had continued (at the same level of compensation) without the interruption or leave, reduced by the salary reduction contributions, if any, actually made for the member during the period of the interruption or leave. Except to the extent provided under section 414(u) of the Internal Revenue Code, this right applies for five (5) years following the resumption of employment (or, if sooner, for a period equal to three (3) times the period of the interruption or leave).

715:10-19.7. Methods of computing maximum Program contribution [REVOKED]

(a) The maximum amount salary reduction contributions to the Program for any calendar year shall not exceed the applicable dollar amount in Internal Revenue Code Section 402(g)(1) for the year. The applicable dollar amount is Sixteen Thousand Five Hundred Dollars ($16,500) for 2009 for all elective deferrals made by a member. The applicable dollar amount limit is adjusted for cost-of-living after 2009 to the extent provided under Internal Revenue Code Section 402(g).

(b) A member who will attain age fifty (50) or older by the end of the calendar year may elect to make an additional amount of salary reduction contributions to the Program in excess of the applicable dollar amount under Internal Revenue Code Section 402(g)(1). The maximum dollar amount of the
age fifty (50) catch-up salary reduction contributions for a calendar year is Five Thousand Five Hundred Dollars ($5,500) for 2009 for all elective deferrals made by a member. The maximum dollar amount of age fifty (50) catch-up salary reduction contributions is adjusted for cost of living after 2009 to the extent provided under Internal Revenue Code Section 414(v).

c. A special catch-up provision allows members who have more than fifteen years of service with their employer to make additional contributions up to Three Thousand Dollars ($3,000) per year. However, aggregate contributions of all years above the limits may not exceed Fifteen Thousand Dollars ($15,000). In addition, a member can no longer make catch-up contributions under this special catch-up provision once his or her prior years’ contributions to any tax-sheltered annuity exceed Five Thousand Dollars ($5,000) multiplied by the years of service (as defined in section 403(b)(1) of the Internal Revenue Code) with the employer.

d. Salary reduction contributions in excess of the applicable dollar amount in Internal Revenue Code Section 402(g)(1) for the year shall be allocated first to the special catch-up provision under subparagraph (c) (if applicable) and next as an age fifty (50) catch-up contribution under subparagraph (b).


(a) Distributions from members’ accounts must be made in accordance with the Internal Revenue Code. TRS will distinguish pre-1986 and post-1986 account balances. Both account balances will be distributed in accordance with the applicable Internal Revenue Code provisions as they pertain to individual retirement accounts or annuities. The post-1986 account balance will include earnings after 1986 on the pre-1987 account balance. TRS will adjust each balance as required under IRS rules and regulations.

(b) Distribution of deposits made, or income earned, after December 31, 1988, will not be made to members except under one of the following circumstances:

   (1) attainment of age fifty-nine and one-half (59 1/2).
   (2) death.
   (3) disability within the meaning of section 72(m)(7) of the Internal Revenue Code.
   (4) severance from employment (with the member’s employer). However, a severance from employment also occurs on any date on which a member ceases to be an employee of an educational organization, even though the member may continue to be employed by a related employer that is another unit of the State or local government that is not an educational organization or in a capacity that is not employment with an educational organization (e.g., ceasing to be an employee performing services for an educational organization but continuing to work for the same state or local government employer).
   (5) retirement.
   (6) financial hardship (this distribution does not include accumulated earnings).
   (7) transfer to another section 403(b) plan in accordance with subsection (n) of this section.
   (8) qualified reservist distribution under Code Section 72(o).
   (9) pursuant to a qualified domestic relations order.
   (c) Distributions from this tax-sheltered annuity program are subject to federal and state income taxes. Certain distributions may also be subject to penalties and/or excise taxes under the Internal Revenue Code. Members should seek tax advice prior to requesting distributions.
   (d) Upon filing a properly executed distribution request application, a portion or all of a member’s tax-sheltered annuity balance that qualifies under Internal Revenue Code regulations, may be distributed. Distributions, other than required minimum distributions and hardship withdrawals, are subject to a mandatory federal withholding of twenty percent (20%). (Distribution of these deposits shall not affect membership status.)
   (e) Members who have attained age fifty-nine and one-half (59 1/2) are eligible to withdraw all or any portion of their deposits, subject to the provisions of subsection (b) of this section.
   (f) Members who have not attained age fifty-nine and one-half (59 1/2) and who have not had a severance from employment (retired or terminated employment) may withdraw only contributions made prior to January 1, 1989, unless a financial hardship exists. (See OAC 715:10-19-9.) Notwithstanding the foregoing sentence, a member may transfer his or her Program account to another section 403(b) plan subject to and in accordance with subsection (n) of this section. In addition, the restrictions of this section do not apply to amounts held in a separate rollover account.
   (g) Members who roll over their Program accounts to another section 403(b) plan may transfer these funds back to the Program at a later time subject to and in accordance with paragraph 6 of OAC 715:10-19-5.
   (h) Upon severance from employment, a member may elect one of the following annuity distribution options subject to Internal Revenue Code requirements, including Code Section 403(b)(10), Code Section 401(a)(9), and the incidental death benefit requirements of Code Section 401(a):

   (1) minimum distribution option under Code Section 401(a)(9), with the post-1986 deferrals and all post-1986 earnings subject to the current Internal Revenue Service distribution rules and the pre-1987 account balance subject to the prior applicable Internal Revenue Service distribution rules.
   (2) lump sum surrender option, payable only to the member.
   (3) partial lump sum, where the member selects a specified lump sum payable to the member.
   (4) a nontransferable fixed or variable annuity issued by an insurance company providing for periodic payments to a member and his/her beneficiary.

