TITLE 460 DIVISION OF DISABILITY, AGING, AND REHABILITATIVE SERVICES

NOTE: Under IC 4-28-2-1, the name of the Department of Human Services is changed to Division of Aging and Rehabilitative Services, effective January 1, 1992.

NOTE: Under P.L.4-1993, SECTION 31 and P.L.5-1993, SECTION 44, the name of the Division of Aging and Rehabilitative Services is changed to Division of Disability, Aging, and Rehabilitative Services, effective July 1, 1993.

ARTICLE 1. AGING

Rule 1. Nursing Home Prescreening

460 IAC 1-1-1 Purpose

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-12-33; IC 12-10-12-34; IC 12-15

Sec. 1. The purpose of the health facility preadmission screening program is to determine whether there are community services available for individuals who need assistance with the tasks of daily living that would be more appropriate than care in a health facility and, if so, to deny permission to enter a health facility unless the individual is willing to forego eligibility for certain Medicaid reimbursement for a period of time beginning from the date of admission as specified in IC 12-10-12-33 and IC 12-10-12-34. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-1-1; filed Jul 25, 1985, 3:39 p.m.: 8 IR 1984; filed Aug 7, 1995, 10:00 a.m.: 18 IR 3383; readopted filed Nov 14, 2001, 4:45 p.m.: 25 IR 1270) NOTE: Transferred from the department on aging and community services (450 IAC 1-1-1) to the division of aging and rehabilitative services (460 IAC 1-1-1) by P.L.41-1987, SECTION 23, effective July 1, 1987.*

460 IAC 1-1-2 Definitions

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6-1; IC 12-10-1-1; IC 12-10-1-4; IC 12-10-12; IC 12-14; IC 12-15-2; IC 16-28-2

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "Applicant" means an individual who has directly, or through a responsible party, made application to participate in the nursing home prescreening program under IC 12-10-12 in order to determine the appropriateness of the individual's placement in a health facility.

(c) "Admission to a health facility" means as soon as an individual is physically present in a health facility unless the admittance is designee-approved. A person approved by a designee is considered admitted twenty-four (24) hours after entering the facility.

(d) "Bureau" refers to the bureau of aging and in-home services established within the division under IC 12-10-1-1.

(e) "DDARS" or "division" refers to the Indiana division of disability, aging, and rehabilitative services.

(f) "Designee" means an individual appointed by the prescreening agency, who may authorize temporary admittance to a health facility, under IC 12-10-12-28 through IC 12-10-12-31.

(g) "Equivalent degree" means a bachelor's degree or a master's degree, which meets the following requirements:

(1) The degree is in the same field of study as those listed in section 10(c)(1) of this rule.

(2) The degree requires courses comparable to the courses required for the degrees listed in section 10(c)(1) of this rule.

(3) The degree has a different title than the degree listed in section 10(c)(1) of this rule.

(h) "Health facility" means a facility licensed by the state department of health under IC 16-28-2, whether Medicare or Medicaid certified or not, that:

(1) provides comprehensive:
  (A) nursing care;
  (B) room;
  (C) food;
  (D) laundry;
  (E) administration of medications;
  (F) special diets; and
  (G) treatments; and

(2) may provide rehabilitative and restorative therapies under the order of an attending physician.

The term, for purposes of this rule, does not include intermediate care facilities for the mentally retarded (ICF/MR) or facilities licensed for residential care.

(i) "Level I: Identification Evaluation Screen" refers to a screening tool designed to ascertain whether an individual has or is suspected of having a condition of mental illness (MI) and/or mental retardation /developmental disability (MR/DD).

(j) "Medicaid or medical assistance" means payment for part or all of the cost of medical or remedial services furnished on behalf of eligible needy individuals as defined in IC 12-15-2.

(k) "Medicaid waiver" refers to specific provisions concerning home and community based services as specified under 42 U.S.C. 1396n, which have been approved by the Secretary of the federal Department of Health and Human Services, for implementation in Indiana.

(l) "Office" means the office of Medicaid policy and planning established under IC 12-8-6-1.

(m) "PAS process" means the process specified in section 4 of this rule.

(n) "PAS team" means the screening team under IC 12-10-12-14.

(o) "Preadmission screening", "prescreening", and "screening program" mean the screening process under IC 12-10-12.

(p) "Prescreening agency" or "PAS agency" means an area agency on aging designated by the bureau under IC 12-10-1-4(18).

(q) "Responsible party" means an individual chosen by an applicant or, if the applicant is a minor or has been adjudicated incompetent, a parent or guardian of an applicant who assists in the process of making application for prescreening under this rule. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-1-2; filed Jul 25, 1985, 3:39 p.m.: 8 IR 1984; filed Aug 7, 1995, 10:00 a.m.: 18 IR 3386; readopted filed Nov 14, 2001, 4:45 p.m.: 25 IR 1270) NOTE: Transferred from the department on aging and community services (450 IAC 1-1-2) to the division of aging and rehabilitative services (460 IAC 1-1-2) by P.L.41-1987, SECTION 23, effective July 1, 1987.*

460 IAC 1-1-3 Exemption

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-12; IC 12-13-5; IC 12-14

Sec. 3. The prescreening program under IC 12-10-12 applies to all persons applying for admission to a health facility, except that all persons admitted to a health facility prior to implementation of this section on April 30, 1983, are exempted from the prescreening requirement as set out in IC 12-10-12. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-1-3; filed Jul 25, 1985, 3:39 p.m.: 8 IR 1985; filed Aug 7, 1995, 10:00 a.m.: 18 IR 3387; readopted filed Nov 14, 2001, 4:45 p.m.: 25 IR 1271) NOTE: Transferred from the department on aging and community services (450 IAC 1-1-3) to the division of aging and rehabilitative services (460 IAC 1-1-3) by P.L.41-1987, SECTION 23, effective July 1, 1987.*

460 IAC 1-1-4 PAS process

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-12; IC 12-13-5; IC 12-14

Sec. 4. (a) The PAS process shall be completed for each individual who has agreed to participate in the PAS program.

(b) The PAS process shall consist of the following:

(1) A complete PAS assessment, including the following:

(A) The applicant's medical condition and related service needs.

(B) The applicant's psychosocial status and related service needs.

(C) The applicant's degree of functional impairment and related service needs.

(D) The availability of community services (formal and informal) that are sufficient and appropriate to meet the identified service needs outside of, as opposed to within, a health facility.

(2) A screening team recommendation, based upon the complete assessment, as to the appropriateness of health facility placement.

(3) A final determination by the office, based upon the screening team recommendation, as to the appropriateness of health facility placement.

(c) The PAS process must be completed prior to admission to a health facility, within twenty-five (25) days from the effective date of the PAS application, except in situations involving designee authorization for temporary admission to a health facility. However, for a nonresident, the PAS process must be completed and the findings reported within ten (10) days. *(Division of*

Disability, Aging, and Rehabilitative Services; 460 IAC 1-1-4; filed Jul 25, 1985, 3:39 p.m.: 8 IR 1985; filed Aug 7, 1995, 10:00 a.m.: 18 IR 3387; readopted filed Nov 14, 2001, 4:45 p.m.: 25 IR 1271) NOTE: Transferred from the department on aging and community services (450 IAC 1-1-4) to the division of aging and rehabilitative services (460 IAC 1-1-4) by P.L.41-1987, SECTION 23, effective July 1, 1987.

460 IAC 1-1-5 Application

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-12-7; IC 12-10-12-27.1; IC 16-28-2

Sec. 5. (a) The individual requesting care in a health facility or the individual's responsible party shall fill out and sign an application for the prescreening program prior to admission to a health facility under IC 12-10-12-7. The application is considered to be completed when it is filled out, signed, and given to a representative of a health facility, the designee, or a member of the prescreening team.

(b) The applicant shall, as part of the application process, state the name, address, and telephone number of the physician that he or she requests to serve on the screening team.

(c) The effective date of the application for prescreening is the date on which the prescribed form is signed by the applicant.

(d) A person in a residential living arrangement who is at risk of institutionalization or who could benefit from home-based care may make a request to the PAS agency in the county in which the applicant resides under IC 12-10-12 prior to application for admission to a health facility to determine if home-based services are available and appropriate. The application will be made to the prescreening agency serving the area in which the applicant resides.

(e) An individual who is a resident of a health facility may request to be screened, as part of a discharge planning process, to determine what services are available to help the individual live outside of the health facility. The application will be made to the prescreening agency serving the area in which the health facility is located.

(f) Requirements for a person residing in another state requesting admission to a health facility in Indiana shall be as follows:

(1) The person must participate in the prescreening program under IC 12-10-12-27.1.

(2) An application for the prescreening program by a person residing in another state shall be made to the prescreening agency serving the county in which the health facility is located, and the availability of community services shall be based on services available in the area in which the health facility is located. Determination is to be rendered within ten (10) days of receipt of the required documents.

(g) The screening under IC 12-10-12 shall not be required:

(1) for a person admitted to a health facility following direct discharge from another health facility licensed under IC 16-28-2;

(2) for a person readmitted to a health facility from a hospital after discharge directly from a health facility to the hospital, if his or her placement in a health facility was found to be appropriate under IC 12-10-12 or if he or she was admitted to a health facility prior to April 30, 1983;

(3) for transfer from one (1) nursing facility level of services to another nursing facility level of services in the same health facility or in another health facility;

(4) for a person admitted to an intermediate care facility for the mentally retarded or a facility licensed for residential care; or

(5) for an individual who transfers from a continuing care retirement community bed to the bed of a comprehensive care facility licensed under IC 16-28-2 that serves only residents of that retirement community for a recuperative stay not to exceed five (5) days, but if the individual remains longer than five (5) days, the individual must apply for screening no later than the fifth day.

(h) Authorization for admission under IC 12-10-12-31 may be granted by the designee when a medical emergency exists in that care in the health facility is required within seventy-two (72) hours of the request for admission and the attending physician certifies the need for emergency admission to the prescreening agency following the procedures established by the division. An emergency admission shall only be granted for admission from a noninstitutional living arrangement or an emergency room of an in-state hospital.

(i) For individuals who have undergone the screening process and have been determined to be ineligible for placement in a health facility, that individual shall not apply for participation in further screening for a minimum of one (1) year unless the medical condition or the support system of the individual is significantly changed to the degree that the attending physician believes a new screening process is medically necessary. The attending physician may certify the need for such additional screening to the

prescreening agency. The screening team will make the final decision on the need for another screening based on the attending physician's certification. The screening shall be conducted in accordance with IC 12-10-12. The effective date of the application for additional screening shall be the date of the screening team's final decision on the need for another screening.

(j) For persons not admitted to a health facility, the determination under IC 12-10-12-20 that placement in a health facility is appropriate shall be valid for a period not to exceed ninety (90) days from the date of issuance by the office. If the person has not been admitted to a health facility ninety (90) days after the issuance of the determination, the individual must apply for PAS screening again, and must have a physician's certification of the need for additional screening.

(k) An individual who was not notified of the requirement for prescreening and who is in a health facility may be prescreened after receiving notification of the requirement. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-1-5; filed Jul 25, 1985, 3:39 p.m.: 8 IR 1985; filed Aug 7, 1995, 10:00 a.m.: 18 IR 3388; readopted filed Nov 14, 2001, 4:45 p.m.: 25 IR 1272) NOTE: Transferred from the department on aging and community services (450 IAC 1-1-5) to the division of aging and rehabilitative services (460 IAC 1-1-5) by P.L.41-1987, SECTION 23, effective July 1, 1987.*

460 IAC 1-1-6 Agency cooperation

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-12; IC 12-13-5; IC 12-14

Sec. 6. (a) The county offices of family and children, the Indiana division of mental health, the bureau of developmental disabilities, the office, the division, the prescreening agencies, and all health facilities shall cooperate in the operation of the screening program and shall share such information concerning the applicant as requested by each other, except to the extent that the information is otherwise protected under state or federal law.

(b) The division shall prescribe the forms and procedures and establish the policy to be followed in the implementation of the nursing home prescreening program. The appointed area agencies on aging shall be designated by the division as the prescreening agencies to carry out the duties as outlined in this rule. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-1-6; filed Jul 25, 1985, 3:39 p.m.: 8 IR 1987; filed Aug 7, 1995, 10:00 a.m.: 18 IR 3389; readopted filed Nov 14, 2001, 4:45 p.m.: 25 IR 1273) NOTE: Transferred from the department on aging and community services (450 IAC 1-1-6) to the division of aging and rehabilitative services (460 IAC 1-1-6) by P.L.41-1987, SECTION 23, effective July 1, 1987.*

460 IAC 1-1-7 Prescreening agency; duties

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-12; IC 12-13-5; IC 12-14

Sec. 7. The prescreening agency shall do the following:

(1) Seek cooperation from other public and private agencies in the community which offer services to the disabled and elderly.

(2) Provide information and education to the general public regarding availability of the screening program.

(3) Accept prescreening referrals from individuals, families, human service professionals, and health facility personnel.

(4) Assess health and social needs of referred individuals and identification of services needed to maintain these persons in the least restrictive environment.

(5) Identify available noninstitutional services to meet the care needs of individuals referred.

(6) Compute the cost effectiveness of noninstitutional versus health facility services.

(7) Upon receipt of a completed application, immediately schedule the prescreening activities to be completed within the time designated at IC 12-10-12-28 through IC 12-10-12-31 or within twenty-five (25) days for persons making application under IC 12-10-12-7.

(8) Determine the composition of the PAS teams provided for under IC 12-10-12-14. The division may require the PAS agency to seek approval of PAS team members from the division.

(9) Make appointments and fill vacancies on the PAS team and appoint designees under IC 12-10-12-27.

(10) Appoint to the PAS team at the time of each prescreening, the applicant's physician as required in IC 12-1-12-14(b) *[IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*. In the event that the applicant is unable to specify an attending physician, the prescreening agency may assist to locate a physician who shall be named as a member of the screening team with the approval of the applicant.

(11) Notify each appointee of his or her selection, in writing.

(12) Retain a signed copy of the prescribed notification, application form, and supporting documentation for a period of three (3) years.

(13) Prepare reports as required by the division.

(14) Report to the prosecuting attorney of the county in which the violation occurred the failure of the health facility to notify the individual that he or she must be prescreened prior to admission to the health facility or the failure of the health facility to deliver the signed copy of the notification to the prescreening agency serving the county in which the applicant resides.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-1-7; filed Jul 25, 1985, 3:39 p.m.: 8 IR 1987; filed Aug 7, 1995, 10:00 a.m.: 18 IR 3389; readopted filed Nov 14, 2001, 4:45 p.m.: 25 IR 1273) NOTE: Transferred from the department on aging and community services (450 IAC 1-1-7) to the division of aging and rehabilitative services (460 IAC 1-1-7) by P.L.41-1987, SECTION 23, effective July 1, 1987.

460 IAC 1-1-8 Health facility; duties

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-12; IC 12-13-5; IC 12-14

Sec. 8. (a) When an individual applies to a health facility for admission, the health facility shall notify the applicant:

(1) that he or she must apply to the prescreening agency for participation in the prescreening program;

(2) that the preadmission screening program consists of an assessment of the applicant's need for care in a health facility made by a team of individuals familiar with the needs of persons seeking admission; and

(3) the penalty that the individual will incur under IC 12-10-12-33 and IC 12-10-12-34 if he or she does not comply with the prescreening program.

(b) The notification shall be in writing on forms prescribed by the division and shall contain the information set out in IC 12-10-12-10(a) and IC 12-10-12-10(b).

(c) The applicant must be given one (1) signed copy acknowledging that he or she has received the notice and the date that the notice was received. The health facility that the individual has entered shall keep one (1) signed copy on file for one (1) year from the date of signature or, if the individual is admitted to the health facility, from the date of admission, whichever is later. One (1) signed copy must be forwarded to the prescreening agency within five (5) working days from the date of signature or, if the individual is admitted to the health facility, from the date of admission, whichever is later.

(d) It is the responsibility of the health facility to provide verification that:

(1) the application for prescreening was made prior to admission;

(2) an individual admitted prior to the prescreening determination under IC 12-10-12-20 had designee authorization for admission required under IC 12-10-12-27; and

(3) the copy of the application and other designated documentation were forwarded to the prescreening agency within five (5) working days from the date of designee authorization.

(e) The health facility shall promptly provide to the screening team an estimate of the cost of all services that the individual is anticipated to require in the health facility. The estimate will be at the cost charged to private payors. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-1-8; filed Jul 25, 1985, 3:39 p.m.: 8 IR 1988; filed Aug 7, 1995, 10:00 a.m.: 18 IR 3390; readopted filed Nov 14, 2001, 4:45 p.m.: 25 IR 1274) NOTE: Transferred from the department on aging and community services (450 IAC 1-1-8) to the division of aging and rehabilitative services (460 IAC 1-1-8) by P.L.41-1987, SECTION 23, effective July 1, 1987.*

460 IAC 1-1-9 Applicant's physician or physician member of PAS team; duties

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-12; IC 12-13-5; IC 12-14

Sec. 9. The applicant's physician or physician member of the screening team shall promptly supply all medical information on the applicant that is necessary to complete the assessment and make the findings required by IC 12-10-12-17 and IC 12-10-12-28 through IC 12-10-12-31. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-1-9; filed Jul 25, 1985, 3:39 p.m.: 8 IR 1988; filed Aug 7, 1995, 10:00 a.m.: 18 IR 3391; readopted filed Nov 14, 2001, 4:45 p.m.: 25 IR 1274) NOTE: Transferred from the department on aging and community services (450 IAC 1-1-9) to the division of aging and rehabilitative services (460 IAC 1-1-9) by P.L.41-1987, SECTION 23, effective July 1, 1987.*

460 IAC 1-1-10 PAS team; duties

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-12-16; IC 12-10-12-18; IC 12-13-5; IC 12-14

Sec. 10. (a) The PAS team shall conduct the preadmission assessment pursuant to the policies and procedures prescribed by the division.

(b) The preadmission assessment shall be conducted by the use of the assessment forms developed or approved by the division and shall include the following elements:

(1) Client demographic information.
(2) Present medical condition of client.
(3) Present psychosocial status of client.
(4) Assessment of functional capacity of client.
(5) Present formal or informal services being provided to the client.
(6) Present unmet needs of client.
(7) Formal and informal services that are presently available but are not being provided to the client.
(8) Observations of the PAS team during the on-site visit.
(9) Persons consulted during the screening process.
(10) Client's preference for care.
(11) A preliminary care plan.

(c) Each PAS team member, other than the physician member, shall have one (1) of the following:

(1) A bachelor's degree in social work, psychology, gerontology, sociology, counseling, nursing, or an equivalent degree.
(2) A license as a registered nurse or a bachelor's degree in any field and a minimum of two (2) years of direct service experience with the elderly or persons with disabilities, which includes activities such as the following:
    (A) Assessment.
    (B) Plan development.
    (C) Implementation.
    (D) Monitoring.

A master's degree in a related field may substitute for the required experience.

(d) An individual who meet the educational requirement and a minimum of one (1) year of the required experience may qualify provisionally as a PAS team member. In order for any individual to qualify provisionally as a PAS team member, the PAS agency shall have in place a written plan, approved by the division, outlining the manner in which the individual shall achieve the experience needed to become a PAS team member. The written plan shall include the following:

(1) A specific proposal of how the remaining amount of the deficient experience will be satisfied within a time period equal to the amount of remaining experience needed, but not to exceed twelve (12) months.
(2) Arrangements for the provisional PAS team member to meet, at least biweekly, with a supervisor or an individual who meets the qualifications in section 10(c) of this rule, to discuss the provisional PAS team member's care plans.
(3) A statement asserting that the provisional PAS team member's care plans will be reviewed and approved by the supervisor or an individual who meets the qualifications in section 10(c) of this rule.

Provisional PAS team member certification shall be withdrawn by the division if the terms of the written plan are not met at least twelve (12) months from the date of provisional certification.

(e) Designees shall meet the criteria in subsection (c).

(f) After the assessment is completed, the PAS team shall find whether the placement of the individual in a health facility is appropriate, utilizing the guidelines set forth in section 12(c) and 12(d) of this rule.

(g) The vote of the PAS team shall be conducted at the time and place as set by the member of the screening team who represents the prescreening agency. The vote may either be made by a signature at the time of individual contact, based on a review of all necessary data, or the vote may be conducted by telephone. The vote of the physician team member will be made by completion of and signature on the prescribed form. The assessment of the appointee of the prescreening agency, together with the assessments of any other team member who desires to comment, shall be submitted to the office for the prescreening determination designated under IC 12-10-12-18. All screening forms, narrative reports, and other pertinent applicant data shall be submitted to the office with the findings of the PAS team.

(h) If the PAS team finds that placement in a health facility should be denied, then it shall:

(1) list the reason(s) for denial;
(2) list the community services available to the applicant that would be more appropriate than care in a health facility;
(3) detail the cost of those community services, regardless of the source of payment;
(4) detail the cost of placement in a health facility (which shall include the cost of all services, including those costs in addition to per diem that the applicant will require), regardless of the source of payment;
(5) discuss the alternative service plan with the applicant after completion of the assessment;
(6) submit the findings in writing to the office; and
(7) make appropriate referral for case management services if the services are available.

(i) The member of the PAS team who is appointed as the representative of the prescreening agency shall obtain the information for, and prepare the assessment required by IC 12-10-12-16. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-1-10; filed Jul 25, 1985, 3:39 p.m.: 8 IR 1988; filed Aug 7, 1995, 10:00 a.m.: 18 IR 3391; readopted filed Nov 14, 2001, 4:45 p.m.: 25 IR 1274) NOTE: Transferred from the department on aging and community services (450 IAC 1-1-10) to the division of aging and rehabilitative services (460 IAC 1-1-10) by P.L.41-1987, SECTION 23, effective July 1, 1987.*

460 IAC 1-1-11 Designee; duties

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-12; IC 12-13-5; IC 12-14

Sec. 11. (a) It is the duty of the designee to gather sufficient information to make a decision whether an applicant qualifies for temporary admittance to a health facility under IC 12-10-12-28 through IC 12-10-12-31.

(b) The designee shall submit a decision in writing and supporting documentation regarding the allowance or disallowance of placement in a health facility under IC 12-10-12-28 through IC 12-10-12-31 to the following:
(1) The prescreening agency.
(2) The applicant.
(3) The relevant health facility.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-1-11; filed Jul 25, 1985, 3:39 p.m.: 8 IR 1989; filed Aug 7, 1995, 10:00 a.m.: 18 IR 3392; readopted filed Nov 14, 2001, 4:45 p.m.: 25 IR 1275) NOTE: Transferred from the department on aging and community services (450 IAC 1-1-11) to the division of aging and rehabilitative services (460 IAC 1-1-11) by P.L.41-1987, SECTION 23, effective July 1, 1987.

460 IAC 1-1-12 Office of Medicaid policy and planning; duties

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-12-20; IC 12-13-5; IC 12-14

Sec. 12. (a) The final preadmission screening determination under IC 12-10-12-20(b) shall be rendered by the office within three (3) working days of receipt of the prescreening documentation and recommendation.

(b) The office shall notify:
(1) the applicant;
(2) the prescreening agency; and
(3) the health facility;

in writing of the prescreening determination, including data on alternative community services as identified in the recommendation of the prescreening team.

(c) A final determination that the person is appropriate for nursing facility care shall be rendered when the person's condition meets the nursing facility level of services as set forth in 405 IAC 1-3-1 through 405 IAC 1-3-3 and:
(1) alternative community services are not sufficient to meet the needs of the person;
(2) appropriate and beneficial alternative community services that have been identified are not immediately accessible by the person due to the lack of services in the county or a waiting list for needed services in the county; or
(3) appropriate and beneficial alternative community services that have been identified are immediately accessible, regardless of whether the cost of such services is greater than the cost of nursing home care.

(d) When the criteria in subsection (c) are not met, a final determination that the person is inappropriate for nursing facility care shall be rendered.

(e) The office shall retain a record of each determination that is a disapproval of admission or a waiver of a requirement in this rule for at least three (3) years. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-1-12; filed Jul 25, 1985, 3:39 p.m.: 8 IR 1989; filed Aug 7, 1995, 10:00 a.m.: 18 IR 3392; readopted filed Nov 14, 2001, 4:45 p.m.: 25 IR 1276) NOTE: Transferred from the department on aging and community services (450 IAC 1-1-12) to the division of aging and rehabilitative services (460 IAC 1-1-12) by P.L.41-1987, SECTION 23, effective July 1, 1987.*

460 IAC 1-1-13 Individual compliance with PAS program

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-12-33; IC 12-10-12-34; IC 12-13-5; IC 12-14

Sec. 13. (a) It is the responsibility of each prescreening agency to monitor individual compliance with the PAS program and report to the office. It is the responsibility of the office to impose the PAS penalty under IC 12-10-12-33 and IC 12-10-12-34 if there is noncompliance.

(b) Whenever an individual requests Medicaid payment of per diem for care in a health facility, the office must verify that individual's PAS status. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-1-13; filed Jul 25, 1985, 3:39 p.m.: 8 IR 1990; filed Aug 7, 1995, 10:00 a.m.: 18 IR 3393; readopted filed Nov 14, 2001, 4:45 p.m.: 25 IR 1276) NOTE: Transferred from the department on aging and community services (450 IAC 1-1-13) to the division of aging and rehabilitative services (460 IAC 1-1-13) by P.L.41-1987, SECTION 23, effective July 1, 1987.*

460 IAC 1-1-14 Penalties

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-12; IC 12-13-5; IC 12-14

Sec. 14. (a) A person admitted to a health facility will not incur the penalties set out in IC 12-10-12-33 and IC 12-10-12-34 if authorization for admission from the prescreening agency under IC 12-10-12-28 through IC 12-10-12-31 or approval for admission under IC 12-10-12-20 has been rendered.

(b) A person admitted to a health facility on designee authorization under IC 12-10-12-28 through IC 12-10-12-31 will not incur the penalties set out in IC 12-10-12-33 and IC 12-10-12-34 if, regardless of when the determination is made:

(1) placement in the health facility is determined to be appropriate under IC 12-10-12-20; or

(2) the individual is discharged from the health facility within fourteen (14) days after receipt of the decision that placement in the health facility is determined to be inappropriate.

(c) The penalty under IC 12-10-12-34 shall continue only until the person receives a determination that placement in a health facility certified as a skilled nursing facility is appropriate, but in no case will last more than one (1) year from the date of admission. The time of the penalty will be computed to include the period authorized under IC 12-10-12-28 through IC 12-10-12-31 except that the penalty will not be imposed for the designee authorized time.

(d) A person who refuses to be screened by the PAS team shall incur the penalty set out in IC 12-10-12-33 or IC 12-10-12-34.

(e) However, a person who was not notified of the preadmission screening requirement will incur no penalty, unless the individual refuses to be screened after notification or is found to be inappropriate for services, in which case the individual would incur the penalty beginning with the date of notification that preadmission screening is required.

(f) The penalty set out in IC 12-10-12-33 and IC 12-10-12-34 shall not be levied against an individual who:

(1) is eligible for and requires home and community based services approved by the Secretary of the federal Department of Health and Human Services under 42 U.S.C. 1396n; and

(2) chooses to go into a health facility.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-1-14; filed Jul 25, 1985, 3:39 p.m.: 8 IR 1990; errata, 8 IR 2041; filed Aug 7, 1995, 10:00 a.m.: 18 IR 3393; readopted filed Nov 14, 2001, 4:45 p.m.: 25 IR 1276) NOTE: Transferred from the department on aging and community services (450 IAC 1-1-14) to the division of aging and rehabilitative services (460 IAC 1-1-14) by P.L.41-1987, SECTION 23, effective July 1, 1987.

460 IAC 1-1-15 Waiver of sanctions

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-12-23; IC 12-13-5; IC 12-14

Sec. 15. (a) Application for a waiver under IC 12-10-12-23 of the prescreening sanction may be made to the office. The waiver may be granted if, after investigation, it is found that the conditions under IC 12-10-12-23 were met and if the health facility and hospital when necessary cooperated in the prescreening process promptly. The office shall confer with the prescreening agency to ascertain whether the conditions established in this subsection and IC 12-10-12-23 were met. The office shall maintain written documentation on the waiver decision for a period of not less than three (3) years.

(b) The office shall provide a copy of the findings under IC 12-10-12-23 to the following:

(1) The division.

(2) The prescreening agency.

(3) The applicant.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-1-15; filed Jul 25, 1985, 3:39 p.m.: 8 IR 1990; filed Aug 7, 1995, 10:00 a.m.: 18 IR 3394; readopted filed Nov 14, 2001, 4:45 p.m.: 25 IR 1277) NOTE: Transferred from the department on aging and community services (450 IAC 1-1-15) to the division of aging and rehabilitative services (460 IAC 1-1-15) by P.L.41-1987, SECTION 23, effective July 1, 1987.

460 IAC 1-1-16 Appeals

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-12; IC 12-13-5; IC 12-14

Sec. 16. (a) An applicant aggrieved by a final determination of the office or the division may appeal that determination to the family and social services administration, hearings and appeals office.

(b) The request for a fair hearing must be submitted in writing and signed by the applicant. This request must be received in the family and social services administration, hearings and appeals office within thirty (30) days of the action being appealed. This thirty (30) day period is measured from the date of the applicant's receipt of the PAS decision being appealed.

(c) The office shall provide a copy of the appeal decision to the following:

(1) The division.

(2) The prescreening agency.

(3) The applicant.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-1-16; filed Jul 25, 1985, 3:39 p.m.: 8 IR 1990; filed Aug 7, 1995, 10:00 a.m.: 18 IR 3394; readopted filed Nov 14, 2001, 4:45 p.m.: 25 IR 1277) NOTE: Transferred from the department on aging and community services (450 IAC 1-1-16) to the division of aging and rehabilitative services (460 IAC 1-1-16) by P.L.41-1987, SECTION 23, effective July 1, 1987.

Rule 2. Adult Protective Services

460 IAC 1-2-1 Purpose

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-3; IC 35-42-2-1; IC 35-46-1-13

Sec. 1. The purpose of the adult protective services program is to provide a legal basis for intervention to protect endangered adults within the state of Indiana by receiving reports regarding adults who may be endangered, investigating those reports and providing a coordinated and proper local response to individual cases as they are substantiated. Responsibility for investigating reports of neglect, battery, or exploitation of endangered adults, as well as for securing the appropriate social, medical, and legal intervention, shall rest with adult protective services units, designated by the division of disability, aging, and rehabilitative services.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-2-1; filed Oct 30, 1985, 10:48 a.m.: 9 IR 478; readopted filed Nov 14, 2001, 4:47 p.m.: 25 IR 1278) NOTE: Transferred from the department on aging and community services (450 IAC 1-2-1) to the division of aging and rehabilitative services (460 IAC 1-2-1) by P.L.41-1987, SECTION 23, effective July 1, 1987.

460 IAC 1-2-2 Definitions

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-3; IC 35-42-2-1; IC 35-46-1-13

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "APS unit" is the adult protective services unit, charged with receiving and investigating reports regarding endangered adults, located throughout the state in areas designated by DDARS.

(c) "Available services" means services needed by the individual to sustain his or her life, liberty, health or property which can be obtained from a service provider serving the area in which the endangered adult is living, or which could be provided by a willing neighbor, friend, or relative.

(d) "DDARS" is the division of disability, aging, and rehabilitative services.

(e) "Emergency" refers to a situation in which the possibility of immediate physical danger to the adult exists.

(f) "Endangered adult" means an individual who is eighteen (18) years of age or older and who:

(1) is incapable by reason of mental illness, mental retardation, dementia, habitual drunkenness, excessive use of drugs, or other physical or mental incapacity, of managing or directing the management of the individual's property or providing self-care; and

(2) is harmed or threatened with harm as a result of:

(A) neglect;

(B) battery; or

(C) exploitation of the individual's personal services or property.

The term includes individuals who are endangered as a consequence of their own inability to care for themselves and who would receive little or no help except through the services of an external intervenor.

(g) "Exploitation of the individual's personal services or property" includes, but is not limited to sexual misuse as well as the use of the endangered adult's labor without pay or exerting unauthorized control over the finances or property of the endangered adult.

(h) "Neglect" means that the endangered adult or the person who takes care of the endangered adult is unable or fails to provide adequate food, clothing, shelter or medical care.

(i) "Substantiated" means that endangerment was established to the satisfaction of the APS unit as relates to the definition of an endangered adult.

(j) "Unsubstantiated" means that endangerment of an individual was not established to the satisfaction of the APS unit, within the meaning of IC 12-10-3. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-2-2; filed Oct 30, 1985, 10:48 a.m.: 9 IR 478; readopted filed Nov 14, 2001, 4:47 p.m.: 25 IR 1278) NOTE: Transferred from the department on aging and community services (450 IAC 1-2-2) to the division of aging and rehabilitative services (460 IAC 1-2-2) by P.L.41-1987, SECTION 23, effective July 1, 1987.*

460 IAC 1-2-3 Agency cooperation

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-3; IC 35-42-2-1; IC 35-46-1-13

Sec. 3. All appropriate governmental agencies shall cooperate in the implementation of the provisions of IC 12-10-3 and coordinate services to endangered adults and shall share such information concerning the allegation of battery, neglect, exploitation, or endangerment of adults as requested by each other, except to the extent that the information is otherwise protected under state or federal law. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-2-3; filed Oct 30, 1985, 10:48 a.m.: 9 IR 478; readopted filed Nov 14, 2001, 4:47 p.m.: 25 IR 1278) NOTE: Transferred from the department on aging and community services (450 IAC 1-2-3) to the division of aging and rehabilitative services (460 IAC 1-2-3) by P.L.41-1987, SECTION 23, effective July 1, 1987.*

460 IAC 1-2-4 Division's duties

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-3-7; IC 12-10-3-10; IC 35-42-2-1; IC 35-46-1-13

Sec. 4. DDARS shall do the following:

(1) Provide information and education to the general public regarding the existence of the adult protective services law and available services.

(2) Prescribe the forms and procedures to be followed in the implementation of the program.

(3) Contract with entities, as identified at IC 12-10-3-7, to perform the duties of adult protective services units.
(4) Provide training and technical assistance in program operation and service delivery to the units.
(5) Monitor the program and fiscal activities of the units.
(6) Receive all reports of known or suspected neglect, battery, or exploitation which are communicated in person, in writing, or by telephone:
(A) establish and operate a statewide toll-free telephone line, answered twenty-four (24) hours a day, seven (7) days a week;
(B) document the receipt of all reports, by obtaining all necessary information as per IC 12-10-3-10;
(C) make a determination and classify the status of each report upon receipt as either emergency or nonemergency;
(D) refer all emergency reports received to the appropriate law enforcement agency immediately, and notify the appropriate APS unit of the referral to the law enforcement agency; and
(E) refer all nonemergency reports received to the appropriate APS unit within five (5) working days.
(7) Report to the general assembly before February 2 of each year concerning, at a minimum:
(A) the division's activities in the preceding year under IC 12-10-3; and
(B) program recommendations for continuing protection of endangered adults.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-2-4; filed Oct 30, 1985, 10:48 a.m.: 9 IR 479; readopted filed Nov 14, 2001, 4:47 p.m.: 25 IR 1279) NOTE: Transferred from the department on aging and community services (450 IAC 1-2-4) to the division of aging and rehabilitative services (460 IAC 1-2-4) by P.L.41-1987, SECTION 23, effective July 1, 1987.

460 IAC 1-2-5 Adult protective services unit's duties

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-3; IC 35-42-2-1; IC 35-46-1-13

Sec. 5. The APS unit shall assure that the following activities are carried out:
(1) Secure and maintain a full-time equivalent qualified protective services coordinator, as defined in 460 IAC 1-2-6.
(2) Cooperate with DDARS to provide information and education to the general public within the designated area regarding the existence of the adult protective services law and available services.
(3) Accept all reports of adult battery, neglect and exploitation from individuals, health care and human service professionals, institutions, law enforcement officials, DDARS, and other sources.
(4) Document the receipt of reports on the official report form developed by DDARS, obtaining all available and pertinent information.
(5) Conduct an investigation of all reports of battery, neglect, and exploitation to ascertain the condition and safety of the allegedly endangered adult:
(A) immediately when the possibility of physical danger to the adult exists; or
(B) as soon as possible after receipt of a report (within twenty calendar days).
(6) Follow procedures for coordination with the Indiana state department of health as per IC 12-10-3-17.
(7) Maintain procedures for appropriate access to and for safeguarding of the confidentiality of records.
(8) Be familiar with available community resources.
(9) Seek cooperation from other public and private agencies and individuals in the geographic services region which offer services as may be needed by endangered adults.
(10) Cooperate with all the APS units in Indiana.
(11) Participate in DDARS-sponsored in-service training.
(12) After initial investigation, proper notification that the report is unsubstantiated shall be made to concerned parties, at the discretion of the APS unit.
(13) Report to DDARS on forms provided by DDARS, information concerning each report of battery, neglect, or exploitation received and investigated, within time frames established by DDARS, including those reports made to the state department of health.
(14) Transmit to DDARS all identifying records concerning unsubstantiated reports in accordance with DDARS policy and procedures.
(15) In instances of substantiated reports, obtain an assessment of the endangered adult's situation and needs, and coordinate with the appropriate social services agencies who will develop a service plan for the provision of protective services (in

cooperation with the endangered adult).

(16) The plan for the provision of protective services shall be given to the endangered adult in writing, and shall include:

(A) a statement of the problem;

(B) one (1) or more goal statements;

(C) a description of the desired state of client functioning;

(D) identification of the appropriate and least restrictive services;

(E) the frequency and duration of anticipated service delivery; and

(F) the manner in which the effectiveness of the services will be monitored and evaluated.

(17) Approve said plan and assure that the available necessary protective services for the endangered adult are secured.

(18) Monitor and maintain complete documentation of the implementation of the protective services plan.

(19) Petition, through the prosecuting attorney's office, the court having probate jurisdiction in the county of the adult's residence, for an order to enjoin interference with the delivery of protective services arranged by the division or unit with the consent of the endangered adult, when such interference is occurring.

(20) Petition the probate court having jurisdiction in the county in which the endangered adult resides, to secure a protective order requiring that the adult receive protective services, only when:

(A) the individual does not consent, or withdraws consent previously given, to the receipt of the protective services; and

(B) the individual is an endangered adult under IC 12-10-3-2(a); and

(C) the individual, in the opinion of the APS unit, lacks the capacity to understand the clear consequences of his or her decisions, in accordance with IC 29-1-18.

A petition for a protective order does not constitute an action for guardianship.

(21) When a protective order is required, approve and submit to the court, a plan for the provision of the protective services, which includes, at the minimum, the items identified in subdivision (16) of this section.

(22) Petition the court to modify or terminate a protective services order, as necessary, as per IC 12-10-3-25.

(23) Petition the court to hold a hearing on the question of continuing jurisdiction, as per IC 12-10-3-26.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-2-5; filed Oct 30, 1985, 10:48 a.m.: 9 IR 479; readopted filed Nov 14, 2001, 4:47 p.m.: 25 IR 1279) NOTE: Transferred from the department on aging and community services (450 IAC 1-2-5) to the division of aging and rehabilitative services (460 IAC 1-2-5) by P.L.41-1987, SECTION 23, effective July 1, 1987.

460 IAC 1-2-6 Coordinator's qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-3; IC 35-42-2-1; IC 35-46-1-13

Sec. 6. An adult protective services unit coordinator shall have, at a minimum:

(1) a bachelor's degree in an appropriate area of concentration, with one (1) relevant internship; or

(2) two (2) years of experience in investigation or other relevant work.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-2-6; filed Oct 30, 1985, 10:48 a.m.: 9 IR 480; readopted filed Nov 14, 2001, 4:47 p.m.: 25 IR 1280) NOTE: Transferred from the department on aging and community services (450 IAC 1-2-6) to the division of aging and rehabilitative services (460 IAC 1-2-6) by P.L.41-1987, SECTION 23, effective July 1, 1987.

460 IAC 1-2-7 Complaints regarding residents of health facilities

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-3; IC 16-28; IC 35-42-2-1; IC 35-46-1-13

Sec. 7. DDARS and the APS unit shall:

(1) refer reports concerning individuals who are residents of health facilities licensed under IC 16-28 to the Indiana state department of health immediately; and

(2) cooperate with the Indiana state department of health in these cases and carry out the remaining activities of case processing at the request of the department;

DDARS shall notify the appropriate APS unit of the referral to the Indiana state department of health, and all APS units shall notify DDARS of referrals to the Indiana state department of health. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC*

1-2-7; filed Oct 30, 1985, 10:48 a.m.: 9 IR 480; readopted filed Nov 14, 2001, 4:47 p.m.: 25 IR 1280) NOTE: Transferred from the department on aging and community services (450 IAC 1-2-7) to the division of aging and rehabilitative services (460 IAC 1-2-7) by P.L.41-1987, SECTION 23, effective July 1, 1987.

460 IAC 1-2-8 Indiana state department of health; duties

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-3; IC 16-28; IC 35-42-2-1; IC 35-46-1-13

Sec. 8. The Indiana state department of health shall:

(1) receive reports of endangered adults who are residents of facilities licensed under IC 16-28 from DDARS and the APS units;

(2) refer appropriate cases (as defined by the Indiana state department of health) to DDARS or the APS units for investigation, assessment and to assure the provision of protective services; and

(3) send completed report forms for all reports of endangered adults, whether substantiated or unsubstantiated, and whether primarily reported to the Indiana state department of health, DDARS or the APS units to DDARS for statistical and substantive records.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-2-8; filed Oct 30, 1985, 10:48 a.m.: 9 IR 480; readopted filed Nov 14, 2001, 4:47 p.m.: 25 IR 1280) NOTE: Transferred from the department on aging and community services (450 IAC 1-2-8) to the division of aging and rehabilitative services (460 IAC 1-2-8) by P.L.41-1987, SECTION 23, effective July 1, 1987.

460 IAC 1-2-9 Maintenance of records

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-3-13; IC 35-42-2-1; IC 35-46-1-13

Sec. 9. (a) For substantiated reports, DDARS and the APS units shall maintain identifying records concerning:

(1) reports which identify the endangered adult;

(2) types of protective services provided, and identity of the service provider(s); and

(3) agencies, persons, or institutions who are determined to have permitted or inflicted neglect, battery, or exploitation.

(b) For unsubstantiated reports, DDARS shall:

(1) receive all identifying records concerning unsubstantiated reports (as determined by the APS units) from the APS units;

(2) destroy identifying information on said records within one hundred eighty (180) days after the receipt of those records; and

(3) maintain nonidentifying statistical records concerning unsubstantiated reports, and make this information available to the entities listed at IC 12-10-3-13.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-2-9; filed Oct 30, 1985, 10:48 a.m.: 9 IR 481; readopted filed Nov 14, 2001, 4:47 p.m.: 25 IR 1281) NOTE: Transferred from the department on aging and community services (450 IAC 1-2-9) to the division of aging and rehabilitative services (460 IAC 1-2-9) by P.L.41-1987, SECTION 23, effective July 1, 1987.

460 IAC 1-2-10 Reporting battery, neglect, or exploitation

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-3; IC 35-42-2-1; IC 35-46-1-13

Sec. 10. (a) Persons shall report known or suspected neglect, battery, or exploitation of an adult to DDARS, an APS unit, or a law enforcement agency by telephone, in writing, or in person.

(b) Requirements for confidentiality of reports shall be as follows:

(1) The identity of the reporting person shall be kept confidential and be disclosed only with the written consent of that person or by judicial process.

(2) In no event, however, shall the identity of the person who made the report be disclosed to an alleged abuser, except by judicial order.

(c) Requirements for classification and transmittal of reports shall be as follows:

(1) Every incident of neglect, battery, or exploitation which is received by the unit shall be reported to DDARS on forms

provided by DDARS within twenty (20) calendar days of receiving the report.

(2) Within thirty (30) calendar days of completing the investigation, the unit shall make a determination and classify all reports as substantiated or unsubstantiated, and transmit said determination to DDARS.

(3) When the classification of a substantiated report has changed to unsubstantiated, the unit shall notify DDARS and transmit all identifying records as required in section 5(14) of this rule.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-2-10; filed Oct 30, 1985, 10:48 a.m.: 9 IR 481; readopted filed Nov 14, 2001, 4:47 p.m.: 25 IR 1281) NOTE: Transferred from the department on aging and community services (450 IAC 1-2-10) to the division of aging and rehabilitative services (460 IAC 1-2-10) by P.L.41-1987, SECTION 23, effective July 1, 1987.

460 IAC 1-2-11 Rights of the alleged endangered adult

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-3; IC 35-42-2-1; IC 35-46-1-13

Sec. 11. (a) Requirements for a right to counsel shall be as follows:

(1) At any time, a person who may be designated an endangered adult has the right to secure legal counsel; either a private attorney or if eligible, a legal services attorney.

(2) If the endangered adult does not consent or has withdrawn consent to receive protective services and a petition has been filed in probate court, the endangered adult is entitled:

(A) to be represented by counsel; and

(B) to have the court appoint counsel if said endangered adult is determined to be indigent.

(3) If the endangered adult is receiving protective services and an individual interferes with the provision of those services, the endangered adult is entitled to be represented by the prosecuting attorney's office in obtaining an order to enjoin the interference with the delivery of the service.

(b) The endangered adult has the right to protective services that offer the least restrictive alternative.

(c) The endangered adult has the right to privacy and confidentiality, within the boundaries of IC 12-10-3.

(d) The protective services plan must take into account, to the extent feasible, the expressed preferences of the endangered adult.

(e) A competent adult, even though endangered, has the right to refuse protective services. However, the APS unit should make every effort to fully inform the endangered adult of the benefits available from protective services, and of the problems which could be exacerbated if protective services were refused.

(f) The endangered adult has the right to have court-ordered protective services reviewed by the court once every six (6) months. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-2-11; filed Oct 30, 1985, 10:48 a.m.: 9 IR 481; readopted filed Nov 14, 2001, 4:47 p.m.: 25 IR 1281) NOTE: Transferred from the department on aging and community services (450 IAC 1-2-11) to the division of aging and rehabilitative services (460 IAC 1-2-11) by P.L.41-1987, SECTION 23, effective July 1, 1987.*

460 IAC 1-2-12 Appeal rights of the allegedly endangered adult

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 4-21.5; IC 12-10-3; IC 35-42-2-1; IC 35-46-1-13

Sec. 12. (a) An endangered adult, aggrieved by an action of the adult protective services unit or by DDARS regarding adult protective services may appeal that action to DDARS, after attempting to resolve the problem with the APS unit.

(b) The decision to conduct an investigation pursuant to a report under IC 12-10-3, is not appealable.

(c) The request for a hearing must be submitted in writing and signed by the appellant or his/her representative. This request must be received by DDARS within thirty (30) calendar days of the appellant's notification of the action being appealed.

(d) DDARS shall hold the hearing within thirty (30) calendar days after receipt of the request for a hearing.

(e) The hearing shall be conducted in accordance with the Indiana Administrative Orders and Procedures Act, IC 4-21.5.

(f) DDARS shall notify the appellant and the adult protective services unit by registered mail of the appeal decision within ten (10) calendar days after the hearing. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-2-12; filed Oct 30, 1985, 10:48 a.m.: 9 IR 482; readopted filed Nov 14, 2001, 4:47 p.m.: 25 IR 1282) NOTE: Transferred from the department on aging and community services (450 IAC 1-2-12) to the division of aging and rehabilitative services (460 IAC 1-2-12) by P.L.41-1987,*

SECTION 23, effective July 1, 1987.

Rule 3. Rate-Setting Criteria for Providers in the Assistance to Residents in County Homes Program (ARCH) and the Room and Board Assistance Program (RBA)

460 IAC 1-3-1 Policy; scope

Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 24-4.6-1-101

Sec. 1. (a) This rule sets forth procedures for the reimbursement of providers of residential maintenance services in Indiana's assistance to residents in county homes program (ARCH) and the room and board assistance program (RBA). All payments referred to within this rule for the ARCH or RBA provider are contingent upon the provider's compliance with all applicable statutes and rules.

(b) The procedures described in this rule set forth methods of reimbursement to promote quality residential maintenance, efficiency, economy, and consistency. This reimbursement methodology is predicated on a reasonable, cost related basis which is designed to meet the cost, determined by generally accepted accounting principles, that must be incurred by efficiently and economically operated facilities.

(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to discounting, intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data which caused a rate higher than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a claim from the division, the provider must complete the appropriate billing adjustment form and reimburse the division for the amount of the overpayment with any interest which may be due in accordance with subsection (e).

(d) The division may implement rates prospectively without awaiting the outcome of the administrative appeal process. However, any action by the division to recover an overpayment from previous rate reimbursements, either through deductions of future payments or otherwise, shall await the completion of the provider's administrative appeal within the division, providing the provider avails itself of the opportunity to make such an appeal.

(e) If a provider fails to reimburse the division for the amount of an overpayment or fails to enter into agreement for the repayment of an overpayment within thirty (30) days of receipt of a notification demanding repayment, the division shall assess an interest charge in addition to the overpayment demanded. The interest charge shall not exceed the percentage set out in IC 24-4.6-1-101. The interest charge shall be applied to the amount of the overpayment, beginning with the date of the overpayment. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-1; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2196; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1344)*

460 IAC 1-3-2 Definitions

Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 16-28-2; IC 24-4.6-1-101

Sec. 2. (a) As used in this rule, "activities programs" refers to those services provided by residential facilities licensed under IC 16-28-2 in accordance with 410 IAC 16.2-5-7.

(b) As used in this rule, "all-inclusive rate" means a per diem rate which reimburses for all room, board, laundry, and other services along with minimal administrative direction within a single, comprehensive amount for all facilities licensed under IC 16-28-2, and reimburses for all room, board, and laundry along with minimal administrative direction within a single, comprehensive amount for all facilities not licensed under IC 16-28-2.

(c) As used in this rule, "annual, historical, or budget financial report" refers to a presentation of financial data, including accompanying notes, derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or the changes therein for a period of time in compliance with the reporting requirements of this rule which shall constitute a comprehensive basis of accounting.

(d) As used in this rule, "budgeted/forecasted data" means financial and statistical information that presents, to the best of the provider's knowledge and belief, the expected results of operation during the rate period.

(e) As used in this rule, "central services cost allocation plan" means a plan that identifies and distributes the costs of services provided by various county offices that are essential to support the operation of the county home, and prepared in accordance with

OASC-10 (FMC 74-4 and A-87).

(f) As used in this rule, "change of provider status" means a bona fide sale or capital lease that for reimbursement purposes is recognized as creating a new provider status that permits the establishment of an initial interim rate. Except as provided under sections 11(d) and 17(f) of this rule, the term includes only those transactions negotiated at arm's length between unrelated parties. The term does not include a facility lease transaction that does not constitute a capitalized lease under Financial Accounting Standards Board Statement 13.

(g) As used in this rule, "cost center" means a cost category delineated by cost reporting forms prescribed by the division.

(h) As used in this rule, "debt" means the lesser of the original loan balance at the time of acquisition and original balances of other allowable loans or eighty percent (80%) of the allowable historical cost of facilities and equipment.

(i) As used in this rule, "desk audit" means a review of a written audit report and its supporting documents by a qualified auditor, together with the auditor's written findings and recommendations.

(j) As used in this rule, "division" means the Indiana state division of disability, aging, and rehabilitative services or its successor agency.

(k) As used in this rule, "equity" means allowable historical costs of facilities and equipment, less the unpaid balance of allowable debt at the provider's reporting year end.

(l) As used in this rule, "field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts by auditors.