(i) The beneficiary(ies) designated on a member’s regular retirement account also shall serve as beneficiary(ies) for the Program account, unless otherwise designated by the member.
(j) In the calendar year following the calendar year of the member’s death, if the member dies before distribution of the member’s account, the member’s account shall be paid to his or her designated beneficiary in a lump sum. Alternatively, if the designated beneficiary with respect to the member’s account is
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a natural person, at the designated beneficiary's election, distribution can be made in annual installments with the distribution period determined under this paragraph.

(k) If the designated beneficiary is the member's surviving spouse, the distribution period is equal to the beneficiary's life expectancy using the single life table in section 1.401(a)(9)-9, A-1, of the Income Tax Regulations for the spouse's age on the spouse's birthday for that year. If the designated beneficiary is not the member's surviving spouse, the distribution period is the beneficiary's life expectancy determined in the year following the year of the member's death using the single life table in section 1.401(a)(9)-9, A-1, of the Income Tax Regulations for the beneficiary's age on the beneficiary's birthday for that year, reduced by one for each year that has elapsed after that year.

(l) In the event there is no designated beneficiary, or if the member's estate or trust or a charitable organization is the designated beneficiary, the entire account balance must be distributed by the fifth year following the member's death. For any year, a beneficiary can elect distribution of a greater amount (not to exceed the amount of the remaining account balance) in lieu of the amount calculated under this paragraph.

(m) In no event shall any distribution begin later than the later of (i) April 1 of the year following the calendar year in which the member attains age seventy and one-half (70 1/2) or (ii) April 1 of the year following the year in which the member retires or otherwise has a severance from employment. If distributions commence in the calendar year following the later of the calendar year in which the member attains age seventy and one-half (70 1/2) or the calendar year in which the severance from employment occurs, the distribution on the date that distribution commences must be equal to the annual installment payment for the year that the member has a severance from employment and an amount equal to the annual installment payment for the year after severance from employment must also be paid before the end of the calendar year of commencement. For purposes of this paragraph, annual installment payments through the year of the member's death are calculated as the amount payable each year equal to a fraction of the member's account balance equal to one divided by the distribution period set forth in the Uniform Lifetime Table at section 1.401(a)(9)-9, A-2, of the Income Tax Regulations for the member's age on the member's birthday for that year. If the member's age is less than age seventy (70), the distribution period is twenty seven and four tenths (27.4) plus the number of years that the member's age is less than age seventy (70). At the member's election, this annual payment can be made in monthly or quarterly installments. The account balance for this calculation (other than the final installment payment) is the account balance as of the end of the year prior to the year for which the distribution is being calculated. For any year, the member can elect distribution of a greater amount (not to exceed the amount of the remaining account balance) in lieu of the amount calculated using this formula. Notwithstanding anything to the contrary in this Section, distribution of elective deferrals made prior to January 1, 1987 (but not any interest accumulated with respect thereto) need not commence until April 1 of the calendar year following the calendar year in which the Participant attains age seventy-five (75).

(o) A plan-to-plan transfer from the Program to another section 403(b) plan may be made on behalf of an active member if the following conditions are satisfied:

1. The member is an employee of the employer for the receiving plan;
2. The receiving plan provides for the receipt of transfers;
3. The member whose assets are being transferred has an accumulated benefit immediately after the transfer that is at least equal to the accumulated benefit of that member immediately before the transfer;
4. The receiving plan provides that, to the extent any amount transferred is subject to any distribution restrictions under section 1.403(b)-6 of the Income Tax Regulations, the receiving plan shall impose restrictions on distributions to the member whose assets are being transferred that are not less stringent than those imposed on the Program; and
5. If the transfer does not constitute a complete transfer of the member's interest in the Program, the receiving plan shall treat the amount transferred as a continuation of a pro rata portion of the member's interest in the Program.

Permissive Service Credit Transfers.

1. If a member is also a member in a tax-qualified defined benefit governmental plan (as defined in section 414(d) of the Code) that provides for the acceptance of plan-to-plan transfers with respect to the member, then the member may elect to have any portion of the member's account transferred to the defined benefit governmental plan. A transfer under this section may be made before the member has had a severance from employment.