(m) As used in this rule, "forms prescribed by the division" means forms provided by the division or substitute forms which have received prior written approval by the division.

(n) As used in this rule, "general line personnel" means management personnel above the division head level who perform a policy making or supervisory function impacting directly on the operation of the facility.

(o) As used in this rule, "generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

(p) As used in this rule, "health related services" means the following services provided by residential facilities licensed under IC 16-28-2:

(1) Medical and dental services provided in accordance with 410 IAC 16.2-5-3.

(2) Medications, treatments, and nursing services provided in accordance with 410 IAC 16.2-5-4.

(3) Pharmaceutical services provided in accordance with 410 IAC 16.2-5-6.

(q) As used in this rule, "market area limitation" or "MAL" means a rate ceiling for all rates established by the division that is calculated on allowable costs using forecasted data submitted by providers when requesting rate review.

(r) As used in this rule, "minimal administrative direction" means those nonmedical services rendered to residents which are absolutely necessary in order to provide residential care.

(s) As used in this rule, "ordinary residents related costs" means costs of services that are necessary in delivery of resident maintenance by similar providers within the state.

(t) As used in this rule, "other services" means those services provided by residential facilities licensed under IC 16-28-2 in accordance with 410 IAC 16.2-5 and all other applicable rules of the Indiana state department of health.

(u) As used in this rule, "profit add-on" means payment to providers, in addition to allowable costs, as an incentive for efficient and economical operation of facilities licensed under IC 16-28-2.

(v) As used in this rule, "reasonable allowable costs" means those costs which must be incurred by an efficiently and economically operated facility that a prudent, cost conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in this rule.

(w) As used in this rule, "related party/organization" means that the provider is associated or affiliated with, or has the ability to control, or be controlled by, the organization furnishing the service, facilities, or supplies as described in sections 11 and 17 of this rule.

(x) As used in this rule, "residents maintenance" means those program services delivered to an enrolled resident by an enrolled provider.

(y) As used in this rule, "unit of service" means all resident maintenance included in the established per diem rate required for the maintenance of a resident for one (1) day (twenty-four (24) hours).

(z) As used in this rule, "use fees" means the reimbursement provided to fully amortize both principal and interest of allowable debt under the terms and conditions specified in this rule. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-2; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2197; filed Jun 6, 1996, 9:00 a.m.: 19 IR 3051; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1119)*

460 IAC 1-3-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location

Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 16-28-2; IC 24-4.6-1-101

Sec. 3. (a) The basis of accounting used under this rule is a comprehensive basis of accounting other than generally accepted accounting principles. However, generally accepted accounting principles shall be followed in the preparation and presentation of all financial reports and all reports detailing proposed change of provider transactions unless otherwise prescribed by this rule.

(b) Each provider must maintain financial records for a period of three (3) years after the date of submission of financial reports to the division. The accrual basis of accounting shall be used in all data submitted to the division except for government operated providers that are otherwise required by law to use a cash system. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the division. Facilities licensed under IC 16-28-2 must maintain records to substantiate other services as defined in section 2(t) of this rule reported on the financial reports that are verifiable by an audit.

(c) In the event that a field audit visit indicates that the provider's records are inadequate to support data submitted to the division, and the auditor is unable to complete the audit and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the division shall not grant any rate increase to the provider until the cited deficiencies are corrected and certified to the division by the provider. However, the division may:

(1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;

(2) document such adjustments in a finalized exception report; and

(3) incorporate such adjustments in prospective rate calculations under section 1(d) of this rule.

(d) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual financial report and budget financial report coincidental with the time period for any type of rate review for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to GAAP, and be consistent between years. Any change of central office allocation bases must be approved by the division prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the division at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to resident maintenance and the provider can demonstrate that the central office costs improved efficiency, economy, or quality of resident maintenance. The burden of demonstrating that costs are resident related lies with the provider. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-3; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2199; filed Jun 6, 1996, 9:00 a.m.: 19 IR 3050)*

460 IAC 1-3-4 Financial report to division; annual schedule; prescribed form; extensions; penalty for untimely filing

Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 24-4.6-1-101

Sec. 4. (a) Each provider shall submit an annual financial report to the division not later than ninety (90) days after the close of the provider’s reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial acceptance of a provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider’s records and the annual financial report.

(b) The provider’s annual financial report shall be submitted using forms prescribed by the division. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following, as a minimum:

(1) Resident census data.

(2) Statistical data.

(3) Ownership and related party information.

(4) Statement of all expenses and all income.

(5) Detail of fixed assets and resident related interest bearing debt.

(6) Complete balance sheet data.

(7) Certification by the provider that the data is true, accurate, related to resident maintenance, and that expenses not related to resident maintenance have been clearly identified.

(8) Certification by the preparer, if different from the provider, that the data was compiled from all information provided to the preparer by the provider and as such are true and accurate to the best of the preparer's knowledge.

(c) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the division circumstances that preclude a timely filing. Requests for extensions shall be submitted to the division, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The division shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the division.

(d) Failure to submit an annual financial report in the time limit required shall result in the following actions:

(1) No rate review requests shall be accepted or acted upon by the division until the delinquent report is received.

(2) When an annual financial report is thirty (30) days past due and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth day the annual financial report is past due, and shall so remain until the first day of the month after the delinquent annual financial report is received by the division. No rate adjustments will be allowed until the first day of the first month after the delinquent annual financial report is received by the division. Reimbursement lost because of the penalty cannot be recovered by the provider.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-4; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2200; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1345)

460 IAC 1-3-5 New provider; initial financial report to division; criteria for establishing initial interim rates; supplemental report; base rate setting

Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 24-4.6-1-101

Sec. 5. (a) Rate requests to establish initial interim rates for a new operation or for a change of provider status shall be filed by completing the budget financial report form and submitting it to the division on or before thirty (30) days after notification of the date of approval to participate. The budget financial report shall reflect the forecasted data of operating for the first twelve (12) months and shall be subject to appropriate reasonableness tests as set out in this rule. Initial interim rates shall be effective upon provider approval to participate.

(b) The methodology, set out in this rule, used to compute rates for active providers shall be followed to compute initial interim rates for new providers, except that historical data is not available, and the maximum allowable annual rate increase limitation shall not apply.

(c) Since an initial interim rate is established based upon forecasted financial data only, the provider shall file a nine (9) month financial report within sixty (60) days following the end of the first nine (9) months of operation, together with forecasted data for twelve (12) months of operation. This twelve (12) month period of forecasted data shall start on the first day of the tenth month from the date of approval to participate for the facility. The nine (9) months of historical financial data and the twelve (12) months of forecasted data shall be used to determine the provider's base rate. The base rate shall be effective from the first day of the tenth month from the date of approval to participate until the next regularly scheduled annual review. An annual financial report need not be submitted until the provider's first fiscal year end that occurs after the rate effective date of a base rate. In determining the base rate, limitations and restrictions otherwise outlined in this rule, except the annual rate limitation, shall apply. For purposes of this subsection, in determining the nine (9) months of the historical financial report, if the first day of acceptance falls on or before the fifteenth day of a calendar month, then that calendar month shall be considered the provider's first month of operation. If the first day of enrollment falls after the fifteenth day of a calendar month, then the immediately succeeding calendar month shall be considered the provider's first month with approval to participate.

(d) The base rate may be in effect for longer or shorter than twelve (12) months of forecasted data. In such cases, the various applicable limitations shall be proportionately increased or decreased to cover the actual time frame, using a twelve (12) month period as the basis for the computation.

(e) The base rate established from the nine (9) months of historical data and the twelve (12) months of forecasted data shall be the rate used for determining subsequent limitations on annual adjustments.

(f) Extension of the sixty (60) day filing period shall not be granted unless the provider substantiates to the division

circumstances that preclude a timely filing. Request for extension shall be submitted to the division, prior to the date due, with full and complete explanation of the reason an extension is necessary. The division shall review the request and notify the provider of approval or disapproval within ten (10) days of receipt. If the extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the division.

(g) In the event the provider fails to submit nine (9) months of historical financial data and the twelve (12) months of forecasted data as required in subsection (c), the following action shall be taken:

(1) When submission of the nine (9) months of historical financial data and the twelve (12) months of forecasted data is thirty (30) days past due and an extension has not been granted, the initial rate shall be reduced by ten percent (10%), effective on the first day of the tenth month after acceptance and shall so remain until the first day of the month after receipt of the report by the division. No rate adjustments will be allowed until the first day of the first month after the delinquent reports are received by the division.

(2) Reimbursement lost because of the penalty cannot be recovered by the provider.

(h) Neither an initial interim rate nor a base rate shall be established for a provider whose change of provider status was a related party transaction as defined in this rule.

(i) The change of provider status shall be rescinded if subsequent transactions cause a capitalized lease to be reclassified as an operating lease under the guidelines established by the American Institute of Certified Public Accountants. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-5; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2200; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1346)*

460 IAC 1-3-6 Active providers; rate review; annual request; additional requests; requests due to change in law; request concerning capital return factor; computation of factor

Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 24-4.6-1-101

Sec. 6. (a) As a normal practice, rates shall be reviewed once each year using the annual financial report as the basis of the review. The rate effective date shall be the first day of the fourth month following the provider's reporting year end, provided the annual financial report is submitted within ninety (90) days of the end of the provider's reporting period. If the provider requests that the rate be reviewed, a budget financial report covering the twelve (12) month period immediately following the expected rate effective date shall be prepared by the provider and submitted with the annual financial report.

(b) A provider shall not be granted an additional rate review until the review indicated in subsection (a) has been completed. A provider may request no more than one (1) additional rate review during its budget reporting year when the provider can reasonably demonstrate the need for a change in the rate based on more recent historical and forecasted data. This additional rate review shall be completed in the same manner as the annual rate review, using all other limitations in effect at the time the annual review took place.

(c) To request the additional review, the provider shall submit, on forms prescribed by the division, a minimum of six (6) months of historical data of which at least four (4) months must be subsequent to the fiscal year end of the annual financial report. In addition, a budget financial report covering the twelve (12) month period immediately following the expected rate effective date shall be submitted. Any new rate resulting from this additional review shall be effective on the first day of the month following the submission of data to the division.

(d) The division may consider changes in federal or state law or regulation during a calendar year to determine whether a significant rate change may result. This review shall be considered separately by the division and shall not be considered as an additional rate review.

(e) When changes to historical costs meet the requirements of sections 5 and 7 of this rule, and amount to five percent (5%) or more of the historical cost of the facilities and equipment as reported on the most recent annual or historical report, the provider may request a rate review to establish a new basis for computation of the capital return factor portion of the rate. The change in the capital return factor shall be allowed subject to the maximum allowable annual rate increase limitation, adjusted by the difference between the capital return factor allowed before the change and the capital return factor allowed after the change. The capital return factor allowed after the change shall be computed using the actual occupancy level for existing beds plus, where appropriate, those added census days needed to project the census in the additional beds at the greater of ninety percent (90%) or the occupancy the provider could reasonably anticipate for the additional beds. In no event shall the occupancy used to calculate the capital return factor be less than ninety percent (90%) of total beds available. Rate reviews completed under this section will not constitute the provider's

additional rate review in one (1) reporting year. This review shall be completed in the same manner as the annual rate review, using the MAL and all other limitations in effect at the time the annual review or base rate review took place, whichever is later. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-6; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2201; filed Jun 6, 1996, 9:00 a.m.: 19 IR 3054)*

460 IAC 1-3-7 Request for rate review; budget component; occupancy level assumptions; effect of inflation assumptions

Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 24-4.6-1-101

Sec. 7. (a) Under this rate setting system, emphasis is placed on proper planning, budgeting, and cost control by the provider. To establish consistency in the submission and review of forecasted costs, the following apply:

(1) Each rate review request shall include a budget financial report. If a budget financial report is not submitted, the rate review will not result in an increase in rates, but may result in a rate decrease based on historical or annual financial reports submitted.

(2) All budget financial reports shall be submitted using forms prescribed by the division. All forecasted data and required attachments shall be completed to provide full financial disclosure and will include as a minimum the following:

(A) Resident census data.

(B) Statistical data.

(C) Ownership and related party information.

(D) Statement of all expenses and all income.

(E) Detail of fixed assets and resident related interest bearing debt.

(F) Schedule of private pay charges. Charges shall be the lowest usual and ordinary charge on the rate effective date of the rate review.

(G) Certification by the provider that forecasted data has been prepared in good faith, with appropriate care by qualified personnel, using appropriate accounting principles and assumptions, and that the process to develop the forecasted data uses the best information that is reasonably available and is consistent with the plans of the provider. The certification shall state that all expenses not related to resident maintenance have been clearly identified or removed.

(H) Certification by the preparer, if the preparer is different from the provider, that the forecasted data were compiled from all information provided to the preparer and that the preparer has read the forecasted data with its summaries of significant assumptions and accounting policies and has considered them to be not obviously inappropriate.

(3) The provider shall submit adequate disclosure of all significant assumptions, with supporting basis or rationale, used to prepare the forecasted data.

(4) Forecasted data shall be based on a projected census figure. In preparing the budget financial report, the provider shall divide projected costs by the highest of the following:

(A) Ninety percent (90%) of bed days.

(B) Historical resident days for the most recent historical period, unless the provider can justify the use of a lower figure for the resident days.

(C) Forecasted resident days for the twelve (12) month budget period.

(5) Budget financial reports submitted to the division at less than percentage of occupancy in this section will not be considered as meeting the filing requirements of this section.

(6) The provider and the division shall recognize and adjust forecasted data accordingly for the inflationary or deflationary effect on historical data for the period between the midpoint of the historical or annual financial report time period and the midpoint of the budget financial report. Forecasted data may be adjusted based upon reasonably anticipated rates of inflation.

(b) Budget financial reports shall be prepared in accordance with the guidelines established by the American Institute of Certified Public Accountants. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-7; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2202; filed Jun 6, 1996, 9:00 a.m.: 19 IR 3054)*

460 IAC 1-3-8 Limitations or qualifications to ARCH/RBA reimbursement; advertising; vehicle basis; litigation expenses

Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 24-4.6-1-101

Sec. 8. (a) Advertising is not an allowable cost under this rule except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with statutory and regulatory requirements. Advertising costs are not allowable in connection with public relations, fundraising, or to encourage patient utilization.

(b) Each facility and home office shall be allowed only one (1) resident care related automobile to be included in the vehicle basis for purposes of cost reimbursement under this rule. "Vehicle basis" means the purchase price of the vehicle used for facility or home office operation. If a portion of the use of the vehicle is for personal purposes or for purposes other than operation of the facility or home office, then such portion of the cost must not be included in the vehicle basis. The facility and home office are responsible for maintaining records to substantiate operational and personal use for one (1) allowable automobile. This limitation does not apply to vehicles with a gross vehicle weight of more than six thousand (6,000) pounds.

(c) Except as provided in subsections (d) and (e), legal fees, expenses related to expert witnesses, accounting fees, and other consulting fees shall not be reimbursed by the division as reasonably related resident expenses under the program if the expenses are incurred in an administrative or judicial proceeding against any agency of the state or the federal government.

(d) Providers may report the reasonable costs incurred in an administrative or judicial proceeding if all of the following conditions are met:

(1) The costs have actually been incurred and paid.

(2) The costs are reasonable expenditures for the services obtained.

(3) The provider has made a good faith effort to settle all disputed issues before the completion of the administrative or judicial proceeding.

(4) The provider prevails on all issues that were in dispute.

(e) If a cost based provider satisfies the conditions of subsection (d), the provider may report the costs for potential cost recognition in the fiscal period when a final determination in the administrative or judicial proceeding is made. Costs reported under this section are subject to the same limiters used to determine allowable costs and to set rates as all other areas of reporting. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-8; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2203; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1346)*

460 IAC 1-3-9 Criteria limiting rate adjustment granted by division

Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 12-15-14; IC 16-28-2; IC 24-4.6-1-101; P.L.24-1997, SEC.68

Sec. 9. The reimbursement system for facilities licensed under IC 16-28-2 is based on recognition of the provider's allowable costs, plus a potential profit add-on payment. The reimbursement system for facilities that are not licensed under IC 16-28-2 is based on recognition of the provider's allowable costs. The payment rate is subject to several limitations. Rates will be established at the lowest of the following six (6) limitations:

(1) MAL applies to all providers covered by this rule. The limitation shall be computed using forecasted data submitted by providers for rate reviews on a statewide basis for facilities providing assistance to residents in county homes program (ARCH) and room and board assistance program (RBA) maintenance service. For residential facilities licensed under IC 16-28-2, the MAL is an amount that shall be one hundred thirty percent (130%) of the average allowable cost of facilities licensed under IC 16-28-2, weighted by beds. For facilities not licensed under IC 16-28-2, the MAL is an amount that shall be one hundred thirty percent (130%) of the average allowable cost of residential facilities not licensed under IC 16-28-2, weighted by beds. The average allowable cost shall be maintained by the division, and a revision shall be made to this rate limitation four (4) times per year effective on March 1, June 1, September 1, and December 1.

(2) The calculated rate for facilities licensed under IC 16-28-2 is the sum of the allowed per diem costs, plus the allowed profit add-on payment. The profit add-on is equal to thirty-five percent (35%) of the difference between a provider's allowed per diem cost and forty-six percent (46%) of the average daily rate of reimbursement paid under IC 12-15-14 for nursing facilities licensed under IC 16-28, weighted by beds, if that difference is greater than zero (0). The calculated rate for facilities that are not licensed under IC 16-28 is the sum of the allowed per diem costs.

(3) The maximum allowable annual rate increase shall not be greater than the average rate of change, expressed as a decimal, of the most recently reported eight (8) quarters of historical data plus the most recently reported four (4) quarters of forecasted data of the Gross National Product Implicit Price Deflator. The maximum rate allowed by the annual rate increase limitation shall be applicable to any rate established during the twelve (12) month period between annual rate reviews. The maximum rate allowed by the annual rate increase limitation shall be equal to the rate in effect immediately prior to the rate effective

date of the annual rate review, times the sum of one (1), plus the maximum allowable annual rate increase applicable at the rate effective date of the annual rate review.

(4) In no instance shall the approved rate be higher than the rate paid to that provider by the general public for the same type of services.

(5) Should the rate calculations produce a rate higher than the reimbursement rate requested by the provider, the approved rate shall be the rate requested by the provider.

(6) The rate may not exceed forty-six percent (46%) of the average daily rate of reimbursement paid under IC 12-15-14 for nursing facilities licensed under IC 16-28, weighted by beds.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-9; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2203; filed Jun 6, 1996, 9:00 a.m.: 19 IR 3055; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1121; filed Feb 6, 1998, 10:30 a.m.: 21 IR 2079; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1347)

460 IAC 1-3-10 Computation of rate; allowable costs; review of cost reasonableness

Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 12-15; IC 16-28-2; IC 24-4.6-1-101

Sec. 10. (a) The per diem room rate shall be established as a ratio between total allowable costs and resident days, subject to all other limitations described in this rule.

(b) Costs and revenues shall be reported as required on the financial report forms. Resident maintenance costs shall be clearly identified.

(c) The provider shall report as resident maintenance costs only costs that have been incurred in the providing of resident maintenance services. The provider shall certify on all financial reports that costs not related to resident maintenance have been separately identified on the financial report.

(d) In determining reasonableness of costs, the division may compare line items, cost centers, or total costs of providers statewide. The division may request satisfactory documentation from providers whose costs do not appear to be reasonable.

(e) The division's test of reasonableness shall consist of three (3) levels of review. Each level is based on a professional analysis of forecasted data. These levels of review are as follows:

(1) The first level of review is a general line item review. In this step, the rate setter will review each forecasted line item for reasonableness based upon comparison with the previous annual financial report and consideration of current economic conditions. If an exceptional line item is not adequately supported, even when taking into account possible misclassification by the provider, the line item shall be adjusted to the annual financial report per diem cost that has been inflated according to this rule.

(2) The second level of review is a comparison of forecasted per diem cost by cost center and in total to annual financial report data. This step is performed only on those budgets that are above the seventy-fifth percentile in total routine per diem cost. It also takes into account previous rate setter adjustments made under the general line item review in subdivision (1). When an exceptional cost center per diem amount is not adequately supported, it shall be adjusted to the inflated per diem cost of the annual financial report according to this rule.

(3) The third level of review is a cost center comparison of the provider's forecasted per diem cost to allowed per diem cost of other providers statewide, excluding adjustments made under this subdivision, in the resident care information system (RCIS) class. The RCIS class used for this purpose contains enrolled providers throughout Indiana that provide resident care. As an upper limit, the division will adjust the cost center to reflect the following ceilings for each cost center in the RCIS classification:

(A) Dietary: ninetieth percentile.
(B) Laundry and housekeeping: ninetieth percentile.
(C) Plant operations: seventy-fifth percentile.
(D) General and administrative: seventy-fifth percentile.
(E) Employee benefits: seventy-fifth percentile.
(F) Health related services: ninetieth percentile.
(G) Activities programs: ninetieth percentile.

Health related services and activities programs apply only to enrolled providers licensed under IC 16-28-2. For enrolled providers not licensed under IC 16-28-2, costs for health related services and activities programs are not allowable and shall

not be utilized in the calculation of the percentile limitation. In addition, the costs of health related services provided to individuals eligible for Medicaid under IC 12-15 and applicable rules and for which the facility receives Medicaid reimbursement shall not be allowable. The data base used to calculate the ceilings for the health related services and the activities program cost centers shall include only those residential facilities licensed under IC 16-28-2.

(f) Other services, except health related services and activities programs that are subject to the percentile limitations in this section, shall be considered allowable costs.

(g) Indiana state taxes, including local taxes, shall be considered an allowable cost. Federal income taxes are not considered allowable costs. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-10; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2204; filed Jun 6, 1996, 9:00 a.m.: 19 IR 3056; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1348)*

460 IAC 1-3-11 Allowable costs; services provided by parties related to provider (Expired)

Sec. 11. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 1-3-12 Allowable costs; capital return factor

Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 24-4.6-1-101

Sec. 12. (a) Providers shall be reimbursed for the use of facilities and equipment, regardless of whether they are owned or leased, by means of a capital return factor. The capital return factor shall be composed of a use fee to cover the use of facilities, land and equipment, and a return on equity. Such reimbursement shall be in lieu of the costs of all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose resident care related depreciation, interest, or lease expense is allocated to the facility.

(b) The capital return factor portion of the established rate is the sum of the use fee and the return on equity, divided by the greater of ninety percent (90%) of available bed days or actual occupancy. In no event may the occupancy used to calculate the capital return factor be less than ninety percent (90%) of total bed days available.

(c) Allowable resident maintenance related rent, lease payments, and fair rental value of property used through contractual arrangement shall be subjected to limitations of the capital return factor as described in this rule. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-12; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2205; filed Jun 6, 1996, 9:00 a.m.: 19 IR 3056)*

460 IAC 1-3-13 Allowable cost; capital return factor; computation of use fee component; interest; allocation of loan to facilities and parties

Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 24-4.6-1-101

Sec. 13. (a) The use fee limitation is based on the following:

(1) The assumption that facilities and equipment are prudently acquired and financed.

(2) Providers will obtain independent financing in accordance with a sound financial plan.

(3) Owner capital will be used for the balance of capital requirements.

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

(c) The use fee component of the capital return factor shall be limited by the lesser of:

(1) the original loan balance at the time of acquisition;

(2) eighty percent (80%) of the historical cost of the facilities and equipment; or

(3) eighty percent (80%) of the maximum allowable property basis at the time of the acquisition plus one-half (½) of the difference between that amount and the maximum property basis per bed on the rate effective date.

(d) The maximum interest rate allowed in computing the use fee shall not exceed one and one-half percent (1.5%) above the U.S. Treasury Bond, thirty (30) year amortization, constant maturity rate plus three percent (3%) rounded to the nearest one-half

percent (.5%) or the actual interest rate, whichever is lower. The date that the financing commitment was signed by the lender and borrower shall be fixed as the date upon which the allowable rate shall be determined.

(e) Refinancing of mortgages shall be amortized over the amortization period of the refinancing; however, the amortization period for the refinanced mortgage shall not be less than twenty (20) years. Refinancing shall not be recognized until eight (8) years after the date of the original mortgage. Refinancing arrangements entered into after eight (8) years shall only be recognized for sums up to seventy-five percent (75%) of the historical cost, and interest rates on the refinancing shall not be allowable in excess of the interest rate limit established on the date the commitment was signed and the interest rate fixed by the lender and borrower.

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

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

(h) Interest costs on operating loans each reporting period shall be limited to interest costs of principal amounts that do not exceed a value equal to two (2) months of the lesser of proposed revenues or proposed occupancy times the maximum allowable annual rate increase if applicable, otherwise the proposed assistance to residents in county homes (ARCH) and room and board assistance (RBA) rate. Interest on such loans shall only be recognized if the provider can demonstrate that such loans were reasonable and necessary in providing resident related services. Working capital interest must be reduced by investment income. Working capital interest is an operating cost and will not be included in calculating the use fee.

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

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

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

(1) Recalculate the use fee for the reporting year based upon the provider's average actual rate of interest paid.

(2) Compare the use fee allowed in the reporting year and the recalculated use fee and determine the variance (amount by which the amount allowed in the prior rate case exceeded or was less than the amount earned under the recalculation in subdivision (1)).

(3) Calculate the prospective use fee based upon the interest rate in effect at the end of the provider's reporting year.

(4) The use fee on the prospective rate is the amount forecasted in subdivision (3) plus or minus the variance in subdivision (2).

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-13; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2205; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1349)

460 IAC 1-3-14 Allowable costs; capital return factor; computation of return on equity component

Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 24-4.6-1-101

Sec. 14. (a) The return on equity shall be computed on the actual equity in allowable facilities and equipment up to a maximum of eighty percent (80%) of allowable historical cost of facilities and equipment.