2. A transfer may be made under this section only if the transfer is either for the purchase of permissive service credit (as defined in section 415(n)(3)(A) of the Code) under the receiving defined benefit governmental plan or a repayment to which section 415 of the Code does not apply by reason of section 415(c)(3) of the Code.

3. In addition, if a plan-to-plan transfer does not constitute a complete transfer of the member's or Beneficiary's interest in the transferor plan, the Program shall treat the amount transferred as a continuation of a pro rata portion of the member's or Beneficiary's interest in the transferor plan (e.g., a pro rata portion of the member's or Beneficiary's interest in any after-tax employee contributions).


(a) Financial hardship is defined as an immediate and heavy financial need experienced by the member, resulting from a sudden and unexpected illness or accident of the member or of a dependent of the member, loss of the member's property due to casualty, or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the member. The circumstances that constitute a financial hardship will depend upon the relevant facts and circumstances of each case, but, in any case, payment may not be made to the extent that such financial hardship is or may be relieved.
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715:10-19-11. Rollovers from Program to other eligible retirement plans [REVOKED]

(a) Notwithstanding any other provision of the administrative code, a member, a member's spouse, a member's former spouse who is the alternate payee under a qualified domestic order, as defined in OAC 715:10-25-1, may elect at the time and in the manner prescribed by TRS, to have all or a portion of an eligible rollover distribution (as defined in Internal Revenue Code 402(c)(4)) from the Program paid directly to another eligible retirement plan as defined under Internal Revenue Code 402(c)(8)(B) and the regulations thereto. In addition, a designated beneficiary other than a surviving spouse may elect to roll over an eligible rollover distribution directly from the Program to an individual retirement plan that has been established on behalf of the beneficiary as an inherited individual retirement plan, subject to and in accordance with section 408(d)(3)(C) of the Internal Revenue Code.

(b) The following definitions shall apply for purposes of the words and phrases used in this Section:

1. an "eligible rollover distribution" includes any distribution of all or any portion of the tax-sheltered annuity benefit to the credit of a member, a member's spouse, a member's former spouse who is the alternate payee under a qualified domestic order, as defined in OAC 715:10-25-1, or a deceased member's designated beneficiary except that an eligible rollover distribution does not include the following:
   (A) any distribution that is one of a series of substantially equal periodic payments, paid not less frequently than annually, made for the life or life expectancy of the member or the member's spouse;
   (B) any distribution that is one of a series of substantially equal periodic payments for a specified period of ten years or more;
   (C) any distribution to the extent such distribution is required under Internal Revenue Code Section 401(a)(9).
   (D) any distributions during a year that are reasonably expected to total less than $200.

2. an "eligible retirement plan" includes an individual retirement account or annuity described in Internal Revenue Code Sections 408(a) or (b), a qualified trust described in Internal Revenue Code 401(a), an annuity program described in Internal Revenue Code Sections 403(a) or 403(b), or an eligible governmental plan described in Internal Revenue Code 457(b) that is willing to accept the distributee's eligible rollover distribution. In addition, an eligible retirement plan includes a Roth IRA under Internal Revenue Code Section 408A. However, in the case of a distribution to a beneficiary who at the time of the member's death was neither the spouse of the member nor the spouse or former spouse of the member who is an alternate payee under a domestic relations order, a direct rollover is payable only to an individual retirement account or individual retirement annuity that has been established on behalf of the Beneficiary as an inherited IRA (within the meaning of section 408(d)(3)(C) of the Code).

(c) Eligible rollover distributions may be paid to not more than two eligible retirement plans, as selected by the distributee, when a direct rollover is elected.

715:10-19-12. The Oklahoma Teachers' Deferred Savings Incentive Plan Fund [REVOKED]

(a) The Oklahoma Teachers' Deferred Savings Incentive Plan Fund, established and funded pursuant to Enrolled House Bill 1428 of the first session of the 47th Oklahoma State Legislature, shall be used for payment by TRS of matching contributions into the Program accounts of active, contributing TRS members. Accounts eligible to receive matching
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Contributions are those maintained by TRS in accordance with section 403(b) of the Internal Revenue Code.

(b) TRS shall hold and invest funds in the Oklahoma Teachers' Deferred Savings Incentive Plan Fund in the same manner determined by the Board of Trustees.

(e) If the Oklahoma Teachers' Deferred Savings Incentive Plan Fund is insufficiently funded to fully pay such contributions in any month, payments shall be suspended until sufficient monies are available.

715:10-19-13. Contributions from the Oklahoma Teachers' Deferred Savings Incentive Plan Fund into Program accounts of active contributing TRS members

[REVOKED]

Provided funds in the Oklahoma Teachers' Deferred Savings Incentive Plan Fund are sufficient to fully fund such contributions, TRS shall contribute $25.00 per month into the Program account of each active contributing TRS member who contributes at least $25.00 per month into his or her Program account maintained pursuant to section 403(b) of Internal Revenue Code.

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