(b) The return on equity factor shall be equal to the interest rate used in computing the use fee plus one percent (1%), or one percent (1%) below the U.S. Treasury Bond, thirty (30) year amortization, constant maturity rate plus three percent (3%) on the last day of the reporting period, whichever is higher. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-14; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2206; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1350)*

460 IAC 1-3-15 Allowable costs; capital return factor; use fee; depreciable life; property basis

Authority: IC 12-8-6-5; IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6; IC 12-10-6; IC 24-4.6-1-101

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

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

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

Acquisition Date	Maximum Property Basis Per Bed
7-1-76	$10,120
4-1-77	$10,604
10-1-77	$10,956
4-1-78	$11,264
10-1-78	$11,704
4-1-79	$12,232
10-1-79	$12,892
4-1-80	$13,288
10-1-80	$13,992
4-1-81	$14,696
10-1-81	$15,312
4-1-82	$15,752
9-1-82	$16,000
3-1-83	$16,080
9-1-83	$16,480
3-1-85	$16,960
9-1-85	$16,960
3-1-86	$17,120
9-1-86	$17,200
3-1-87	$17,520
9-1-87	$17,920
3-1-88	$18,080
9-1-88	$18,400
3-1-89	$18,480
9-1-89	$18,640
3-1-90	$18,880
9-1-90	$19,120
3-1-91	$19,600
9-1-91	$19,760

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

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

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

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

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

(C) the allowable interest rate per bed is the U.S. Treasury Bond, thirty (30) year amortization, constant maturity rate plus three percent (3%) rounded to the nearest one-half percent (.5%) plus one and one-half percent (1.5%) at the earlier of the acquisition date of the beds or the commitment date of the attendant permanent financing.

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

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

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

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

(d) The following costs, which are attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has been previously made under the Assistance to Residents in County Homes program and the Room and Board Assistance program, shall not be recognized as an allowable cost:

(1) Legal fees.

(2) Accounting and administrative costs.

(3) Travel costs.

(4) The costs of feasibility studies.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3-15; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2207; filed Dec 18, 2000, 10:10 a.m.: 24 IR 1350)

460 IAC 1-3-16 Capital return factor; basis; historical cost; mandatory record keeping; valuation (Expired)

Sec. 16. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 1-3-17 Capital return factor; basis; sale or capital lease of facility; valuation; sale or lease among family members (Expired)

Sec. 17. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 1-3-18 Unallowable costs; cost adjustments; charity and courtesy allowances; discounts; rebates; refunds of expenses (Expired)

Sec. 18. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 1-3-19 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation (Expired)

Sec. 19. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 1-3-20 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees; fringe benefits (Expired)

Sec. 20. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 1-3-21 Administrative reconsideration; appeal (Expired)

Sec. 21. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

Rule 3.5. Residential Care Assistance

460 IAC 1-3.5-1 Definitions

Authority: IC 12-9-2-3; IC 12-10-6
Affected: IC 16-28

Sec. 1. (a) The definitions in this rule apply throughout this article.

(b) "Applicant" means an individual who has applied for residential care assistance.

(c) "County home" means a residential facility owned, staffed, maintained, and operated by a county government that provides residential care to individuals.

(d) "County office" means the county office of family and children.

(e) "Division" means the division of disability, aging, and rehabilitative services.

(f) "Director" means the director of the division.

(g) "Processing an application" means completing the application for residential care assistance, all activity required for determining whether an individual is eligible for residential care assistance, and notifying the applicant of the decision.

(h) "Prospective applicant" means an individual who has completed an application inquiry for residential care assistance.

(i) "Recipient" means an individual who is receiving residential care assistance.

(j) "Residential care" means room, board, and laundry, along with minimal administrative direction.

(k) "Residential care assistance" means state financial assistance through the division for residential care.

(l) "Residential home" means a facility licensed under IC 16-28 or an accredited Christian Science facility listed and certified by the Commission for Accreditation of Christian Science Nursing Organization/Facilities, Inc. that meets certain life safety standards considered necessary by the state fire marshal, that provides residential care to individuals. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3.5-1; filed Jun 27, 1997, 4:20 p.m.: 20 IR 3014)*

460 IAC 1-3.5-2 Availability of funds

Authority: IC 12-9-2-3; IC 12-10-6
Affected: IC 12-10-6

Sec. 2. (a) The availability of residential care assistance for an individual is contingent upon the availability of residential care assistance funding to the division.

(b) If the division director, or the director's designee, makes a written determination that sufficient funds are not appropriated or otherwise available to support the costs of residential care assistance for those not already receiving residential care assistance, the division shall accept application inquiries in accordance with the provisions specified in this rule.

(c) The director shall cause the posting of written notice in conspicuous places in county offices when a determination has been made as described in subsection (b). The written notice shall state the following:

(1) That, as of a date certain, the division is no longer processing applications for residential care assistance because of insufficient funds.

(2) Any other information the division may deem necessary.

(d) The director shall cause the posting of the notice set forth in subsection (c) at least five (5) working days prior to terminating the processing of applications for residential care assistance.

(e) Completed applications in the possession of the county office prior to the date processing applications ceases, but upon which no eligibility determination has been made, shall be processed.

(f) If the director, or the director's designee, makes a written determination that processing of applications shall not continue, the county office shall, nevertheless continue to obtain, from prospective applicants, an application inquiry containing the following information:

(1) The prospective applicant's name, address, and telephone number.

(2) Any other additional information required by the director.

(g) The county office shall inform the prospective applicant that completing an application inquiry does not mean the division will process the application inquiry. The prospective applicant shall also be informed that the mailing of the application inquiry by

the county office to the division does not ensure eligibility for residential care assistance. The county office shall also provide any additional information to the prospective applicant as may be required by the director.

(h) The county office shall send the information provided in accordance with subsection (f) to the division within five (5) working days of the receipt of the application inquiry. The county office shall also keep a copy of all application inquiries.

(i) If the director, or the director's designee, subsequently makes a written determination that sufficient funds are appropriated or otherwise available to support the costs of additional residential care assistance, the division shall do the following:

(1) Notify the county office to process residential care assistance applications of prospective applicants in the order that the application inquiry information described in subsection (f) was received by the county office, to the extent that funds will support the costs of additional residential care assistance.

(2) If sufficient funds are available to support the costs of residential care for all individuals who have completed application inquiries, the division shall resume processing residential care assistance applications and notify the county offices that the division is processing applications.

(j) If the director, or the director's designee, subsequently makes a written determination that sufficient funds are appropriated or otherwise available to support the costs of additional residential care assistance, the county office shall do the following:

(1) Notify those individuals whose application inquiries are in the possession of the county office and who may be eligible to have their application for residential care assistance processed, that a residential care assistance application may be processed. The written notice must state the following:

(A) That the prospective applicant must contact the county office to complete an application.

(B) That the prospective applicant's failure to contact the county office within fifteen (15) calendar days of notification shall result in their application not being processed.

(2) Notice shall be given to the applicant, and the facility, where necessary.

(3) The county office shall keep copies of the written notification to prospective applicants and shall make a written record of any other efforts made to notify prospective applicants.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3.5-2; filed Jun 27, 1997, 4:20 p.m.: 20 IR 3014)

460 IAC 1-3.5-3 Enrollment at a facility

Authority: IC 12-9-2-3; IC 12-10-6
Affected: IC 16-28

Sec. 3. (a) A recipient has the right to enroll in any residential home or county home the recipient chooses, subject to the following:

(1) The residential home or county home must have or agree to enter into a contract for residential care assistance with the division.

(2) The recipient's income must qualify for residential care assistance at the residential home or county home.

(3) The residential home or county home agrees to admit the individual.

(4) An individual with mental retardation may not be admitted to a residential home.

(5) An individual with a mental illness may not enroll in a Christian Science facility unless the facility is licensed under IC 16-28.

(b) A recipient may transfer to another residential home or county home, subject to the following:

(1) Appropriated funds, as determined by the director or the director's designee, must be available to support the recipient at the residential home or county home to which the recipient wishes to transfer.

(2) A rate for that residential home or county home must have been established by the division.

(3) The recipient's income must qualify for residential care assistance at the residential home or county home to which the recipient wishes to transfer.

(4) The residential home or county home agrees to admit the individual.

(5) An individual with mental retardation may not transfer to a residential home.

(6) An individual with a mental illness may not transfer to a Christian Science facility unless the facility is licensed under IC 16-28.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3.5-3; filed Jun 27, 1997, 4:20 p.m.: 20 IR 3015; errata filed Aug 15, 1997, 11:00 a.m.: 21 IR 111)

460 IAC 1-3.5-4 Return to a facility

Authority: IC 12-9-2-3; IC 12-10-6
Affected: IC 12-10-6

Sec. 4. If a resident has exhausted his or her funded leave pursuant to 460 IAC 5-1-15(d)(2), and has not returned to the residential home or county home in which the recipient is enrolled, and requires additional time away from the residential home or county home because the recipient needs:

(1) nursing facility care;
(2) hospitalization; or
(3) other recuperative leave;

the recipient may request that the division maintain the recipient's enrollment for residential care assistance at the residential home or county home, in which the recipient is enrolled, for up to thirty (30) calendar days. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3.5-4; filed Jun 27, 1997, 4:20 p.m.: 20 IR 3015)*

Rule 3.6. Residential Care Assistance Program

460 IAC 1-3.6-1 Definitions

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-6
Affected: IC 12-30; IC 16-28

Sec. 1. (a) The definitions in this section apply throughout this rule.

(b) "County home" means a residential facility owned, staffed, maintained, and operated by a county government that provides residential care to individuals.

(c) "County office" means the county office of family and children.

(d) "Division" means the division of disability, aging, and rehabilitative services.

(e) "Residential care" provided in a county home is nonmedical assistance provided to a resident. Residential care provided in a residential home is room, board, and laundry, along with minimal administrative direction.

(f) "Residential care assistance" means state financial assistance through the division paid on behalf of a resident of a county home or residential home who has been found to be eligible for assistance.

(g) "Residential home" means a residential care setting licensed under IC 16-28 or an accredited Christian Science facility listed and certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc., that meets certain life safety standards considered necessary by the state fire marshal. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3.6-1; filed Nov 14, 2001, 4:50 p.m.: 25 IR 1140)*

460 IAC 1-3.6-2 Eligibility for assistance for county home residents

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-6
Affected: IC 12-30

Sec. 2. (a) An individual is eligible for residential care assistance in a county home if the individual:

(1) is at least sixty-five (65) years of age, blind, or disabled;
(2) is a resident of a county home; and
(3) would be eligible for federal Supplemental Security Income assistance except for the fact that the individual is residing in a county home.

(b) An individual will be determined to be eligible for federal Supplemental Security Income assistance if the individual does any of the following:

(1) Presents verification that the individual is currently receiving federal Supplemental Security Income benefits.
(2) Presents verification that the individual is currently receiving Medicaid benefits.
(3) It is determined by the county office that the individual is eligible for federal Supplemental Security Income benefits. An individual shall be determined to be eligible for federal Supplemental Security Income benefits if the individual:
    (A) has a disability that meets the definition of disability contained in 42 U.S.C. 1382c(a)(3)(A) and 42 U.S.C. 1382c(a)(3)(B); and

(B) is financially eligible for federal Supplemental Security Income benefits.

(c) An individual who is disabled because of mental illness may be admitted to a county home only to the extent that money is available for the individual's care. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3.6-2; filed Nov 14, 2001, 4:50 p.m.: 25 IR 1140)*

460 IAC 1-3.6-3 Eligibility for assistance in a residential home

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-6
Affected: IC 12-10-6

Sec. 3. (a) An individual is eligible for residential care assistance in a residential home if the individual:

(1) is a current recipient of Medicaid or federal Supplemental Security Income benefits; and

(2) can be adequately cared for in a residential care setting.

(b) An individual will be determined to be able to be adequately cared for in a residential home if an individual is admitted to or cared for in a residential home.

(c) An individual diagnosed with mental retardation may not be admitted to a residential home.

(d) An individual who is disabled because of mental illness may be admitted to a residential home only to the extent that money is available for the individual's care. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3.6-3; filed Nov 14, 2001, 4:50 p.m.: 25 IR 1140)*

460 IAC 1-3.6-4 Continuing financial eligibility

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-6
Affected: IC 12-30

Sec. 4. An individual who is receiving residential care assistance and has an increase in income that would render the individual ineligible for residential care assistance may elect to continue to be eligible for residential care assistance by paying the excess income to the county home or residential home that provides residential care to the individual. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3.6-4; filed Nov 14, 2001, 4:50 p.m.: 25 IR 1141)*

460 IAC 1-3.6-5 Annual review

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-6
Affected: IC 12-30

Sec. 5. Eligibility for residential care assistance shall be redetermined by the county office on an annual basis, upon a change in the eligible individual's status as a recipient of Medicaid or federal Supplemental Security Income benefits, or upon a change in the medical status of a resident of a county home that would render the resident ineligible for federal Supplemental Security Income benefits. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-3.6-5; filed Nov 14, 2001, 4:50 p.m.: 25 IR 1141)*

Rule 4. Community and Home Options to Institutional Care for the Elderly and Disabled Program

460 IAC 1-4-1 Purpose

Authority: IC 12-9-2-3; IC 12-10-10-6
Affected: IC 12-10-10

Sec. 1. The purpose of this rule is to implement the community and home options to institutional care for the elderly and disabled program, authorized by IC 12-10-10, which provides case management services, assessment, and in-home and community services to individuals who are at least sixty (60) years of age or persons of any age who have a disability due to a mental or physical impairment and who are found to be at risk of losing their independence. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-4-1; filed Dec 5, 1995, 8:30 a.m.: 19 IR 1103; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)*

460 IAC 1-4-2 Definitions

Authority: IC 12-9-2-3; IC 12-10-10-6
Affected: IC 12-7-2-184; IC 12-10-1-1; IC 12-10-1-4; IC 12-10-10

Sec. 2. As used in this rule, the following definitions apply:

(1) "AAA" refers to the agency designated by the bureau in each planning and service area under IC 12-10-1-4(18).

(2) "Adult day care services" means the provision of a comprehensive structured program in a protective setting during the daytime and early evening hours.

(3) "Advocate" means any legal representative or any other person whom the applicant or participant chooses to assist him or her at any stage of the appeals process.

(4) "Applicant" means an individual who resides in Indiana and who has submitted an application to the area agency on aging for the CHOICE program.

(5) "At risk of losing the individual's independence" means that the individual meets the criteria specified in IC 12-10-10-4(b).

(6) "Attendant care services" means assistance with nonmedical personal care services such as:

(A) personal hygiene activities;
(B) ambulation and transfer of the individual;
(C) assisting the individual with communication;
(D) disposal of bodily waste;
(E) meeting the individual's nutritional needs; and
(F) ensuring the individual's physical safety.

(7) "Bureau" refers to the bureau of aging and in-home services established within the division under IC 12-10-1-1.

(8) "Care plan" means the plan of services developed by the AAA under IC 12-10-10-1(2).

(9) "Case management" means the administrative functions performed by the AAA under IC 12-10-10-1.

(10) "CHOICE" refers to the community and home options to institutional care for the elderly and disabled program.

(11) "CHOICE guidelines and procedures manual" refers to the document published by the division to define the protocol of the CHOICE program.

(12) "CHOICE representative" means a person authorized to act on behalf of an individual, as specified under section 4 of this rule, if the individual lacks the capacity to make a knowing and informed decision regarding his or her own care.

(13) "Community and home care services", "in-home and community services", or "CHOICE services" means those services specified in IC 12-10-10-2.

(14) "Division" or "DDARS" refers to the division of disability, aging, and rehabilitative services.

(15) "Home delivered meals" means an appropriate, nutritionally balanced meal that meets at least one-third (1/3) of the current recommended dietary allowance (RDA) delivered to the individual's home.

(16) "Home health services and supplies" means services and supplies that include all health monitoring activities performed in the home, the supervision of medication, care and maintenance of any appliances or equipment necessary to maintain health, safety, and independence, and dressing changes.

(17) "Homemaker services" means those household tasks that enable an individual to live in a clean, safe, and healthy home environment, including grocery shopping and meals preparation.

(18) "Institutional care" means continuous, twenty-four (24) hour residential care provided by, among others, hospitals, nursing facilities, intermediate care facilities for the mentally retarded, community residential facilities for the developmentally disabled, residential facilities for the mentally ill, and state owned and operated institutions.

(19) "Other services necessary to prevent institutionalization" includes, but is not limited to, the following:

(A) "Minor home modifications" means selected internal and external modifications to the home environment, related specifically to the individual's functional limitations, which will assist the individual in remaining in the current living situation.

(B) "Adaptive aids and devices" means controls, appliances, or supplies determined necessary to enable the individual to increase the ability to function in a home and community-based setting with independence and physical safety.

(20) "Respite care services" means services provided temporarily or periodically to participants in the absence of the usual unpaid caregiver, including services provided in the home or on an overnight basis in an approved out-of-home setting such as a nursing facility.

(21) "Transportation" means transporting the individual to and from medical or therapeutic activities that are directly related

to maintaining the individual's independence.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-4-2; filed Dec 5, 1995, 8:30 a.m.: 19 IR 1104; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)

460 IAC 1-4-3 Selection of local administrative units

Authority: IC 12-9-2-3; IC 12-10-10-6
Affected: IC 12-10-10-1

Sec. 3. (a) The division shall contract with the AAAs to administer CHOICE funds. These activities include local administrative functions, including, but not limited to, the following:

(1) Budgeting.
(2) Case management.
(3) Oversight.
(4) Monitoring.
(5) Quality assurance.
(6) Submission of fiscal claims to the division.

(b) Each AAA shall submit a plan to the division that contains the following:

(1) The referral and intake process, including a description of how the process of eligibility determination will take place.
(2) The assessment process, format, and procedures used by case managers employed by the AAA to do assessments.
(3) Procedures for an offer of an assessment to current nursing home residents who apply for CHOICE.
(4) Policies for the selection and qualifications of staff.
(5) Procedures for development of and expected timelines for care plan development, including the process for involving the client or family in the development of the care plan.
(6) All available long term support services, both public and private, within the area.
(7) Policies and procedures for the case management and service coordination system.
(8) Policies and procedures for coordinating CHOICE with the Medicaid waivers and other funding sources for in-home and community-based services.
(9) The CHOICE cost sharing plan, including cost share collection procedures.
(10) The current appeal procedures, including procedures for notifying applicants or participants of the right to an administrative hearing.
(11) Policies and procedures for waiting lists for CHOICE services.
(12) Policies and procedures for approved waivers and for requesting state approved waivers.
(13) Description of the development of the budget, as approved by the division, including the following:
    (A) A breakdown of proposed spending on client services.
    (B) Assessments.
    (C) Care plan development.
    (D) Reassessments.
    (E) AAA administration.
    (F) Any other appropriate costs.
(14) The estimated number of individuals who have a high functional need that warrants exceeding the established benchmark by twice the stated amount, and the methods of managing those costs.
(15) Procedures for selection of service providers.
(16) Policies and procedures for case file documentation and record keeping.
(17) Description of follow-up evaluation.
(18) The manner in which care plans and services are to be evaluated and monitored.

(c) Each AAA shall arrange for the provision of individually needed CHOICE services through local provider agencies or individuals.

(d) An AAA may provide community and home care services to individuals in the CHOICE program if the division determines that an appropriate alternative provider agency is not available. Before an AAA can provide community and home care services to individuals in the CHOICE program, the AAA must be granted a waiver from the division for the specific services to be delivered by the AAA.

(e) Under subsection (d), an AAA submitting a waiver request to provide services shall include documentation of the unavailability of appropriate alternative providers, including, but not limited to, failure to obtain responses after advertising the availability of CHOICE funds and description of the efforts that it has exercised to solicit provider expansion into the given area or description of the efforts utilized to stimulate new provider growth.

(f) The contract period for an AAA shall be two (2) years.

(g) The AAA and all CHOICE providers shall abide by all applicable state and federal laws and regulations. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-4-3; filed Dec 5, 1995, 8:30 a.m.: 19 IR 1104; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)*

460 IAC 1-4-4 Participant involvement in decision making

Authority: IC 12-9-2-3; IC 12-10-10-6
Affected: IC 12-10-10; IC 16-36-1

Sec. 4. (a) An individual has the right to be involved in the formulation of the care plan and shall be involved at every stage of decision making regarding his or her care and living situation.

(b) If the case manager has reason to believe that an individual lacks the capacity to make a knowing and informed decision regarding his or her own care, the case manager shall consult with the individual's physician. The individual's physician shall make a determination regarding the individual's capacity to make a knowing and informed decision. If the physician determines that the individual lacks the capacity to make a knowing and informed decision regarding his or her own care, the application and the care plan and any revisions must be approved and signed by the individual's CHOICE representative.

(1) An individual's CHOICE representative is any person who is legally authorized to make health care decisions on behalf of the individual under IC 16-36-1.

(2) If there is no person authorized to make health care decisions on behalf of the individual, then the individual's attending physician may act as the individual's CHOICE representative.

(c) If the individual is physically unable to sign the application or care plan, but has the capacity to make a knowing and informed decision regarding his or her own care, the individual may indicate his or her assent and authorize another to sign.

(d) Notwithstanding the fact that an individual needs a CHOICE representative, the case manager shall work and consult with the individual who will be receiving the services and shall take his or her preferences into consideration when developing a care plan, to the extent that the individual's health or safety is not threatened. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-4-4; filed Dec 5, 1995, 8:30 a.m.: 19 IR 1105; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)*

460 IAC 1-4-5 Assessment

Authority: IC 12-9-2-3; IC 12-10-10-6
Affected: IC 12-10-10

Sec. 5. (a) The long term care services eligibility screen developed by the division shall be used by the AAA to assess the applicant's risk of losing his or her independence and to assist in the development of a care plan if appropriate.

(b) Every applicant is eligible for an assessment. Applicants shall not be charged a fee for the assessment.

(c) The initial application and approval of the care plan must be signed by the applicant or by his or her CHOICE representative.

(d) Before each assessment, an explanation of the following must be given to the applicant:

(1) The purpose of the CHOICE assessment.

(2) The applicant's right to decide at any time to stop the process, and to refuse the offered in-home and community services.

(3) The applicant's right to appeal AAA decisions regarding eligibility or services to be provided.

(e) The AAA shall make a program eligibility determination based upon the results of the long term care services eligibility screen.

(f) When a decision is made regarding eligibility, the AAA shall notify the individual in writing of the following:

(1) Whether or not the applicant is eligible for the CHOICE program and, if eligible:

(A) that the applicant is approved for the development of a care plan; or

(B) that, due to the lack of availability of funds, the applicant will be placed on a waiting list if one is available.

(2) That the applicant has the right to appeal this eligibility decision.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-4-5; filed Dec 5, 1995, 8:30 a.m.: 19 IR 1106; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)

460 IAC 1-4-6 Care plan

Authority: IC 12-9-2-3; IC 12-10-10-6
Affected: IC 12-10-3; IC 12-10-10

Sec. 6. (a) If the applicant is eligible for CHOICE services, the AAA shall develop a care plan regardless of the applicant's income and assets.

(b) Notwithstanding subsection (a), a care plan shall not be developed in any of the following circumstances:

(1) If the applicant or his or her CHOICE representative does not want to proceed with the development of a care plan.

(2) If the applicant or his or her CHOICE representative refuses to release the information that is necessary to develop a care plan.

(3) If the AAA does not have the resources, within the available funds, to develop and carry out a care plan.

(c) All CHOICE service decisions regarding the individual shall be made in accordance with the best interests of that individual.

(d) The applicant and his or her CHOICE representative shall be involved in the development of the care plan. The applicant or his or her CHOICE representative may decide whether family or others may participate in the development of the care plan and in any update of the care plan.

(e) A care plan shall describe each of the following:

(1) The services needed to maintain independence.

(2) The services already being provided by other sources.

(3) The cost of the services still needed.

(4) The payment sources of those services.

(5) The no-cost or voluntary services that can be provided to meet the individual's needs.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-4-6; filed Dec 5, 1995, 8:30 a.m.: 19 IR 1106; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)

460 IAC 1-4-7 Duties of the AAA

Authority: IC 12-9-2-3; IC 12-10-10-6
Affected: IC 12-10-3; IC 12-10-10

Sec. 7. (a) Each AAA shall maintain individual case records for each individual who applies for or receives services. Each individual's records shall be maintained by the AAA for a minimum of three (3) years after the individual's termination from the program or other final action.

(b) The AAA shall maintain the confidentiality of CHOICE files and records at all times. Such files and records shall not be disclosed except:

(1) to the individual or his or her CHOICE representative;

(2) to a person representing the individual in an appeal from a CHOICE decision;

(3) to the division or other state agencies for purposes of securing in-home and community services;

(4) to an adult or child protective services investigator under IC 12-10-3 and IC 31-6-11-3 *[IC 31-6 was repealed by P.L.268-1995, SECTION 17, effective July 1, 1995.]*;

(5) under court order; or

(6) as authorized by the individual or his or her CHOICE representative.

(c) The AAA shall use CHOICE records for purposes of the CHOICE program and for the coordination of other related services only. Any disclosure of information in an individual's CHOICE file for purposes of coordinating related services shall be limited to the information that is directly relevant to and required by the other related services.

(d) CHOICE funding shall be used after all other possible payment sources have been identified and all reasonable efforts have been employed to utilize those sources.

(e) The AAA shall reduce services that are paid by CHOICE in any of the following circumstances:

(1) When the assessed level of need diminishes as established by an updated care plan.

(2) When the AAA's CHOICE service funds are insufficient to meet the service commitment to current participants, all reasonable efforts have been made to secure resources to avoid service reductions, the AAA has stopped performing new assessments and care plans, and the AAA has adopted a fair and equitable policy for distributing service reductions among participants.

(3) When an individual receiving services becomes eligible under a Medicaid home and community-based services waiver and begins receiving those services that are allowable through the Medicaid program.

(4) When a current participant becomes eligible for in-home and community services from other sources for which he or she was not previously eligible and is receiving those services.

(5) When other resources become available in the community and the individual begins receiving those services that were not available at the time of the development of the previous care plan.

(6) If services needed by the applicant, as determined by the assessment, would be so costly that CHOICE payment for the needed services would cause the AAA to exceed the allowable cost per individual determined by the division.

(f) The AAA shall terminate services that are paid by CHOICE in any of the following situations:

(1) When the individual's health or personal circumstances have improved so that he or she no longer needs in-home and community-based services to maintain his or her independence in a safe, noninstitutional environment.

(2) When the health, welfare, or safety of the participant or of others who interact with the individual can no longer be reasonably assured.

(3) When the services being provided are detrimental to the individual's health.

(4) When the individual or his or her CHOICE representative has fraudulently obtained or misused CHOICE funded services.

(5) Upon the death of the individual receiving services.

(6) When the individual or his or her CHOICE representative refuses to comply with cost sharing under section 8 of this rule.

(7) When the individual or his or her CHOICE representative voluntarily requests termination.

(8) When the individual or his or her CHOICE representative refuses services necessary for his or her health and well-being.

(g) A participant who is found eligible for CHOICE services, but does not receive CHOICE services for a period of six (6) months due to institutionalization or lack of need, may be terminated from CHOICE services. Restoration of services, after this six (6) month period, shall be within the availability of funds and continued need for services.

(h) No CHOICE services funds shall be used to purchase real estate.

(i) No CHOICE services funds shall be used to provide care or services to an individual residing in an institution. However, funds may be used for assessment and care plan development for current residents in institutions who could return to their homes if determined to be eligible for the CHOICE program.

(j) Unless no CHOICE funds are available, the AAA shall offer initial assessments and, when appropriate, individual care plans to applicants, regardless of the applicant's income and assets.

(k) The division shall establish a maximum level of CHOICE fund expenditure per individual based on costs calculated by the division. This maximum expenditure is not to be applied monthly, but over a period of three (3) consecutive months. The dollar amount shall be published in the CHOICE guidelines and procedures. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-4-7; filed Dec 5, 1995, 8:30 a.m.: 19 IR 1106; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)*

460 IAC 1-4-8 Cost sharing

Authority: IC 12-9-2-3; IC 12-10-10-6
Affected: IC 12-10-11-8

Sec. 8. (a) Cost sharing is a method of cost reimbursement for those individuals who can pay all or a portion of the cost of CHOICE services rendered under IC 12-10-11-8(11).

(b) Each AAA shall comply with the cost of services formula established under IC 12-10-11-8(11).

(c) The collection of cost share shall be the responsibility of the AAA in conjunction with the service provider. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-4-8; filed Dec 5, 1995, 8:30 a.m.: 19 IR 1107; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)*

460 IAC 1-4-9 Conflicts of interest

Authority: IC 12-9-2-3; IC 12-10-10-6
Affected: IC 12-10-10

Sec. 9. (a) The AAA shall not contract for CHOICE services with any service provider that is owned or controlled by a member of the AAA's board of directors or a member of the AAA's staff.

(b) The AAA shall not contract for CHOICE services with any service provider that is owned or controlled by a relative (father, mother, brother, sister, uncle, aunt, husband, wife, son, daughter, son-in-law, daughter-in-law, grandmother, grandfather, grandson, or granddaughter) of any member of the AAA's board of director or executive staff, including the executive director.

(c) An AAA that wishes to contract with a service provider contrary to this section, due to the lack of an alternative provider or because it is in the best interest of the participant, must request and be granted a waiver from the division. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-4-9; filed Dec 5, 1995, 8:30 a.m.: 19 IR 1108; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)*

460 IAC 1-4-10 Appeals

Authority: IC 12-9-2-3; IC 12-10-10-6
Affected: IC 4-21.5-1; IC 4-21.5-3-27; IC 12-10-10

Sec. 10. (a) Except as provided in subsection (b), applicants, participants, or their CHOICE representative shall have a right to appeal decisions regarding CHOICE eligibility and services if:

(1) they are found ineligible for the CHOICE program;

(2) they disagree with the decision either to deny a service which they believe they should receive or to discontinue or reduce a particular service which they are currently receiving; and

(3) they believe that any decision made or action taken concerning the CHOICE services they receive was not appropriate or in their best interests.

(b) The case manager is responsible for answering questions and attempting to resolve any problems or complaints before the applicant or participant resorts to the appeal process. The case manager is also responsible for documenting all complaints and actions taken in the case file in order to create a complete record for appeal.

(c) In case of applicants or participants who lack the capacity to make a knowing and informed decision regarding their own care, their CHOICE representative may appear on their behalf throughout the appeals process.

(d) Individuals or their CHOICE representative shall comply with the following appeals process:

STEP ONE: Individuals or their CHOICE representative shall first discuss any questions, concerns, or problems regarding CHOICE services with the case manager and the case manager supervisor. This informal meeting may take place either at the agency or at the applicant's or participant's home. The applicant or participant may be accompanied by an advocate. Within five (5) working days of the date of the informal meeting, the case manager supervisor shall inform the applicant or participant in writing of the decision reached on the issues raised at the meeting. The case manager supervisor shall also inform the applicant or participant that he or she may request an agency review to the AAA's executive director or designee within eighteen (18) calendar days of the date of the case manager supervisor's decision.

STEP TWO: Agency review as follows:

(A) The executive director or his or her designee shall conduct the agency review at the applicant's or participant's home or at the AAA office, whichever is more convenient for the applicant or participant. The applicant or participant, his or her advocate (if desired), and the case manager or the case manager's supervisor shall attend the review.

(B) Applicants and participants shall be given the opportunity to testify, present supporting materials, and explain why they disagree with the action or decision and what they would view as an appropriate alternative. The case manager or case manager supervisor may testify and explain the reasons for the decision or action taken.

(C) Immediately following the review, the executive director or designee conducting the review shall consider the comments of the applicant or participant, his or her advocate, and the case manager or the case manager's supervisor.

(D) Within five (5) working days, the executive director, or designee after consulting with the executive director, shall prepare the agency's final decision, in writing, including findings of fact and the specific reason for the decision. The applicant or participant and his or her advocate, if any, shall each be sent a copy of the decision by registered or certified mail, return receipt requested. The decision shall inform the applicant or participant of his or her right to have an administrative hearing under STEP THREE if dissatisfied with the agency's final decision.

STEP THREE: Administrative hearing as follows:

(A) If an applicant or participant is dissatisfied with the decision reached at the agency review, then he or she may appeal the decision by requesting an administrative hearing. The applicant, participant, or CHOICE representative shall

make the request for an administrative hearing, in writing, including a statement of the issues the applicant or participant wishes reviewed. The request shall be signed and dated. The written request shall be sent to the deputy director of the division, bureau of aging and in-home services within eighteen (18) days of the date of the decision from the agency review.

(B) Administrative hearings shall be conducted by administrative law judges (ALJs), or hearing officers, appointed by the DDARS director. The ALJ shall notify the applicant or participant and all involved persons of the date, time, and location of the hearing at least five (5) working days in advance. The applicant or participant shall be notified by registered or certified mail, return receipt requested. The AAA shall forward all written case documentation to the ALJ prior to the date of the hearing. The hearing shall be conducted in accordance with IC 4-21.5-1.

(C) Immediately, but no later than five (5) days following the hearing, the ALJ shall prepare the proposed decision, including a report of the findings of fact and the reasons for the decision based on those findings of fact. In accordance with IC 4-21.5-3-27, the ALJ shall forward the proposed decision to the DDARS director. A copy of the proposed decision shall be sent to the AAA, the applicant or participant, and his or her advocate, if any, by registered or certified mail, return receipt requested.

(D) The director of the division shall either affirm, modify, or dissolve the ALJ's proposed decision. The AAA, the applicant or participant, and his or her advocate shall be notified of the director's final order by registered or certified mail, return receipt requested.

(e) If a participant appeals a decision that terminates any service that is already being provided, then the service in question will usually be continued until the appeal is resolved, unless:

(1) the services would be harmful to the participant; or

(2) the services violate state or federal law or regulations and internal policies of the CHOICE program or the division.

(f) An applicant or participant may bring to his or her informal review, agency review, and administrative hearing any person he or she wishes to be present, including legal counsel. The division shall not pay for legal counsel for an applicant or participant during the appeal process.

(g) Interpreter services will be made available to assist the deaf or non-English speaking person upon request. Reader services will be made available to assist the blind person upon request. However, if the applicant or participant requires these services for participation in the agency review or administrative hearing, the applicant or participant, prior to the date of the review, shall discuss the arrangements with the case manager.

(h) The AAA shall have in place at all times an appeals process that complies with this section. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-4-10; filed Dec 5, 1995, 8:30 a.m.: 19 IR 1108; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)*

460 IAC 1-4-11 Guidelines and procedures

Authority: IC 12-10-10-6
Affected: IC 12-10-10

Sec. 11. (a) CHOICE guidelines and procedures shall be established by the division for the effective management of the program. These shall be in the form of a published manual.

(b) Revisions of the CHOICE guidelines and procedures may occur in the following circumstances:

(1) As necessary, as determined by the division, to provide clarity and consistency of program activities.

(2) CHOICE guidelines and procedures shall be open for comment at least annually.

(3) Revisions to the CHOICE guidelines and procedures may be made by the division after consideration of consumer needs, AAA recommendations, state law, division policy, or CHOICE board recommendations.

(4) The division shall provide notice to the public of revisions in guidelines and procedures by publications in the CHOICE board agenda posted before each meeting in the office of the division, bureau of aging and in-home services. Comments and recommendations for revision may be given during an official CHOICE board meeting.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-4-11; filed Dec 5, 1995, 8:30 a.m.: 19 IR 1109; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)

Rule 5. Adult Guardianship Services Program

460 IAC 1-5-1 Purpose

Authority: IC 12-9-2-3; IC 12-10-7-7
Affected: IC 12-10-7

Sec. 1. The purpose of this rule is to implement the adult guardianship services program authorized by IC 12-10-7, which includes the provision of full guardianships and least restrictive services to indigent adults who are unable to care for themselves properly or manage their own affairs without assistance due to certain incapacities or developmental disabilities. Program services include the identification and evaluation of adults who may need adult guardianship services. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-5-1; filed Jul 25, 1995, 12:00 p.m.: 18 IR 3394; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)*

460 IAC 1-5-2 Definitions

Authority: IC 12-9-2-3; IC 12-10-7-7
Affected: IC 12-9-1-1; IC 12-10-1-1; IC 12-10-7; IC 12-10-14-2; IC 16-36-1; IC 29-3-8; IC 30-5

Sec. 2. The following definitions apply throughout this rule:

(1) "Adult guardianship services" includes full guardianship and least restrictive services.

(2) "BAIHS" or "bureau" refers to the bureau of aging and in-home services established under IC 12-10-1-1, which monitors and coordinates the adult guardianship services program.

(3) "Division" or "DDARS" refers to the division of disability, aging, and rehabilitative services as established under IC 12-9-1-1.

(4) "Dual signature checking account" means an account that allows a recipient to write checks on his or her own but requires another person's signature before the checks are valid.

(5) "Guardian" means an individual or organization named by order of a court to exercise any or all powers specified in IC 29-3-8.

(6) "Incapacitated individual" means an individual as defined in IC 12-10-7-1.

(7) "Indigent adult" means an individual as defined in IC 12-10-7-2.

(8) "Least restrictive" means a course of action that allows the individual to live, learn, and work in a setting that places as few limits on the individual's rights and personal freedoms as appropriate to meet the needs of the individual.

(9) "Least restrictive services" refers to those services specified in IC 12-10-7-8.

(10) "Protected person" means an individual for whom a guardian has been appointed.

(11) "Provider" means an entity designated by the division under section 3 of this rule.

(12) "Recipient" means an individual receiving guardianship or least restrictive services.

(13) "Region" means a population or geographic area identified in a provider's adult guardianship services plan and approved by the division.

(14) "Representative" means any person who is legally authorized to make decisions on behalf of another under IC 16-36-1, or a power of attorney under IC 30-5.

(15) "Representative payee" means an individual or organization as defined in IC 12-10-14-2.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-5-2; filed Jul 25, 1995, 12:00 p.m.: 18 IR 3394; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)

460 IAC 1-5-3 Selection of providers

Authority: IC 12-9-2-3; IC 12-10-7-7
Affected: IC 12-10-7-8; IC 29-3

Sec. 3. (a) The division shall contract in writing with the designated adult guardianship services provider.

(b) In order to be designated as an adult guardianship services provider, an interested agency shall submit a proposal and an adult guardianship services plan to the division. The plan shall contain the following:

(1) The population or geographic area to be served.

(2) Qualifications and policies for the selection of employees.

(3) The referral and intake process.

(4) The assessment and reassessment process.
(5) Functions that volunteers may perform in the program.
(6) Policies and procedures for recruiting, training, and assigning volunteers.
(7) Policies and procedures for case file documentation and record keeping.
(8) A description of the manner in which ongoing cases will be evaluated and monitored.
(9) The criteria by which program activities will be evaluated.
(10) Policies and procedures for prioritization of eligible individuals on waiting lists for adult guardianship services.
(11) A description of the development of the budget, including a breakdown of proposed spending on adult guardianship services, assessments, service plan development, reassessments, provider administration, and any other appropriate costs.
(12) Procedures to avoid a conflict of interest for the provider in providing adult guardianship services to each recipient.

(c) The provider shall perform local administrative functions, including, but not limited to, the following:
(1) Budgeting.
(2) Oversight.
(3) Monitoring.
(4) Quality assurance.
(5) Submission of fiscal claims to the division.
(6) Case intake, assessment, and plan development.

(d) The provider shall have an employee devoted at least halftime to the adult guardianship services program as coordinator. The adult guardianship services coordinator shall be free from conflict of interest and shall have the following minimum qualifications:
(1) A bachelor's degree from a four (4) year accredited college or university. Two (2) years of experience serving as guardian to an individual over eighteen (18) years of age under IC 29-3 may substitute for one (1) year of college or university training.
(2) Two (2) years of experience in social services.
(3) One (1) year of management experience.

(e) The board of directors of the provider shall recruit and appoint from the community an adult guardianship services committee of at least five (5) persons to provide advice to the employees and to the board of directors on action pertaining to adult guardianship services and program activities.

(f) The adult guardianship services committee must include, but is not limited to, at least one (1) representative from each of the following categories:
(1) An attorney or financial professional knowledgeable about guardianship issues.
(2) A psychiatrist, clinical psychologist, or psychiatric social worker.
(3) A developmental disabilities specialist.
(4) A person sixty (60) years of age or older, or a representative of older adults knowledgeable about guardianships.
(5) One (1) member of the board of directors. Except for one (1) member from the board of directors, an individual appointed to the adult guardianship services committee shall not be a member of the board of directors or employee of the provider.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-5-3; filed Jul 25, 1995, 12:00 p.m.: 18 IR 3395; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)

460 IAC 1-5-4 Participant involvement in decision making

Authority: IC 12-9-2-3; IC 12-10-7-7
Affected: IC 12-10-7-8

Sec. 4. An individual referred to the provider or the individual's representative shall be involved in the formation of the service plan and shall be consulted at every stage of decision making. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-5-4; filed Jul 25, 1995, 12:00 p.m.: 18 IR 3396; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)*

460 IAC 1-5-5 Assessment

Authority: IC 12-9-2-3; IC 12-10-7-7
Affected: IC 12-10-7

Sec. 5. (a) The provider shall use the adult guardianship assessment instrument developed by the division to assess whether

an individual referred to the provider is indigent or incapacitated, or both, and to assist in the development of a service plan to meet the individuals' needs.

(b) Within the availability of funds, every individual who is referred to the provider is eligible for an initial assessment. Individuals shall not be charged a fee for the initial assessment. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-5-5; filed Jul 25, 1995, 12:00 p.m.: 18 IR 3396; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)*

460 IAC 1-5-6 Service plan

Authority: IC 12-9-2-3; IC 12-10-7-7
Affected: IC 12-10-7-8

Sec. 6. (a) If the individual referred to the provider is determined through the assessment to be eligible for adult guardianship services, the provider shall formulate and adopt an individualized service plan that provides the least restrictive service.

(b) The service plan shall describe each of the following:

(1) The individual's primary difficulties.

(2) The reason the individual was referred to the provider.

(3) The services needed and referrals made to obtain those services.

(4) Short term and long term objectives.

(5) Rationale for services.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-5-6; filed Jul 25, 1995, 12:00 p.m.: 18 IR 3396; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)

460 IAC 1-5-7 Specific tasks of the provider

Authority: IC 12-9-2-3; IC 12-10-7-7
Affected: IC 12-10-7-8; IC 29-3

Sec. 7. The provider shall perform the following duties:

(1) Provide adequate physical security of confidential data.

(2) Maintain a file for each protected person that documents any and all actions taken.

(3) Participate in contract performance reviews as requested by BAIHS.

(4) Develop program guidelines, policies, and procedures that conform to all applicable state and federal laws and BAIHS policies.

(5) Keep records and make reports as required by BAIHS and the court.

(6) Recruit and train appropriate volunteers as guardian assistants.

(7) Provide guidance and oversight to guardian assistants in the performance of their assigned duties.

(8) Recruit attorneys to provide legal services necessary to obtain guardianship services, preferably on a pro bono or reduced fee basis.

(9) Assist attorneys, as appropriate, in preparing material for legal presentation to the court.

(10) Assess each referred person to determine eligibility for guardianship or least restrictive services.

(11) Assure active participation of the adult guardianship services committee in determining the necessity of a guardianship or least restrictive service for each assessed individual.

(12) Perform all duties in accordance with IC 29-3 and any court order.

(13) Assess each recipient's income and disburse payment as appropriate for recipients receiving representative payee services.

(14) Maintain a separate account for each recipient whose funds are handled by the provider.

(15) Perform tasks associated with handling recipient funds in a manner that assures provider fiscal accountability.

(16) Monitor and evaluate all program activities on an ongoing basis.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-5-7; filed Jul 25, 1995, 12:00 p.m.: 18 IR 3396; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)

460 IAC 1-5-8 Provider policy conformance

Authority: IC 12-9-2-3; IC 12-10-7-7
Affected: IC 12-10-7-8

Sec. 8. (a) The provider shall coordinate with service providers in the area to obtain necessary direct services for the recipient. The provider shall not provide any other service to the recipient directly except guardianship and least restrictive services.

(b) If the direct services are not available from another provider, or if there are extraordinary circumstances making the provision of those services by the provider preferable, the provider must request a waiver from the division. The division may grant a waiver if there are no other providers available and willing to provide the direct services.

(c) The provider shall use standardized adult guardianship services program forms provided by the BAIHS.

(d) Where the assessment of an individual indicates the need for guardianship, the provider shall seek guardianship appointments from the court and may serve as the guardian. The provider shall provide least restrictive services.

(e) The provider shall not subcontract for the provision of guardianship or any least restrictive service or in any way delegate responsibility for any guardianship or least restrictive service. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-5-8; filed Jul 25, 1995, 12:00 p.m.: 18 IR 3396; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)*

460 IAC 1-5-9 Confidentiality

Authority: IC 12-9-2-3; IC 12-10-7-7
Affected: IC 12-10-7-8

Sec. 9. (a) The provider shall receive and maintain all information, including, but not limited to, recipient information in a confidential manner.

(b) All recipient information shall remain confidential, and access shall be limited to authorized employees of the provider. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-5-9; filed Jul 25, 1995, 12:00 p.m.: 18 IR 3397; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)*

460 IAC 1-5-10 Conflict of interest

Authority: IC 12-9-2-3; IC 12-10-7-7
Affected: IC 12-10-7-8

Sec. 10. (a) The provider shall avoid even the appearance of a conflict of interest or impropriety when dealing with the needs of the recipient. Impropriety or conflict of interest refers to a situation in which the provider has a personal or financial interest, or both, that may be perceived as self-serving or adverse to the position or the best interest of the recipient.

(b) Employees of the provider shall be free from conflict of interest.

(c) The provider's adult guardianship services program volunteers shall be free from conflict of interest.

(d) The provider's adult guardianship services program advisory committee shall have a written plan for resolving conflicts of interest. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-5-10; filed Jul 25, 1995, 12:00 p.m.: 18 IR 3397; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)*

Rule 6. Alzheimer's Disease and Related Senile Dementia Program

460 IAC 1-6-1 Purpose

Authority: IC 12-9-2-3; IC 12-10-4-6
Affected: IC 12-10-4

Sec. 1. The purpose of this rule is to establish criteria for the award of grants to be used for Alzheimer's disease and related senile dementia activities and to govern respite care pilot projects established under the Alzheimer's disease and related senile dementia program. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-6-1; filed Aug 17, 1995, 8:30 a.m.: 19 IR 37; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)*

460 IAC 1-6-2 Definitions

Authority: IC 12-9-2-3; IC 12-10-4-6
Affected: IC 12-9-1-1; IC 12-10-4; IC 12-10-5-2; IC 12-10-10-1

Sec. 2. The following definitions apply throughout this rule:

(1) "Adult day care services" refers to the provision of a comprehensive structured program in a protective setting during the daytime and early evening hours.

(2) "Alzheimer's disease" refers to a progressive degenerative disease that attacks the brain and results in impaired memory, thinking, and behavior as diagnosed by a qualified physician.

(3) "Alzheimer's disease and related senile dementia program" or "Alzheimer's program" refers to the program established under IC 12-10-4.

(4) "Dementia" or "related senile dementia" refers to a group of symptoms identified by a qualified physician, including, but not limited to, a decline in intellectual functioning that is severe enough to interfere with the ability of an individual diagnosed with related senile dementia to perform routine activities.

(5) "Division" refers to the division of disability, aging, and rehabilitative services established under IC 12-9-1-1.

(6) "Institutional care" refers to continuous, twenty-four (24) hour residential care provided by facilities such as the following:

(A) Hospitals and nursing facilities.

(B) Intermediate care facilities for the mentally retarded.

(C) Community residential facilities for developmentally disabled.

(D) State owned and operated institutions.

(7) "Respite care services" refers to those services provided temporarily or periodically to an individual diagnosed with Alzheimer's disease or related senile dementia, in the absence of the usual unpaid caregiver, and including services provided in the home or on an overnight basis in an approved out-of-home setting such as a nursing facility.

(8) "Task force" refers to the Alzheimer's disease and related senile dementia task force established under IC 12-10-5-2.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-6-2; filed Aug 17, 1995, 8:30 a.m.: 19 IR 37; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)

460 IAC 1-6-3 Grants

Authority: IC 12-9-2-3; IC 12-10-4-6
Affected: IC 12-10-4-1; IC 12-10-4-5

Sec. 3. (a) The division may make grants available for the following:

(1) Training and development of training materials for individuals listed in IC 12-10-4-1 who participate or assist in the care or treatment of individuals diagnosed with Alzheimer's disease or related senile dementia.

(2) Pilot programs or services, including respite care, adult day care, and other services necessary to prevent premature institutionalization of individuals with Alzheimer's disease and related senile dementia.

(3) Studies or research related to Alzheimer's disease and related senile dementia.

(4) Education or development of educational materials for individuals listed in IC 12-10-4-1 who participate or assist in the care or treatment of individuals diagnosed with Alzheimer's disease or related senile dementia.

(5) Other projects or services necessary to reduce or prevent premature institutionalization of individuals diagnosed with Alzheimer's disease or related senile dementia.

(b) Grants shall be available only to those entities who meet the requirements specified in IC 12-10-4-5(a).

(c) The division shall announce the availability of grant funds. Any announcement shall include, but not be limited to, the following:

(1) The purpose for which the funding is available.

(2) A description of the application process, including deadlines for submission and format for applications.

(3) A requirement for an evaluation of the project or services for which funding is available.

(4) A requirement for a final written report regarding the activities of the project or services for which funding is available.

(d) The division shall select among applicants for grant funds based on the criteria specified in section 4 of this rule. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-6-3; filed Aug 17, 1995, 8:30 a.m.: 19 IR 37; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)*

460 IAC 1-6-4 Selection criteria

Authority: IC 12-9-2-3; IC 12-10-4-6
Affected: IC 12-10-4-5

Sec. 4. Application for grants shall be reviewed and selected based on the following criteria:
(1) Timely submission of all information required in the division's announcement of available grant funds.
(2) Clear definition of the problems or issues to be addressed through the project.
(3) Project or service goals specified in the application.
(4) Statement of specific and measurable objectives directed at reaching the stated goals.
(5) Statement of strategies to be used to meet each objective.
(6) Identification of resources, other than grant funds, including a plan for obtaining other resources for continuation of the project after the grant period, when applicable.
(7) Attention to the needs of underserved groups identified in the application.
(8) Appropriate budget information, using the budget form provided by the division.
(9) Plan for evaluating outcomes of the project.
(10) Letters of support.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-6-4; filed Aug 17, 1995, 8:30 a.m.: 19 IR 38; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)

460 IAC 1-6-5 Consultation

Authority: IC 12-9-2-3; IC 12-10-4-6
Affected: IC 12-10-4-3

Sec. 5. The division shall consult with the following entities, as necessary, in developing and evaluating activities and services for which grant funds are available under section 3 of this rule:
(1) The division of mental health.
(2) The state department of health.
(3) The task force.
(4) Other organizations knowledgeable about Alzheimer's disease and related senile dementia, or who have an interest in the welfare of individuals with Alzheimer's disease and related senile dementia.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-6-5; filed Aug 17, 1995, 8:30 a.m.: 19 IR 38; readopted filed Oct 1, 2001, 3:38 p.m.: 25 IR 528)

Rule 7. Indiana Long Term Care Ombudsman Program

460 IAC 1-7-1 Purpose

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-13

Sec. 1. The purpose of this rule is to implement the long term care ombudsman program authorized by IC 12-10-13-17 and 42 U.S.C. 3058g which includes identifying, receiving, investigating, resolving, or attempting to resolve complaints and concerns regarding the health, safety, welfare, or rights of residents. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-1; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1640)*

460 IAC 1-7-2 Definitions

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-9-1-1; IC 12-10-3; IC 12-10-13-3.3; IC 16-18-2-167

Sec. 2. (a) The definitions in this section apply throughout this rule.
(b) “Adult protective services program” means the program established under IC 12-10-3.
(c) “Adult protective services unit” means the unit defined in 460 IAC 1-2-2.
(d) “Conflict of interest” means that other interests intrude upon, interfere with, threaten to negate, or give the appearance of interfering with or negating the ability of the state ombudsman, state level staff of the office, local ombudsmen, volunteers, or local ombudsman entities to advocate without compromise on behalf of residents of long term care facilities. It also means any situation that would create a reasonable appearance of a conflict of interest.

(e) "Consult" or "consultations" means to share information with and to keep apprised.

(f) "Dedesignation" means revocation of the designation of a representative of the office or a local ombudsman entity by the state ombudsman.

(g) "Division" means the division of disability, aging, and rehabilitative services established in IC 12-9-1-1.

(h) "Financial interest" means the following:

(1) Any ownership or investment interest represented by equity, debt, or other financial relationship in a long term care facility, long term care service, or home care organization; or

(2) The right to receive, directly or indirectly, remuneration, in cash or in kind, under a compensation agreement with an owner or operator of a long term care facility or home care organization.

(i) "Health facility" or "nursing facility" means a facility as defined in IC 16-18-2-167.

(j) "Identifying information" means the name, age, address, social security number, telephone number, name of facility, diagnosis, physical disability, or any other information that may be used to identify the individual or individuals to whom the complaint refers, or the individual or individuals making the complaint.

(k) "Immediate family member" means a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, child, or stepchild.

(l) "Legal representative" has the meaning specified in IC 12-10-13-3.3.

(m) "Local ombudsman" means an individual designated by the state ombudsman under section 8 of this rule.

(n) "Local ombudsman entity" means an entity designated by the state ombudsman under section 5 of this rule as the entity to house the local ombudsman.

(o) "Long term care facility" or "facility" means a health facility or an adult care home.

(p) "Office" means office of the state long term care ombudsman established under IC 12-10-13.

(q) "Officer" means the president, vice-president, chairperson, director, executive director, or chief executive officer of an agency or entity.

(r) "Person" means an association, a corporation, a limited liability company, an individual, a governmental agency, or a partnership.

(s) "Program" means the long term care ombudsman program authorized under IC 12-10-13 and 42 U.S.C. 3058g.

(t) "Program records" means the following:

(1) The medical, financial, and social records of residents or clients obtained for the purpose of identifying, investigating, or attempting to resolve a complaint or concern by or on behalf of residents or clients.

(2) Records obtained which are necessary for the investigation of a complaint by or on behalf of residents or clients.

(3) Administrative records, policies, and documents of long term care facilities and home care service organizations obtained during the process of investigating or attempting to resolve a complaint or concern.

(4) Any data relating to complaints and conditions in long term care facilities or home care organizations.

(5) Any other records compiled and maintained by representatives of the office in carrying out their duties pursuant to this rule.

(u) "Representative of the office" means the state ombudsman, other state level ombudsman staff, local ombudsmen, or volunteer ombudsmen.

(v) "Resident" means the resident of a long term care facility.

(w) "State long term care ombudsman" or "state ombudsman" means an individual appointed by the director of the division.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-2; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1640)

460 IAC 1-7-3 Appointment of the state long term care ombudsman; qualifications

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-13-8; IC 12-10-13-10

Sec. 3. (a) The director of the division shall appoint an individual as state long term care ombudsman to direct the office on a full-time basis.

(b) An individual appointed as state ombudsman shall have the following qualifications:

(1) A bachelor's degree.

(2) Experience in the field of gerontology or long term care. An individual has experience in the field of gerontology if he or she has at least one (1) year working experience in a setting or in an agency, public or private, that provides directly or arranges for the provision of services to older individuals.

(3) Knowledge of laws and regulations pertaining to long term care, including Title XVIII and Title XIX of the Social Security

Act and the legal system serving older adults, persons with disabilities, and low-income individuals.

(4) Experience with dispute resolution techniques, including, but not limited to, investigation, mediation, and negotiation. This requirement is satisfied if the individual has had training in dispute resolution techniques.

(5) Expertise and familiarity in the fields of long term care and advocacy. This requirement is satisfied if the individual has at least one (1) year working experience in an agency, public or private, that represents the interests or rights of vulnerable individuals.

(6) No conflict of interest as required by this rule.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-3; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1641)

460 IAC 1-7-4 Duties of the state ombudsman; independence

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-1-3; IC 12-10-1-4; IC 12-10-13

Sec. 4. (a) The state ombudsman shall, in consultation with the director of the state unit on aging, direct the office of the long term care ombudsman program.

(b) The state ombudsman shall, personally or through representatives of the office, perform the following duties:

(1) Identify, investigate, resolve, or attempt to resolve complaints by or on behalf of residents and clients.

(2) Provide services to protect the health, safety, welfare, and rights of residents, including, but not limited to:

(A) Information and referral services.

(B) Education and training for residents, their family members, staff of long term care facilities, and the public. These services may be provided by dissemination of written information, presentations, workshops, individual meetings with residents or their family members, or any other appropriate means.

(3) Inform residents, family members, long term care facility staff, and the public about ombudsman program services, how residents can access those services, or how services can be accessed on behalf of residents.

(4) Inform residents about the means of obtaining services provided through providers of long term care services or their representatives, public agencies, and health and social service agencies.

(5) Ensure that residents statewide have regular and timely access to representatives of the office through resident visits.

(6) Ensure that complainants, clients, and residents receive timely responses to complaints and requests for assistance.

(7) Advocate on behalf of residents in the following nonexclusive ways:

(A) Identify problems affecting residents at the facility, local, state, or national levels and attempt to resolve those problems.

(B) Identify problems in the long term care system and advocate for changes to that system.

(C) Represent the interests of residents before governmental agencies.

(D) Analyze, comment on, provide public testimony, and monitor the development and implementation of proposed or existing federal, state, and local laws, regulations, government policies, and actions that affect residents.

(E) Facilitate public comment.

(8) Seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of residents.

(9) Designate and dedesignate local ombudsman entities and representatives of the office in accordance with this rule.

(10) Consult in the development of the contract between the division and the local ombudsman entity regarding that portion of any contract related to the ombudsman program.

(11) Direct the program related activities of the local ombudsmen in consultation with the local ombudsman entity. The state ombudsman shall, in consultation with the local ombudsman entity, provide oversight to the work of the local ombudsmen.

(12) Provide administrative and technical assistance to representatives of the office and local ombudsman entities.

(13) Monitor and evaluate the activities and performance of representatives of the office and local ombudsman entities in accordance with this rule.

(14) Consult with the following agencies or programs:

(A) The Indiana state department of health.

(B) The adult protective services program.

(C) The Indiana protection and advocacy services.

(D) Other state agencies and programs whose duties and services affect residents.

(15) Provide technical support for the development and maintenance of resident and family councils.

(16) Promote the development of citizen organizations to participate in the program.

(17) Prepare an annual report in accordance with the Older Americans Act.

(18) Ensure that the confidentiality of program records is maintained in accordance with this rule.

(19) Identify duties to be performed by volunteer ombudsmen in consultation with the local ombudsman, local ombudsman entity, and the division.

(20) Perform other duties the federal commissioner on aging determines to be appropriate.

(c) The state ombudsman shall report directly to the director of the state unit on aging. The state ombudsman shall be independent in all actions, but shall consult with the director of the state unit on aging or his or her designee to ensure identification and resolution of agency-wide issues, programmatic and fiscal integrity, and coordination of efforts. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-4; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1642)*

460 IAC 1-7-5 Local ombudsman entity; designation; term; dedesignation; notice

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-13-4.5; IC 12-10-13-13

Sec. 5. (a) The state ombudsman may designate local ombudsman entities to carry out the duties specified in section 6 of this rule. The state ombudsman shall consult with the division in the selection of a local ombudsman entity.

(b) An entity applying for designation must:

(1) be a public or private nonprofit entity;

(2) have demonstrated capability to carry out duties of the ombudsman program, such as experience in advocating for the individual and collective rights of vulnerable individuals; and

(3) be free of conflicts of interest as required by this rule.

(c) An entity shall be designated for a period not to exceed two (2) years.

(d) The state ombudsman may dedesignate a local ombudsman entity at any time, for cause, which may include, but is not limited to, the following:

(1) Failure to satisfactorily perform the duties of the entity as specified in section 6 of this rule.

(2) Failure to report or correct a conflict of interest.

(3) Violation of confidentiality provisions required under state or federal statutes or regulations, this rule, or office policy.

(e) The state ombudsman shall give written notice of the dedesignation to the local ombudsman entity. The notice shall include:

(1) reasons for the dedesignation;

(2) effective date of the dedesignation; and

(3) appeal rights.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-5; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1643)

460 IAC 1-7-6 Responsibilities of local ombudsman entity

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-13

Sec. 6. The local ombudsman entity shall:

(1) assure continual ombudsman coverage by a designated and certified ombudsman;

(2) remain free of conflicts of interest as defined in this rule;

(3) provide nonombudsman program related supervision, i.e., attendance, appropriate office behavior, etc.;

(4) provide space, phone, computer access, utilities, supplies, postage, mail service, and other program support;

(5) inform the office prior to dismissal of a local ombudsman for reasons unrelated to the duties of the office;

(6) adhere to all the state and federal laws, regulations, and rules governing the Indiana long term care ombudsman program;

(7) not give the local ombudsman other job assignments that conflict with ombudsman responsibilities; and

(8) provide confidentiality to the state ombudsman, to the local ombudsman, to the office, to residents, to families, and to anyone filing a complaint on behalf of a resident.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-6; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1643)

460 IAC 1-7-7 Responsibilities of state ombudsman as to local ombudsman entity

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-13

Sec. 7. The state ombudsman shall:

(1) provide programmatic direction, instruction, guidance, and assistance to the local ombudsman entity;

(2) assess the local ombudsman entity;

(3) assess the local ombudsman's performance in consultation with the local ombudsman entity; and

(4) involve the local ombudsman entity in program planning and policy development.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-7; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1643)

460 IAC 1-7-8 Local ombudsman; designation; exemption; certification; dedesignation; notice

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-13-4.5; IC 12-10-13-13

Sec. 8. (a) The state ombudsman may designate a local ombudsman as representative of the office to carry out the duties specified in section 9 of this rule. If the local ombudsman is housed in a local ombudsman entity, the state ombudsman shall consult with the local ombudsman entity in the designation process.

(b) In order to be designated as a local ombudsman, an individual shall meet the following criteria:

(1) Have a bachelor's degree in counseling, gerontology, nursing, psychology, sociology, social work, physical, occupational, or recreational therapy, special education, rehabilitation counseling, or other human services field or have at least four (4) years work experience in the field of long term care. Accredited college training in the areas listed above may substitute for the required work experience on a year-for-year basis.

(2) Successfully complete the Indiana long term care ombudsman program training and certification program.

(3) Be free of conflicts of interest as required by this rule.

(c) An individual serving as local ombudsman before the effective date of this rule shall be exempt from the requirements in this section except those referring to conflicts of interest.

(d) Each local ombudsmen *[sic., ombudsman]* designated in accordance with subsection (a) shall be certified by the state ombudsman to perform the duties in section 9 of this rule for a period not to exceed two (2) years.

(e) In order to be recertified, a local ombudsman shall:

(1) satisfactorily perform the duties specified in section 9 of this rule;

(2) remain free of conflicts of interest as required by this rule; and

(3) satisfactorily meet any additional requirements specified by law or regulation.

(f) The state ombudsman may, at any time, dedesignate a local ombudsman for cause. If the local ombudsman is housed in a local ombudsman entity, the state ombudsman shall consult with the local ombudsman entity in the dedesignation process. Cause for dedesignation includes, but is not limited to, the following:

(1) Failure of the local ombudsman to follow state and federal laws, regulations, and this rule.

(2) Failure to satisfactorily perform the duties specified in section 9 of this rule.

(3) Failure to follow the direction and supervision of the state ombudsman or appropriate state level office staff.

(4) Taking any action which endangers the health, safety, welfare, or rights of residents or clients.

(5) Failure to disclose or correct a conflict of interest.

(g) The state ombudsman shall give written notice of the dedesignation to the local ombudsman. The notice shall include:

(1) reasons for the dedesignation;

(2) effective date of the dedesignation; and

(3) appeal rights.

(h) The state ombudsman must inform the local ombudsman entity of the decision not to recertify or to dedesignate a local ombudsman prior to issuing the written notice to the local ombudsman. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-8; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1643)*

460 IAC 1-7-9 Duties of the local ombudsman

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-13

Sec. 9. The local ombudsman shall perform the following duties:

(1) Identify, investigate, resolve, or attempt to resolve complaints made by or on behalf of residents that relate to actions, inactions, or decisions that may adversely affect the health, safety, welfare, or rights of residents. The local ombudsman shall inform the complainant, the resident, or their legal representatives of the findings of an investigation or the reasons why a complaint cannot be investigated.

(2) Provide services to protect the health, safety, welfare, and rights of long term care facility residents, including, but is not limited to:

(A) information and referral services; and

(B) education and training for residents, their family members, staff of long term care facilities, and the public.

(3) Provide residents regular and timely access to the program through frequent resident visits.

(4) Respond to complaints and requests for assistance.

(5) Support the development and maintenance of resident and family councils and assist in addressing council concerns.

(6) Inform residents, their family members, citizens' organizations, the public, and long term care facility staff about the ombudsman program.

(7) Advocate on behalf of residents in the following nonexclusive ways:

(A) Identify problems affecting residents at the facility, local, state, or national levels and attempt to resolve those problems.

(B) Identify problems in the long term care system and advocate for changes to that system.

(C) Represent the interests of residents before government agencies, legislative committees, individual legislators, and other individuals, groups, or entities where issues that affect residents are addressed.

(D) Communicate directly with legislators, policy makers, and the media about issues affecting residents and other consumers of long term care.

(E) Analyze, comment on, provide public testimony, and monitor the development and implementation of proposed or existing federal, state, and local laws, regulations, government policies, and actions that affect residents.

(F) Facilitate public comment.

(G) Provide information regarding the problems and concerns of residents and recommendations for resolving those problems and concerns to:

(i) public agencies;

(ii) private entities; and

(iii) state and federal legislators.

(H) Take any other action relating to the ombudsman program determined to be appropriate by the state ombudsman.

(8) Pursue administrative, legal, and other remedies on behalf of residents.

(9) In accordance with federal and state laws and regulations, share information related to long term care facilities with the Indiana state department of health.

(10) Whenever possible, participate in surveys of long term care facilities conducted by the Indiana state department of health.

(11) Document and report activities as required by the office.

(12) Accept the direction, instruction, guidance, and assistance of the state ombudsman, in consultation with the local ombudsman entity, in all program activities.

(13) Follow federal and state laws and these rules.

(14) Carry out other program-related activities that the state ombudsman determines to be appropriate.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-9; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1644)

460 IAC 1-7-10 Volunteer ombudsman; designation; certification; dedesignation

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-13-4.5

Sec. 10. (a) The state ombudsman may designate a volunteer ombudsman to perform specific office duties.

(b) To be designated as a volunteer ombudsman, an individual shall:

(1) successfully complete the Indiana long term care volunteer ombudsman program training; and

(2) be free of conflicts of interest as required by this rule.

(c) Each volunteer ombudsman designated in accordance with subsection (a) must be certified for a period not to exceed two (2) years.

(d) The local ombudsman shall assess each volunteer ombudsman at least every two (2) years and make a recommendation regarding recertification to the state ombudsman. In order to be recertified, the volunteer ombudsman shall:

(1) satisfactorily perform the duties of the position;

(2) remain free of conflicts of interest as required by this rule; and

(3) meet any additional requirements specified by law or regulation.

(e) The state ombudsman, in coordination with the local ombudsman, may dedesignate a volunteer ombudsman for cause, including, but not limited to, the following:

(1) Failure of the volunteer ombudsman to follow the direction and supervision of the state or local ombudsman.

(2) Acting outside the area of responsibility.

(3) Taking any action which endangers the health, safety, welfare, or rights of residents.

(4) Failure to disclose or correct a conflict of interest.

(5) Failure to satisfactorily perform the duties of a volunteer ombudsman.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-10; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1645)

460 IAC 1-7-11 Conflict of interest; state ombudsman and state level office staff

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-13

Sec. 11. Any individual who has the following conflicts of interest, or any individual who has an immediate family member with these conflicts of interest, shall not be appointed as state ombudsman or to the staff of the state office:

(1) Having a financial interest in a long term care facility or a long term care service within three (3) years before the date of appointment.

(2) Employment in a long term care facility within one (1) year before the date of appointment.

(3) Current direct involvement in the licensing or certification of a long term care facility or a provider of a long term care service.

(4) Current employment in, contractual arrangement with, or participation in the management of a long term care facility.

(5) Current membership in a trade association of long term care facilities.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-11; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1645)

460 IAC 1-7-12 Conflict of interest; board members, officers, and employees of local ombudsman entities

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-13

Sec. 12. (a) Board members of the local ombudsman entity who are not free from conflicts of interest shall not participate in any discussion or vote on any matters pertaining to the program, and such recusal shall be made a part of the minutes or other official record of the local entity's board of directors or other comparable governing body. Such conflicts of interest include the following:

(1) Current direct involvement in the licensing or certification of a long term care facility or a provider of a long term care service.

(2) Current employment in, contractual arrangement with, or participation in the management of a long term care facility.

(3) A current financial interest in a long term care facility or a long term care service.

(4) Current membership in a trade association of long term care facilities.

(b) In order to receive and maintain designation or to be redesignated as a local ombudsman entity, officers of those entities seeking to be designated or redesignated as local ombudsman entities shall be free from conflicts of interest, which include the following:

(1) Current direct involvement in the licensing or certification of a long term care facility or a provider of a long term care service.

(2) Current employment in, contractual arrangement with, or participation in the management of a long term care facility.

(3) A current financial interest in a long term care facility or a long term care service.

(4) Current membership in a trade association of long term care facilities.

(c) In order to receive designation, or redesignation, as a local ombudsman entity, employees of those entities who supervise a local ombudsman shall be free from conflicts of interest, which include the following:

(1) Current direct involvement in the licensing or certification of a long term care facility or a provider of a long term care service.

(2) Current employment in, contractual arrangement with, or participation in the management of a long term care facility.

(3) A current financial interest in a long term care facility or a long term care service.

(4) Current membership in a trade association of long term care facilities.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-12; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1645)

460 IAC 1-7-13 Conflict of interest; local ombudsman and volunteer ombudsman; family members

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-13

Sec. 13. (a) In order to receive designation or certification, or to avoid dedesignation, as a local ombudsman or a volunteer ombudsman, an individual shall be free from conflicts of interest, which include the following:

(1) A financial interest in a long term care facility or a long term care service within three (3) years before the date of designation.

(2) Acting as local ombudsman or volunteer ombudsman in a long term care facility in which the individual was employed within one (1) year before the date of designation.

(3) Current direct involvement in the licensing or certification of a long term care facility or a provider of long term care service.

(4) Current employment in, contractual arrangement with, or participation in the management of a long term care facility.

(5) Current membership in a trade association of long term care facilities.

(6) Currently serving as an officer of a local ombudsman entity.

(7) Currently serving as a supervisor of other programs that may come in conflict with the duties of the ombudsman program.

(8) Currently performing duties or providing services other than those required in this rule that are in conflict with, or that may create a conflict with, the duties required in this rule.

(9) Currently serving as:

(A) a resident's agent;

(B) a resident's legal representative;

(C) the sole witness for do not resuscitate orders or other medical directives; or

(D) a member of a long term care facility's ethics committee which makes medical decisions for residents.

(b) A family member who serves as a resident who is their family member's agent or legal representative shall not be regarded as having a conflict of interest.

(c) In order to receive designation or certification, or to avoid dedesignation, as a local ombudsman or a volunteer ombudsman, an individual's immediate family members shall be free from conflicts of interest, which include the following:

(1) Current direct involvement in the licensing or certification of a long term care facility or a provider of a long term care service.

(2) Current participation through direct employment or contractual arrangement in the management of a long term care facility in the volunteer ombudsman's or local ombudsman's service area.

(3) A current financial interest in a long term care facility or a long term care service.

(4) Current membership in a trade association of long term care facilities.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-13; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1646)

460 IAC 1-7-14 Ombudsman program records; confidentiality; access; disclosure of identity of complainant or resident

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-13-16.4; IC 12-10-13-16.8

Sec. 14. (a) All program records developed or maintained by the local ombudsman or volunteer ombudsman in the course of work for the office become the property of the office.

(b) All program records shall be kept confidential and released only pursuant to state law and this rule.

(c) Ombudsman program records shall be maintained in secure files to ensure confidentiality. Measures shall be implemented by the division and the local ombudsman entity to ensure confidentiality to the local ombudsman, state ombudsman, and the state level staff of the office with respect to the receipt of complaints by mail, fax, telephone, or personal interview, which measures shall include means for the delivery of mail, addressed to representatives of the office by name or title, unopened.

(d) Access to program records shall be limited to the following, and to them only for purposes associated with their official duties:

(1) The state ombudsman.

(2) The state level staff of the office.

(3) The local ombudsman.

(e) The state ombudsman, the state level staff of the office, the local ombudsman, and the volunteer ombudsman shall not disclose the identity of a complainant or resident, except:

(1) with the written consent of the resident or complainant or his or her legal representative;

(2) with the oral consent of the resident or complainant or his or her legal representative, and the consent is documented contemporaneously on a form prescribed or approved by the office; or

(3) the disclosure is required by court order.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-14; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1646)

460 IAC 1-7-15 Access to facilities and facilities' records

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 5-14-3-8; IC 12-10-13-16.2; IC 12-10-13-16.5

Sec. 15. (a) Representatives of the office shall have access to long term care facilities at all times.

(b) Representatives of the office shall have access to those records of a long term care facility that residents or the general public have access to as a matter of law, or to records or documentation when such records or documentation are *[sic., is]* relevant to a complaint or an investigation and disclosure is not prohibited by state or federal laws or regulations governing the confidentiality of such records or documentation. Records and documentation of a long term care facility are relevant if they relate to or address the subject matter of the complaint or investigation.

(c) Representatives of the office shall be permitted to make or obtain copies of these records. A long term care facility may charge for the copies at a rate not to exceed the rate specified by state law.

(d) Representatives of the office shall have access to a resident's medical, financial, and social records as provided under IC 12-10-13. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-15; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1647)*

460 IAC 1-7-16 Access to agency records

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-13-16.6

Sec. 16. (a) Representatives of the office shall have access to records of a state or local government agency that are relevant to a complaint or investigation, except as prohibited by state or federal law or regulation. For purposes of this section, the term "relevant records" refers to those records that address the subject matter of a complaint, or investigation, or that pertain to a long term care facility that is involved in a complaint, or that is the subject of an investigation.

(b) If the records pertain to a particular resident, the representative of the office shall obtain consent to access the records in accordance with state law. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-16; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1647)*

460 IAC 1-7-17 Legal counsel

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-13

Sec. 17. (a) State and local ombudsmen shall have access to legal counsel that is able, without conflict of interest, to provide advice and consultation necessary to:

(1) protect the health, safety, welfare, and rights of residents of long term care facilities; and

(2) assist the state and local ombudsmen in the performance of their official duties.

(b) The division shall be responsible for arranging for legal representation of state and local ombudsmen against whom legal action is brought or threatened to be brought in connection with the performance of the official duties of the ombudsmen. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-17; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1647)*

460 IAC 1-7-18 Monitoring

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-13

Sec. 18. (a) The state ombudsman shall monitor and assess the performance of the local ombudsman entity and the local ombudsman to ensure compliance with all applicable laws and regulations governing the program and this rule. Monitoring shall include, but shall not be limited to, a review of local ombudsman case records. The state ombudsman and the state level staff of the office shall have access to all necessary records containing the identity or identifying information of residents or complainants in order to conduct the monitoring and assessment. Monitoring and assessment shall be conducted by the state ombudsman and the state level staff office as follows:

(1) The local ombudsman entity shall be responsible for monitoring and assessing administrative compliance using a tool developed by the state ombudsman.

(2) The state ombudsman and the state level staff of the office shall be responsible for assessment of the performance of program duties and for case record monitoring and assessment in order to maintain the confidentiality of program files.

(3) The results of the administrative monitoring and assessment and the case record monitoring and assessment shall be shared among the state ombudsman, the local ombudsman, and the local ombudsman entity.

(b) The results of the monitoring and assessment shall be considered a factor by the state ombudsman in determining whether to redesignate the local ombudsman entity and recertify the local ombudsman. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-18; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1647)*

460 IAC 1-7-19 Noninterference

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-13

Sec. 19. (a) A person shall not exert inappropriate or improper influence on a representative of the office or take any action which will in any way compromise, delay, or limit:

(1) the investigation or outcome of complaints;

(2) the representative's role as advocate for the rights and interests of residents;

(3) the representative's attempt to resolve issues related to the rights, quality of care, and quality of life of the residents; or

(4) the representative's responsibility to provide information or recommendations regarding problems and concerns of residents or clients, as necessary, to public and private agencies, legislators, or other persons.

(b) Any interference with the duties of a representative of the office by an officer or employee of the division or an officer or employee of the local ombudsman entity shall be deemed a breach of the duties of the division or local ombudsman entity, as specified in this rule. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-19; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1648)*

460 IAC 1-7-20 Violations

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 12-10-13-20

Sec. 20. A person who takes any of the following actions commits a Class B misdemeanor:

(1) Intentionally prevents the work of the office.

(2) Knowingly offers compensation to the office in an effort to affect the outcome of an investigation or a potential

investigation.

(3) Retaliates against a resident, a client, an employee, or another person who files a complaint or provides information to the office.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-20; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1648)

460 IAC 1-7-21 Administrative reconsideration; appeals

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-10-13-17
Affected: IC 4-21.5

Sec. 21. (a) A local ombudsman entity that is dedesignated or that is not redesignated may request a reconsideration of the decision to the state ombudsman. The state ombudsman shall provide a response to the request for reconsideration within fifteen (15) days from the date the request is received, including a notice of the right to appeal the decision. A local ombudsman entity that is dissatisfied with the decision on reconsideration may appeal the decision. The appeal shall be conducted in accordance with IC 4-21.5.

(b) A local ombudsman who is dedesignated or who is not redesignated may, in coordination with the local ombudsman entity or independently, seek reconsideration from the state ombudsman. The state ombudsman shall provide a response to the request within fifteen (15) days of the date the request is received, including a notice of the right to appeal the decision. A local ombudsman who is dissatisfied with the decision may, in coordination with the local ombudsman entity or independently, appeal the decision. The appeal shall be conducted in accordance with IC 4-21.5. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1-7-21; filed Mar 6, 2000, 7:51 a.m.: 23 IR 1648)*

ARTICLE 2. DIVISION OF REHABILITATION SERVICES

Rule 1. Office of Services for the Blind and Visually Impaired–Vending Program for the Blind (Repealed)

(Repealed by Division of Disability, Aging, and Rehabilitative Services; filed Aug 23, 2001, 2:30 p.m.: 25 IR 82)

Rule 2. Board of Interpreter Standards

460 IAC 2-2-1 Purpose

Authority: IC 12-9-2-3; IC 12-12-7-5
Affected: IC 12-12-7

Sec. 1. The purpose of this rule is to protect the public and persons who are deaf or hard of hearing from misrepresentation, by establishing a board of interpreter standards and providing powers and duties to enable the board to determine the necessary competency and proficiency standards for sign language interpreters and oral interpreters. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-2-1; filed Mar 25, 1997, 10:00 a.m.: 20 IR 2114)*

460 IAC 2-2-2 Definitions

Authority: IC 12-9-2-3; IC 12-12-7-5
Affected: IC 12-9-1-1; IC 12-12-1-2; IC 12-12-7

Sec. 2. The following definitions apply throughout this rule:

(1) "ASL" means American Sign Language.

(2) "ASLTA" means American Sign Language Teacher Association.

(3) "Board" means the board of interpreter standards under the administration of the unit.

(4) "Deaf person" or "hard of hearing person" means a person who meets the following criteria:

(A) Has a hearing loss that prevents the person from receiving and understanding voice communication with or without amplification.

(B) Uses at least one (1) of the following as primary means of communication:

(i) ASL.

(ii) English-based signed systems.

(iii) Tactile methods.
(iv) Writing.
(v) Reading.
(vi) Speech reading.
(vii) Fingerspelling.
(viii) Beneficial assistive devices.

(5) "Division" means the division of disability, aging, and rehabilitative services established under IC 12-9-1-1.

(6) "Educational interpreter" means a person who performs the service of interpreting or transliterating in an educational setting.

(7) "Interpreter" means a person who performs the service of interpreting or transliterating.

(8) "Interpreting" means any method of interfacing communication between a deaf or hard of hearing person and a person who is not deaf or hard of hearing, and includes:

(A) oral interpreting;
(B) sign language interpreting; or
(C) transliterating.

(9) "NAD" means National Association of the Deaf.

(10) "Oral interpreting" means the process of interpreting or transliterating a spoken message from a hearing person to a deaf or hard of hearing person, or from a deaf or hard of hearing person to a hearing person, excluding sign language interpreting, as follows:

(A) Using clear articulation or voiceless repetition.
(B) Using natural facial expressions and natural gestures.
(C) Placing an emphasis on speech reading.
(D) Understanding and repeating the message and the intent of the message.
(E) Understanding and repeating the speech and mouth movements of the deaf or hard of hearing person.

(11) "Registered interpreter" means a person who has met the criteria established by the board in accordance with section 4 *[sic.]* of this rule, and is registered by the board.

(12) "RID" means Registry of Interpreters for the Deaf.

(13) "Sign language interpreting" means:

(A) the process of conveying a message produced in ASL into an equivalent message in spoken or written English; or
(B) the process of conveying a message in spoken or written English into an equivalent message in ASL.

(14) "Transliterating" means:

(A) the process of presenting written or spoken English into an English-based sign system; or
(B) the process of presenting an English-based sign system in written or spoken English.

(15) "Unit" means the unit for the deaf and hard of hearing services established under IC 12-12-1-2.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-2-2; filed Mar 25, 1997, 10:00 a.m.: 20 IR 2114)

460 IAC 2-2-3 Appointment of the board

Authority: IC 12-9-2-3; IC 12-12-7-5
Affected: IC 12-12-7

Sec. 3. (a) The unit shall make a public announcement to all prospective candidates in Indiana who wish to serve on the board. The prospective candidates shall submit a vitae to the unit within thirty (30) days of the date of the public announcement.

(b) The board shall consist of seven (7) members. At least three (3) out of the seven (7) members shall be persons who are deaf or hard of hearing.

(c) Board members shall meet at least one (1) of the following:

(1) Knowledge of the interpreting process, which includes having at least three (3) of the following:

(A) RID, NAD, or ASLTA certification.
(B) Membership in a deaf association.
(C) Graduation from an interpreter education program.
(D) One hundred (100) clock hours of attendance in a workshop regarding the interpreting process.
(E) One hundred (100) clock hours of ASL studies.

(2) At least five (5) years of documented experience as a provider or consumer of interpreting services.

(3) Three (3) letters of recommendation attesting to the following:

(A) Knowledge of interpreting.

(B) Fluency in ASL and English.

(d) Original appointments to the board shall be made in the following manner:

(1) Four (4) members for a term of two (2) years.

(2) Three (3) members for a term of three (3) years.

All members subsequently appointed shall serve a term of three (3) years and may be appointed for one (1) additional term. If a member of the board resigns, dies, or is removed, the new appointee shall serve the remainder of the unexpired term. Board members shall not be eligible for reappointment for at least one (1) year after serving two (2) consecutive terms.

(e) The board shall meet as needed and upon request by the board chairperson and board members.

(f) The board members shall elect a chairperson who shall serve a term of two (2) years and shall be eligible for reelection for an additional two (2) years.

(g) The board may request from the unit, the purchase of materials for the operation of the board.

(h) The board, in cooperation with the unit, shall annually hold a public meeting to receive recommendations from consumers on upgrading the qualifications, functions, and registration of interpreters, and on policies concerning registration of interpreters. However, the board may receive program recommendations at any time prior to or after the annual public hearing. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-2-3; filed Mar 25, 1997, 10:00 a.m.: 20 IR 2115)*

Rule 3. Interpreter Standards for the Deaf and Hard of Hearing

460 IAC 2-3-1 Purpose; exclusion

Authority: IC 12-12-7-5
Affected: IC 12-12-7

Sec. 1. (a) The purpose of this rule is to establish standards pursuant to IC 12-12-7-5 that determine the necessary standards of behavior, competency, and proficiency in sign language and oral interpreting and ensure quality, professional interpreting services in order to protect the public and persons who are deaf or hard of hearing from misrepresentation.

(b) The provisions of this rule will not apply to interpreters while they are interpreting in a public or private primary or secondary school setting. This exception will expire at the earlier of:

(1) the promulgation of educational interpreter standards; or

(2) July 1, 2002.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-1; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3084)

460 IAC 2-3-2 Definitions and acronyms

Authority: IC 12-12-7-5
Affected: IC 12-12-7; IC 20-10.1-7-17; IC 20-12-72

Sec. 2. (a) The definitions and acronyms in this section apply throughout this rule unless specifically noted.

(b) "ASL" means American Sign Language.

(c) "BIS" means board of interpreter standards.

(d) "CEU" means continuing education unit.

(e) "Consumer" means the persons for and between whom the interpreter is facilitating communication, and includes both hearing and deaf consumers.

(f) "DDARS" means the division of disability, aging, and rehabilitative services.

(g) "DHHS" means deaf and hard of hearing services.

(h) "Interpreter" refers to both interpreters and transliterators.

(i) "ITP" means interpreter training program.

(j) "NAD" means National Association of the Deaf.

(k) "Payee" means a person who contracts with a freelance interpreter on behalf of a public or private agency, organization, or business for a particular assignment involving one (1) or more deaf clients and one (1) or more hearing consumers.

(l) "RID" means Registry of Interpreters for the Deaf.

(m) "Setting" means the context within which an interpreting assignment takes place.

(n) "TECUnit" means Testing, Evaluation and Certification Unit, Inc. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-2; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3085)*

460 IAC 2-3-3 Certification requirements

Authority: IC 12-12-7-5
Affected: IC 12-12-7

Sec. 3. (a) In order to receive certification as an interpreter under this rule by the state, an individual must register with DHHS in the manner prescribed by DHHS and fulfill at least one (1) of the following criteria:

(1) Pass the RID written generalist test, hold NAD Level III, and obtain two (2) CEUs per year for up to five (5) years.

(2) Pass the RID written generalist test, be a graduate of an accredited ITP, and obtain two (2) CEUs per year for up to five (5) years.

(3) Hold NAD Level IV or above.

(4) Hold RID certification.

(5) Hold RID oral certification for situations requiring an oral interpreter only.

(6) Hold certification from TECUnit and have passed the RID written generalist test for situations requiring a cued speech transliterator.

(b) Commencing July 1, 2007, in order to receive certification by the state, an individual must fulfill the requirements in subsection (a) and also hold a bachelor's degree from an accredited college or university. An interpreter who has met the requirements of subsection (a) prior to July 1, 2007, shall be exempt from the additional requirement of this subsection.

(c) Interpreters holding NAD or RID certifications must maintain these certifications in good standing in order to maintain their certification by the state, including fulfilling the continuing education requirements of NAD or RID.

(d) Fulfillment of the requirements of subsection (a)(1) or (a)(2) shall allow an interpreter to be certified by the state for a maximum period of five (5) years from the date originally certified. At or before the conclusion of this period, an interpreter must fulfill the requirements of at least one (1) of subsections *[sic., subsection]* (a)(3) through (a)(6) to continue certification by the state.

(e) An interpreter certified by the state shall renew such certification at least every two (2) years in the manner prescribed by DHHS. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-3; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3085)*

460 IAC 2-3-4 Certificate; professional qualifications

Authority: IC 12-12-7-5
Affected: IC 12-12-7

Sec. 4. (a) After being certified by the state, an interpreter shall be issued a certificate signed by the DHHS deputy director and DDARS director evidencing such certification. An interpreter shall also be issued an identification card signed by the DHHS deputy director and DDARS director, which the interpreter shall carry with him or her during interpreting assignments as proof of certification.

(b) An interpreter shall accurately present his or her Indiana identification card, certificate, professional qualifications, and/or credentials upon request. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-4; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3085)*

460 IAC 2-3-5 Code of ethics; confidentiality

Authority: IC 12-12-7-5
Affected: IC 12-12-7

Sec. 5. An interpreter shall maintain the confidentiality of all information covered during an interpreting assignment and all information about interpreting services being performed, including identity of those consumers present, regardless of perceived importance, except for the following:

(1) An interpreter may reveal information to his or her employer, members of the employer's staff, or a professional team designated by the employer for purposes of record keeping, program management, or supervision.

(2) An interpreter may share information with peer interpreters employed by the same employer, which is necessary to best serve consumers in an ongoing interpreting situation or assignment.

(3) Unless the consumer otherwise directs, an interpreter may disclose factual information or professional assessment of the language and communication process regarding the current interpreting assignment to the payee of the interpreter or the payee's designee. Disclosure of further information requires consent of the consumer.

(4) Information that is public or not otherwise confidential under this rule or any other rule or law may be disclosed.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-5; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3086)

460 IAC 2-3-6 Code of ethics; rendering of interpreting services; language used

Authority: IC 12-12-7-5
Affected: IC 12-12-7

Sec. 6. (a) Interpreting services shall be rendered faithfully, conveying all communication messages with the exact spirit, intent, and affect of the communicator.

(b) An interpreter shall withdraw from an assignment if his or her personal feelings interfere with performing the duties in subsection (a).

(c) An interpreter shall use the language or mode of communication most readily understood or preferred by all consumers involved. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-6; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3086)*

460 IAC 2-3-7 Code of ethics; impartiality of interpreter

Authority: IC 12-12-7-5
Affected: IC 12-12-7

Sec. 7. (a) The interpreted message shall be transmitted impartially without the interjection of personal advice, counsel, or opinions of the interpreter.

(b) An interpreter shall not omit or add to anything that is signed or vocalized by a party, even when asked to do so by other parties involved.

(c) An interpreter shall not attempt to take on any dual role but shall act only as interpreter to assist in communications between parties involved.

(d) An interpreter may communicate directly with a party involved in order to clarify to that party the interpreter's role of facilitating communication.

(e) An interpreter should refrain from providing interpreter services in situations where family members or close personal or professional relationships may affect impartiality. However, this is not to be construed as a ban on interpreting for family, friends, or close associates in emergency situations or where the interpreter is otherwise compelled to interpret for such people. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-7; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3086)*

460 IAC 2-3-8 Code of ethics; appropriateness of assignment for interpreter

Authority: IC 12-12-7-5
Affected: IC 12-12-7

Sec. 8. In determining whether to accept an interpreting assignment, an interpreter:

(1) must use discretion in considering:

(A) his or her skill level;

(B) the setting of the assignment;

(C) the expected content and subject matter of the assignment; and

(D) the consumers involved; and

(2) shall not accept an assignment when any of these factors make it inappropriate to do so in the best interests of the consumers involved.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-8; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3086)

460 IAC 2-3-9 Code of ethics; compensation requests

Authority: IC 12-12-7-5
Affected: IC 12-12-7

Sec. 9. An interpreter shall request compensation for services using accepted business practices and in a professional and judicious manner, taking into account usual fees commensurate with their:

(1) level of skill;
(2) level of certification;
(3) amount of experience;
(4) nature of assignment; and
(5) geographic region.

Terms of compensation shall be arranged in advance of the interpreting assignment whenever possible. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-9; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3086)*

460 IAC 2-3-10 Code of ethics; professional development

Authority: IC 12-12-7-5
Affected: IC 12-12-7

Sec. 10. An interpreter, in order to maintain his or her certification, shall pursue advanced knowledge, increased skills competency, and the maintenance of high professional standards through active participation in workshops, professional meetings, interaction with professional colleagues, and reading literature in the field. As part of this, an interpreter shall obtain continuing education as required in section 3 of this rule. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-10; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3087)*

460 IAC 2-3-11 Code of ethics; interpreter manner and behavior

Authority: IC 12-12-7-5
Affected: IC 12-12-7

Sec. 11. (a) Interpreting services shall be provided completely, impartially, and professionally in a manner appropriate to the situation, including behavior suitable to the particular circumstances of the interpreting assignment.

(b) An interpreter shall attempt to become familiar with the anticipated discussion topic, type of activity, level of formality, expected behaviors, and any presentational materials prior to commencement of the interpreting assignment.

(c) An interpreter shall dress in a manner that will be as unobtrusive to communication facilitation as possible and that will assure the best possible background for signing, including proper skin to clothing color contrasts and avoiding clothing patterns that may tire the eyes of deaf consumers.

(d) An interpreter shall consider background, positioning, and lighting to assure all are adequately within comfortable, nondistracting range for all parties involved.

(e) An interpreter shall assure that all consumers are duly advised that the interpreter assumes a position of neutrality in the relationship between all consumers, despite the fact that a given consumer may have hired the interpreter for the current or previous interpreting assignment, and consumers must be given the option of acceptance or rejection of the interpreter. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-11; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3087)*

460 IAC 2-3-12 Code of ethics; appropriate use of interpreter

Authority: IC 12-12-7-5
Affected: IC 12-12-7

Sec. 12. In situations where the consumer of interpreting services is not familiar with the use of an interpreter, the interpreter should share information on the appropriate use of an interpreter to help make the interpreting process successful. This should be done prior to commencing the interpreting assignment. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-12; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3087)*

460 IAC 2-3-13 Grievances; grievance committee; composition; term

Authority: IC 12-12-7-5
Affected: IC 12-12-7

Sec. 13. (a) DHHS shall create a grievance committee, of which the DHHS deputy director shall be the chair, consisting of a minimum of five (5) other members, which must consist of at least the following:

(1) At least two (2) members who:

(A) are deaf or hard of hearing; and

(B) have experience using interpreters.

(2) Two (2) members must hold either NAD or RID certification.

(3) One (1) member may be a professional other than an interpreter but must be knowledgeable of the interpreter standards set forth in this rule.

(b) The term of grievance committee members shall be three (3) years. However, the initial committee will have three (3) members to be determined by the committee who shall serve two (2) years and the remaining members shall serve three (3) years. After the initial term of each appointment, all members shall be appointed for a term of three (3) years and may be appointed for one (1) additional term. If a member of the committee resigns, dies, or is removed, the new appointee shall serve the remainder of the unexpired term. Committee members shall not be eligible for reappointment for at least one (1) year after serving two (2) consecutive terms.

(c) DHHS shall seek training in negotiation and mediation for the committee members. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-13; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3087)*

460 IAC 2-3-14 Grievances; jurisdiction of grievance committee

Authority: IC 12-12-7-5
Affected: IC 12-12-7

Sec. 14. The jurisdiction of the grievance committee referred to in this rule extends to interpreters certified and working in Indiana. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-14; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3087)*

460 IAC 2-3-15 Grievances; procedures; complaint and response

Authority: IC 4-21.5-3-34; IC 12-12-7-5
Affected: IC 12-12-7

Sec. 15. (a) A complaint may be filed by either of the following:

(1) Any person utilizing interpreting services.

(2) Any person clearly demonstrating a direct or personal interest in the occurrence specified in the complaint.

(b) The complaint must be in writing and filed with the grievance committee referred to in section 13 of this rule.

(c) The complaint must include the following:

(1) The name, address, and phone number of each person against whom charges are being filed.

(2) The date and location of the alleged violation.

(3) The specific action or actions in question making reference to a portion or portions of this rule alleged to have been violated.

(d) The complaint may be filed any time up to ninety (90) days after the date of the alleged violation or date of discovery by the complainant of the alleged violation.

(e) If a matter of extreme urgency should arise requiring immediate review by the grievance committee, the aggrieved party must attach to the complaint a request in writing for immediate review and the specific reasons for the urgency.

(f) Within thirty (30) days of receiving the complaint, each person against whom charges are made may file a response to the allegations against him or her.

(g) The response shall address, either by admitting, denying, or further explaining, each relevant aspect of each allegation stated in the complaint.

(h) The response must be sent to the grievance committee with a copy to the person who filed the complaint. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-15; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3088)*

460 IAC 2-3-16 Grievances; committee action

Authority: IC 4-21.5-3-34; IC 12-12-7-5
Affected: IC 12-12-7

Sec. 16. (a) After a complaint has been received and a response has been filed or the thirty (30) day period has elapsed for filing a response, the DHHS deputy director as grievance committee chairperson shall review the documents and make an initial decision on the merits of the pleadings.

(b) If the DHHS deputy director finds that no violation of this rule occurred and no cause of action exists, the complaint shall be dismissed and all parties notified in writing.

(c) Upon dismissal of the complaint, the complainant may request a hearing by the full grievance committee within thirty (30) days of dismissal.

(d) If the DHHS deputy director determines that an investigation is warranted, the formal charges and grounds upon which they are based shall be set forth in writing and sent to the grievance committee and all parties involved, and the grievance committee may hold a hearing pursuant to section 17 of this rule. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-16; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3088)*

460 IAC 2-3-17 Grievances; hearing procedure

Authority: IC 4-21.5-3-34; IC 12-12-7-5
Affected: IC 12-12-7

Sec. 17. (a) The complainant and respondent, whether or not participating in person, may be advised and represented at the party's own expense by counsel or, unless prohibited by law, by another representative. Representatives may participate in all proceedings.

(b) Any party may present any affidavits, documents, or other written evidence as to any relevant aspect of a charge or defense asserted.

(c) Any party may present witnesses to give testimony as to any relevant aspect of the charge or defense asserted.

(d) The grievance hearing shall meet at a location most convenient to all parties involved.

(e) All parties involved shall be given at least two (2) weeks' notice of the scheduled hearing date, time, and location.

(f) The complainant and the respondent shall bear their own costs and expenses in connection with the grievance process. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-17; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3088)*

460 IAC 2-3-18 Grievances; decision of grievance committee; recommendation

Authority: IC 4-21.5-3-34; IC 12-12-7-5
Affected: IC 12-12-7

Sec. 18. (a) The grievance committee shall carefully review all documents and evidence presented.

(b) Committee members other than the DHHS deputy director may vote on the grievance. The committee's decision shall require a majority vote. If there is no majority following the vote of the committee members, the DHHS deputy director shall cast a vote to determine the majority.

(c) The committee's decision on the charges shall become a written recommendation to the DHHS deputy director and shall identify in detail the charges, the evidence used in reaching a decision, and the relevant standard for ethical behavior citation.

(d) The DHHS deputy director shall review the committee's recommendation and either adopt it, modify it, or dissolve it. The DHHS deputy director may remand the matter, with or without instructions, to the grievance committee for further proceedings.

(e) The DHHS deputy director shall issue a final decision on the grievance. One (1) copy shall be kept for the committee's records, and a copy shall be given to each party. If copies are mailed, they must be sent via certified mail, return receipt requested. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-18; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3088)*

460 IAC 2-3-19 Grievances; enforcement; disciplinary actions

Authority: IC 4-21.5-3-34; IC 12-12-7-5
Affected: IC 12-12-7

Sec. 19. (a) When the standards of ethical behavior set forth in this rule are found by the grievance committee to have been violated, the committee may recommend to the DHHS deputy director that disciplinary action be taken against an interpreter based upon the severity of the interpreter's misconduct.

(b) The available disciplinary actions that the DHHS deputy director may take include the following:

(1) Verbal warning, which is an oral reprimand given by the DHHS deputy director.

(2) Written reprimand, which is a written notification of unsatisfactory performance.

(3) Probation, which is a trial period of a length of time specified by the DHHS deputy director during which the interpreter is required to fulfill a set of conditions or to improve work performance or on-the-job behavior.

(4) Suspension or revocation, which is suspension or revocation of Indiana interpreter certification and referral to the grievance committee of the national organization, either RID or NAD, whose certification is held.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-19; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3089)

460 IAC 2-3-20 Grievances; appeals

Authority: IC 12-12-7-5
Affected: IC 4-21.5; IC 12-12-7

Sec. 20. An interpreter who has received disciplinary action from the DHHS deputy director may request a reconsideration of the decision to the director of DDARS. The director of DDARS shall provide a response to the request within fifteen (15) days of the date the request is received, including a notice of the right to appeal the decision. An interpreter that is dissatisfied with the decision on reconsideration may appeal the decision. The appeal shall be conducted in accordance with IC 4-21.5. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-3-20; filed Jul 21, 2000, 10:01 a.m.: 23 IR 3089)*

Rule 4. Blind and Visually Impaired Services—Indiana Randolph-Sheppard Business Enterprise Program

460 IAC 2-4-1 Purpose

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 1. The Indiana Randolph-Sheppard Business Enterprise Program (BEP) is established to provide blind persons with remunerative employment and to enlarge the economic opportunities for blind persons. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-1; filed Aug 23, 2001, 2:30 p.m.: 25 IR 62)*

460 IAC 2-4-2 Definitions

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-9-1-1; IC 12-12-1-2; IC 12-12-5; 20 U.S.C. 107; 34 CFR 395.1

Sec. 2. The following definitions apply throughout this rule:

(1) "Abandoned" means that a BEP facility is unattended or unoperated after an operator has failed to:

(A) notify the state licensing agency of the operator's absence; and

(B) meet contractual obligations for the facility, including the requirement for continuous operation.

(2) "Active participation" means an ongoing process of good faith negotiation between the state licensing agency and the Indiana committee of licensed managers to achieve joint planning of rules, policies, standards, and practices prior to implementation by the state licensing agency. Active participation shall not supersede the final authority of the division to adopt program policy and to administer the BEP.

(3) "Agreement" means a written contract between the state licensing agency and an operator for the operation of a BEP facility.

(4) "Applicant" means a person who has applied to or has been referred to the BEP, but who has not been accepted as a manager trainee.

(5) "BEP" means the Indiana Randolph-Sheppard Business Enterprise Program authorized by 20 U.S.C. 107 and IC 12-12-5.

(6) "BEP facility" means automatic vending machines, cafeterias, snack bars, cart services, shelters, counters, and other appropriate auxiliary equipment that may be used for the sale of newspapers, periodicals, confections, tobacco products, foods,

beverages, and other articles or services dispensed automatically or manually and prepared on or off the premises in accordance with all applicable health laws, including the vending or exchange of chances for any lottery authorized by state law and conducted by an agency of the state within the state.

(7) "Blind and visually impaired services" or "BVIS" means the unit of services for the blind and visually impaired, established in IC 12-12-1-2(1) as a unit of the rehabilitation services bureau of DDARS, family and social services administration.

(8) "Business days" means regular business days recognized by the state. Regular business days do not include Saturday, Sunday, legal holidays as defined by state statute, or a day when state offices are closed during regular business hours.

(9) "Business Enterprise Program" or "BEP" means the Indiana Randolph-Sheppard Business Enterprise Program authorized by 20 U.S.C. 107 and IC 12-12-5.

(10) "Committee" means the Indiana committee of licensed managers established pursuant to 20 U.S.C. 107b-1.

(11) "Committee of licensed managers" means the committee established pursuant to 20 U.S.C. 107b-1.

(12) "Custodial authority" means the person or entity authorized to contract for the services at a site or facility.

(13) "DDARS" means the division of disability, aging, and rehabilitative services established in IC 12-9-1-1.

(14) "Director" means the director of DDARS.

(15) "Division" means DDARS established in IC 12-9-1-1.

(16) "Division of disability, aging, and rehabilitative services" means the division of disability, aging, and rehabilitative services established in IC 12-9-1-1.

(17) "Federal property" means any building, land, or other real property owned, leased, or occupied by any department, agency, or instrumentality of the United States.

(18) "Legal blindness" or "legally blind" means either of the following:

(A) Visual acuity of not more than 20/200 in the better eye with best corrective lenses.

(B) A limitation to the field of vision in the better eye such that the widest diameter of visual field subtends an angle of no greater than twenty (20) degrees.

(19) "License" means a written instrument that:

(A) is issued by DDARS to a blind person; and

(B) authorizes that person to operate a BEP facility as a licensed manager under this rule.

(20) "Licensed manager" means an individual who has a license issued by DDARS to operate a BEP facility under this rule.

(21) "Management services" means supervision, inspection, quality control, consultation, accounting, regulating, in-service training, and other related services provided by the state licensing agency on a systematic basis to support and improve the operations of BEP facilities. Management services do not include those services or costs that pertain to the ongoing operation of an individual BEP facility after the initial establishment period.

(22) "Manager" means a licensed manager.

(23) "Manager trainee" means a blind individual who has applied for and been found eligible for vocational rehabilitation services and has been accepted for training in the business enterprise program, but who has not received a license from the state licensing agency.

(24) "Net proceeds" means gross sales less the allowable expenses set out in section 34 of this rule that an operator has paid for the operation of the BEP facility, excluding any salary paid to the operator.

(25) "Operator" means a licensed manager, a manager trainee, or a temporary operator who has an agreement with the state licensing agency to operate a BEP facility.

(26) "Other property" has the meaning set out in 34 CFR 395.1(n).

(27) "Permit" means the official approval given to the state licensing agency by a department, agency, or instrumentality in control of the maintenance, operation, and protection of federal property, or person in control of other property, whereby the state licensing agency is authorized to establish a BEP facility under 20 U.S.C. 107.

(28) "Placement list" means an index of licensed managers and manager trainees eligible to bid on an available BEP facility.

(29) "Primary facility" means a licensed manager's BEP facility location with the greatest amount of gross sales as determined annually on June 30 of the most recently complete state fiscal year.

(30) "Probationary period" is the period of time from a manager trainee's placement at a BEP facility until the manager trainee is licensed under this rule.

(31) "Seniority" has the following meaning:

(A) For a licensed manager, seniority is determined from the date a licensed manager is licensed to operate a BEP

facility and continues to accrue as long as the licensed manager holds a valid agreement with the state licensing agency to operate a BEP facility.

(B) For a manager trainee, seniority is determined from the date that BVIS received the manager trainee referral from vocational rehabilitation services.

(32) "Set aside funds" means funds accruing to the state licensing agency from:

(A) a uniform assessment against the net proceeds of assigned BEP facilities; or

(B) vending machines on federal property under 34 CFR 395.8.

(33) "State licensing agency" means DDARS.

(34) "Temporary operator" means a licensed manager, a manager trainee, or any sighted or blind person who enters into an agreement with the state licensing agency to operate a BEP facility on a temporary basis when a licensed manager or manager trainee is not available.

(35) "Ultimate authority" means the director of DDARS.

(36) "Vocational rehabilitation services" means the unit of vocational rehabilitation established in IC 12-12-1-2(2) as a unit of the rehabilitation services bureau in DDARS.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-2; filed Aug 23, 2001, 2:30 p.m.: 25 IR 62)

460 IAC 2-4-3 State licensing agency functions

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 3. The state licensing agency shall:

(1) have the ultimate responsibility for the administration of the BEP under 20 U.S.C. 107 and IC 12-12-5;

(2) carry out the duties of planning programs and setting policies, standards, and procedures with the active participation of the Indiana committee of licensed managers;

(3) select and develop suitable locations for BEP facilities in properties owned, leased in whole or in part, or operated by:

(A) the United States government;

(B) the state;

(C) a county;

(D) a township;

(E) a city;

(F) a town; or

(G) a private entity;

(4) determine the criteria for suitable locations for BEP facility, with the criteria to include the income potential of potential locations;

(5) designate a specific location or locations as a BEP facility;

(6) take reasonable steps to improve the profitability of each BEP facility, including determining whether other locations or sites should be added as part of the facility;

(7) select and supervise licensed managers for BEP facilities, giving preference to blind persons who are in need of employment;

(8) require that all aspects of a licensed manager's operations, including fiscal matters, are in compliance with business enterprise program rules and procedures;

(9) make suitable BEP equipment and adequate initial stock available to operators;

(10) coordinate the state's business enterprise program with the state's vocational rehabilitation program to provide:

(A) initial training in aspects of BEP facility operation;

(B) upward mobility training, including further education, additional training, or retraining for improved work opportunities; and

(C) services after licensing to assure that the maximum vocational potential of each licensed manager is achieved;

(11) provide access in Braille, large print, recorded tape, or computer disk, if reasonably possible, to all financial data of the state licensing agency relevant to the operation of the business enterprise program, including quarterly and annual financial reports, provided that disclosure does not violate applicable federal or state laws pertaining to the disclosure of confidential information;

(12) develop forms and written procedures necessary to implement and carry out the provisions of this rule;
(13) conduct a biennial election of the Indiana committee of licensed managers, with no direct involvement of staff of the state licensing agency in the outcome of the election process;
(14) meet regularly with the Indiana committee of licensed managers to ensure the committee's active participation regarding major administrative decisions, policy, and program development decisions; and
(15) notify the Indiana committee of licensed managers in writing of decisions made or actions taken that are different from the recommendations of the committee, and the reason for the difference or differences.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-3; filed Aug 23, 2001, 2:30 p.m.: 25 IR 64)

460 IAC 2-4-4 Program participants; nondiscrimination

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107; 34 CFR 395.1

Sec. 4. No licensed manager or manager trainee in, or applicant for, the business enterprise program shall be discriminated against on the basis of sex, age, disability, race, creed, color, national origin, organizational affiliation, or political affiliation.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-4; filed Aug 23, 2001, 2:30 p.m.: 25 IR 64)

460 IAC 2-4-5 Qualifications of applicant

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 5. In order to be accepted for training in the business enterprise program, an applicant must:
(1) be legally blind;
(2) be at least eighteen (18) years of age;
(3) be a United States citizen;
(4) hold a high school diploma or equivalent;
(5) be a client of vocational rehabilitation services;
(6) be referred for the business enterprise program by vocational rehabilitation services;
(7) have adequate orientation and mobility skills to travel independently;
(8) have skills sufficient to communicate with the public in a courteous manner and the ability to develop and maintain working relationships with others;
(9) be able to maintain required records and reports;
(10) have mathematical skills sufficient to operate a small business; and
(11) have independent daily living skills sufficient to allow the applicant to meet personal care and facility maintenance needs.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-5; filed Aug 23, 2001, 2:30 p.m.: 25 IR 64)

460 IAC 2-4-6 Effect of nonqualification for the business enterprise program

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 4-21.5; IC 12-12-5; 20 U.S.C. 107

Sec. 6. (a) If the state licensing agency determines that an applicant does not meet the qualifications set out in section 5 of this rule and does not accept the applicant as a manager trainee, the provisions in this section apply.
(b) The state licensing agency shall refer the applicant to the office of vocational rehabilitation services for other services.
(c) The state licensing agency shall notify an applicant in writing of the following:
(1) The specific grounds for the agency's determination that the applicant:
(A) does not meet the qualifications set out in section 5 of this rule; and
(B) is not accepted as a manager trainee in the business enterprise program.
(2) The applicant's right to a full evidentiary hearing, under the provisions of IC 4-21.5, the Administrative Orders and Procedures Act, on the agency's determination upon filing a written request with the deputy director of blind and visually impaired services within fifteen (15) business days of service of the notice.
(d) The applicant has the right to a full evidentiary hearing, under the provisions of IC 4-21.5, the Administrative Orders and

Procedures Act, on the state licensing agency's determination that an applicant does not meet the qualifications set out in section 5 of this rule and is not accepted as a manager trainee in the BEP. For purposes of conducting a full evidentiary hearing, the procedures established in sections 29 and 30 of this rule apply; provided, however, that the provisions of section 30(w)(3) of this rule do not apply to this subsection. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-6; filed Aug 23, 2001, 2:30 p.m.: 25 IR 65; errata filed Jan 10, 2002, 11:37 a.m.: 25 IR 1645)*

460 IAC 2-4-7 Manager trainees; training requirements

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 7. (a) Except as provided in section 8 of this rule, a manager trainee must successfully complete training for the BEP before being licensed as a manager.

(b) Training for the BEP includes the following:

(1) Classroom training in the skills necessary for the general operation of any type of BEP facility, including such topics as:
- (A) accounting;
- (B) banking;
- (C) business administration;
- (D) cash handling;
- (E) communication;
- (F) customer service;
- (G) machine training;
- (H) sanitation;
- (I) marketing and inventory control; and
- (J) orientation to all types of BEP facility operations.

(2) Training on specific types of BEP facilities.

(3) On-the-job training with a licensed manager or at a facility approved by the state licensing agency.

(4) Training on business enterprise program rules, requirements, policies, and procedures.

(5) Training on the application of federal, state, and local laws relating to operating a facility.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-7; filed Aug 23, 2001, 2:30 p.m.: 25 IR 65)

460 IAC 2-4-8 Waiver or modification of training requirements

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 8. (a) A manager trainee may submit a written request to the state licensing agency for a waiver, in whole or in part, or a modification of the training requirements described in this rule. A manager trainee must also submit supporting documentation required by the state licensing agency.

(b) With the active participation of the Indiana committee of licensed managers, the state licensing agency may waive, in whole or in part, or modify the training requirements for a manager trainee on the basis of the manager trainee's previous work experience, knowledge, skills, or training.

(c) The probationary period for a manager trainee required under section 9 of this rule shall not be waived.

(d) If a manager trainee has received a waiver or modification of training requirements under this section, the manager trainee's ranking on the placement list shall be determined by the date when BVIS received the manager trainee referral from vocational rehabilitation services. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-8; filed Aug 23, 2001, 2:30 p.m.: 25 IR 65)*

460 IAC 2-4-9 Manager trainee; probationary period

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 9. (a) A manager trainee must successfully complete a probationary period before being licensed as a manager in the

business enterprise program.

(b) The purpose of the probationary period is to improve the performance of the manager trainee by:

(1) assisting the manager trainee to achieve the most effective adjustment to the business enterprise program and to the assigned facility;

(2) assuring that the manager trainee is aware of and complies with:

(A) the rules and requirements of the BEP; and

(B) the terms of the permit for, or the agreement between the state licensing agency and the custodial authority of, the BEP facility to which the manager trainee is assigned;

(3) evaluating the manager trainee's performance in the work setting or at an assigned BEP facility; and

(4) referring a manager trainee in need of other or additional services to the office of vocational rehabilitation services.

(c) The probationary period begins when a manager trainee is placed in a BEP facility.

(d) The probationary period continues for at least ninety (90) calendar days after a manager trainee is placed in a BEP facility. In addition, the state licensing agency may extend the probationary period for a maximum of sixty (60) calendar days in order to:

(1) provide the manager trainee with additional or remedial training; or

(2) achieve any purpose described in subsection (b).

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-9; filed Aug 23, 2001, 2:30 p.m.: 25 IR 65)

460 IAC 2-4-10 Manager trainees; disciplinary procedures

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 10. (a) This section applies to a manager trainee who is:

(1) receiving initial training, including classroom or on-the-job training; or

(2) in the probationary period.

(b) A manager trainee receiving initial training may be subject to disciplinary action as set out in this section for a violation of, or failure to comply with, a written rule or regulation of the training institution.

(c) A manager trainee in the probationary period may be subject to disciplinary action as set out in this section for a violation of, or failure to comply with:

(1) the provisions of this rule applicable to a licensed manager;

(2) the terms of an agreement between the state licensing agency and the manager trainee for operation of a BEP facility; or

(3) the terms of the permit for, or the agreement between the state licensing agency and the custodial authority of, the BEP facility to which the manager trainee is assigned.

(d) Documentation of disciplinary action shall be kept in the individual's personnel file.

(e) Disciplinary actions shall include the following:

(1) Formal counseling.

(2) Written action plan.

(3) Suspension from training.

(4) Termination of training and participation in the BEP.

(f) Disciplinary action will progress through the steps listed in subsection (e) for:

(1) the first violation or noncompliance under subsection (b) or (c);

(2) a failure to correct a violation or noncompliance under subsection (b) or (c); or

(3) a repeated violation or noncompliance under subsection (b) or (c).

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-10; filed Aug 23, 2001, 2:30 p.m.: 25 IR 66)

460 IAC 2-4-11 Termination of manager trainee's participation in the business enterprise program

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 11. (a) The state licensing agency may terminate a manager trainee's participation in the BEP for cause in accordance with 460 IAC 2-4-10 *[section 10 of this rule]*.

(b) The state licensing agency may terminate a manager trainee's participation in the BEP at any of the following times:

(1) During training.

(2) During the probationary period.

(3) At the end of the probationary period and before licensing.

(c) If the state licensing agency determines that the participation of a manager trainee should be terminated, the following apply:

(1) The state licensing agency shall refer the manager trainee to the office of vocational rehabilitation services for other services.

(2) The state licensing agency shall notify the manager trainee, in writing, of the following:

(A) The specific grounds for the agency's determination that the manager trainee's participation in the BEP should be terminated.

(B) The manager trainee's right to a full evidentiary hearing on the agency's determination by filing a written request with the deputy director of blind and visually impaired services within fifteen (15) business days of service of the notice.

(3) The manager trainee has the right to a full evidentiary hearing on the state licensing agency's determination that the manager trainee's participation in the BEP should be terminated.

(4) For purposes of conducting a full evidentiary hearing, the procedures established in sections 29 and 30 of this rule apply; provided, however, that the provisions of section 30(w)(3) of this rule do not apply to this section.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-11; filed Aug 23, 2001, 2:30 p.m.: 25 IR 66; errata filed Jan 10, 2002, 11:37 a.m.: 25 IR 1645)

460 IAC 2-4-12 Issuance of license

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 12. (a) The state licensing agency shall issue a license to a manager trainee in the BEP who has successfully completed training and a probationary period.

(b) Upon licensing, a manager trainee becomes a licensed manager in the BEP.

(c) A license is issued for an indefinite period of time, but is subject to suspension or termination, after affording the licensed manager an opportunity for a full evidentiary hearing, except as provided in section 24 of this rule. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-12; filed Aug 23, 2001, 2:30 p.m.: 25 IR 67)*

460 IAC 2-4-13 Determination of visual status

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 13. (a) The state licensing agency has the right to request and to obtain from a licensed manager periodic visual evaluations in order to determine continuing compliance with visual requirements.

(b) Agency request for current evidence of visual status include the following:

(1) Upon the written request of the state licensing agency, a licensed manager must provide the state licensing agency with current ophthalmologic or optometric evidence documenting the manger's visual status within sixty (60) days of the agency's request. As used in this subdivision, "current" means evidence of an examination no more than six (6) months old from the date of submitting the evidence to the state licensing agency.

(2) A licensed manager who does not provide the requested ophthalmologic or optometric evidence is presumed not to be legally blind. Action must be taken under section 20(b)(1) of this rule to terminate the manager's license.

(3) If a licensed manager is determined to be not legally blind on the basis of the submitted evidence, action must be taken under section 20(b)(1) of this rule to terminate the manager's license.

(4) A licensed manager shall pay the cost of obtaining ophthalmologic or optometric evidence required by this subsection.

(5) A licensed manager may enter as an allowable expense on the monthly financial report submitted to the state licensing agency, the cost of obtaining ophthalmologic or optometric evidence required by this subsection.

(c) The agency's right to obtain a second opinion as to visual acuity includes the following:

(1) Upon the written request of the state licensing agency, a licensed manager must submit to a visual acuity examination by

an optometrist or physician selected by the state licensing agency, if the agency has information that a manager's vision has improved or does not meet the requirements of section 2(18) of this rule.

(2) The cost of an examination under this subsection shall be paid by the state licensing agency.

(3) A copy of all records of an examination under this subsection shall be provided to the licensed manager.

(4) If a licensed manager is determined to be not legally blind after an examination under this subsection, the provisions of section 20(b)(1) of this rule apply.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-13; filed Aug 23, 2001, 2:30 p.m.: 25 IR 67)

460 IAC 2-4-14 Selection of business enterprise program facility locations

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 14. (a) Determination of BEP facility locations include the following:

(1) The state licensing agency may establish a BEP facility at a particular location only if establishment of a facility at that location is likely to:

(A) contribute to the development of significant economic opportunities for blind persons; and

(B) provide for the productive use of program assets.

(2) The state licensing agency's determination under subsection (a) shall be made on the basis of an evaluation of relevant factors in a survey of the location. Factors to be evaluated include the following:

(A) Population.

(B) Traffic.

(C) Competition.

(D) Continued availability of the location.

(E) Type of premises.

(F) Potential return on investment.

(b) If the sales productivity of a BEP facility is adversely affected by factors beyond the control of the state licensing agency or of the operator, the state licensing agency must review and determine whether the location remains suitable for a BEP facility or for the current type of operation. The state licensing agency shall evaluate all relevant factors, including those set out in subsection (a)(2) in a review of the location. On the basis of this review, the state licensing agency may close a BEP facility or convert the existing facility to another type of operation. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-14; filed Aug 23, 2001, 2:30 p.m.: 25 IR 67)*

460 IAC 2-4-15 Assignment of a business enterprise program facility

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 15. (a) The assignment of a BEP facility shall be made by the state licensing agency with the active participation of the Indiana committee of licensed managers. A bidding process is used to promote upward mobility and to assign available BEP facilities.

(b) When a BEP facility becomes available, the state licensing agency will solicit bids for the facility from eligible persons on the placement list.

(c) Except as provided in subsection (d), the following persons will be placed on the placement list for the assignment of an available BEP facility and are eligible to bid for an available BEP facility:

(1) A licensed manager who has been operating the manager's current BEP facility for a minimum of one (1) year as of the date the bid on an available facility is due.

(2) A manager trainee who has successfully completed the training specified at section 7 of this rule, subject to the provisions of section 8 of this rule.

(3) A licensed manager who submits a letter requesting placement to the state licensing agency during an approved leave of absence.

(d) The following persons will not be placed on the placement list for the assignment of an available BEP facility and are not eligible to bid for an available BEP facility:

(1) A licensed manager who has been operating the manager's current BEP facility for less than one (1) year as of the date the bid on an available facility is due.

(2) A licensed manager or manager trainee who:

(A) accepts the award or assignment of a BEP facility; and

(B) subsequently refuses placement at, or withdraws acceptance of the award or assignment of, that BEP facility;

is not eligible to bid for another BEP facility for a period of one (1) year from the date of acceptance; provided, however, that a licensed manager or manager trainee who has been awarded and has accepted a BEP facility, but who has not been placed in that facility through no fault of his or her own, will be placed on the placement list and is eligible to bid on an available BEP facility.

(e) Eligible bidders shall be evaluated by the state licensing agency, with the active participation of the Indiana committee of licensed managers, according to the following criteria and scoring system:

(1) Fifty percent (50%) of the bidder's seniority as defined in section 2(31) of this rule.

(2) Add twenty-five percent (25%) of the bidder's seniority if, during the ten (10) month period ending on the date the bid is due:

(A) the bidder has not been on a disciplinary action plan; or

(B) the bidder's license has not been suspended.

(3) Add one percent (1%) of the bidder's seniority for any monthly financial report that is submitted to the state licensing agency when due during the ten (10) month period ending on the date the bid is due, for a maximum addition of ten percent (10%) of the bidder's seniority.

(4) Add ten percent (10%) of the bidder's seniority if, during the ten (10) month period ending on the date the bid is due:

(A) the custodial authority of the bidder's BEP facility has not made a written complaint to the state licensing agency or to BVIS concerning the operations of the bidder's BEP facility; or

(B) all of the following have occurred:

(i) The custodial authority of the bidder's BEP facility has made a written complaint to the state licensing agency or to BVIS alleging that the bidder has violated the terms of the permit, or contract between the custodial authority and the state licensing agency, for the bidder's BEP facility.

(ii) The state licensing agency or BVIS has given the bidder written notice of the complaint.

(iii) The bidder has corrected, or taken reasonable steps to correct, the alleged violation.

(iv) The state licensing agency or BVIS has given the bidder written notice that the problem has been corrected or resolved, or in the alternative, the state licensing agency or BVIS has not taken disciplinary action against the bidder as a result of the complaint.

(5) Add five percent (5%) of the bidder's seniority if the bidder has attended or participated in a training activity or conference sponsored in whole or in part, or approved in advance, by the state licensing agency during the ten (10) month period ending on the date the bid is due.

(f) The state licensing agency or BVIS shall offer the assignment of the facility to the eligible bidder with the highest numeric score. The state licensing agency or BVIS shall notify the successful bidder in writing of the offer of an available facility position to that bidder. By 3 p.m. on the tenth business day after receipt of the agency's letter, the successful bidder must notify the state licensing agency or BVIS, in writing, that the offer is accepted or refused. Refusal of an offer is final and irrevocable. A failure to respond within the required time period is deemed a refusal of an offer.

(g) If the bidder with the highest numeric score does not accept the assignment of the facility, the state licensing agency or BVIS shall continue to offer the assignment of the facility to eligible bidders in declining numeric order from the highest numeric score until:

(1) an eligible bidder accepts the assignment; or

(2) all eligible bidders have been offered the assignment.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-15; filed Aug 23, 2001, 2:30 p.m.: 25 IR 68)

460 IAC 2-4-16 Temporary operators; assignment of temporary location

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 16. (a) The state licensing agency, with the active participation of the Indiana committee of licensed managers, may place

a temporary operator in a BEP facility under any of the following circumstances:

(1) No eligible person bids on a BEP facility.

(2) No eligible person accepts the assignment of a BEP facility.

(3) An operator for a BEP facility is not otherwise available.

(b) If a BEP facility is temporarily not assigned to a licensed manager or manager trainee, or if a temporary operator is needed for a BEP facility, the following priorities will be used in assigning a temporary operator to the facility:

(1) A licensed manager displaced from the manager's facility through no fault of the manager, for example, due to the permanent or temporary closing of a BEP facility, is given first priority on any unassigned temporary location. If more than one (1) displaced licensed manager is eligible, selection will be based on seniority.

(2) If a displaced licensed manager is not available for placement or does not accept the placement, the location will be offered next to eligible manager trainees. If more than one (1) manager trainee is eligible, the manager trainee with the most seniority will be selected.

(3) If a manager trainee is not available for placement or does not accept the placement, the location will be offered next to the licensed manager whose legal residence is closest in physical proximity to the unassigned temporary location. If more than one (1) licensed manager meets the proximity requirement, the licensed manager with the most seniority will be selected.

(4) In selecting a temporary operator, the state licensing agency shall give priority to qualified blind persons. A qualified sighted person may be placed as a temporary operator only after the state licensing agency determines that a qualified blind person is not available.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-16; filed Aug 23, 2001, 2:30 p.m.: 25 IR 69)

460 IAC 2-4-17 Operator agreement

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 17. An operator must enter into a written agreement with the state licensing agency for the operation of an assigned BEP facility. A new agreement must be executed each time an operator moves or transfers to another BEP facility. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-17; filed Aug 23, 2001, 2:30 p.m.: 25 IR 69)*

460 IAC 2-4-18 Leave of absence

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 18. (a) A licensed manager may request and take an approved leave of absence for a period up to twenty-four (24) months for the following purposes:

(1) Medical leave for a licensed manager's own serious health condition that prevents the licensed manager from performing any of the essential functions at the manager's assigned BEP facility.

(2) Medical leave to care for the licensed manager's spouse, parent, child, or other legal dependent, who has a serious health condition and who is dependent on the manager for care.

(3) Leave in conjunction with the birth or placement of a child for adoption or foster care, as long as the leave concludes within twelve (12) months following the birth or placement.

(4) Vision rehabilitation.

(b) At least fifteen (15) business days in advance, the licensed manager shall submit a written notice to the state licensing agency of the following:

(1) Manager's intent to take a leave of absence.

(2) The purpose of the leave.

(3) The dates and expected duration of the leave.

If fifteen (15) business days' notice is not possible, the manager shall give notice as soon as practicable. The state licensing agency shall send a written response to the manager and shall indicate whether the leave is approved as requested. Upon request from the state licensing agency, the licensed manager shall provide medical documentation of the need for the leave and concerning the duration of the leave.

(c) If a leave of absence is for six (6) months or less, a licensed manager has the right to retain the assigned BEP facility

throughout the period of the leave. A licensed manager must select an individual, approved in advance by the state licensing agency, to operate the facility in the manager's absence. During the leave, the licensed manager shall remain responsible for the submission of monthly reports and all related duties of the licensed manager. If the licensed manager requests an extension of a leave beyond six (6) months from the beginning of the approved leave, the provisions of subsection (d) shall apply.

(d) Leave of absence for a period greater than six (6) months and up to two (2) years. If the leave of absence is for a period greater than six (6) months, a licensed manager shall not have the right to retain the manager's assigned BEP facility, and the following requirements apply:

(1) The state licensing agency shall assign a temporary operator to the BEP facility until the bidding and assignment process set out in section 15 of this rule is completed.

(2) At any time before the end of an approved leave period, the licensed manager may submit to the state licensing agency a written request for reinstatement in the business enterprise program and for assignment to a BEP facility. At the manager's written request, the state licensing agency shall place the licensed manager's name on the placement list for assignment to an available BEP facility.

(3) The licensed manager must notify the state licensing agency, in writing, at least thirty (30) days before the end of the approved leave period of the following:

(A) That the manager requests to be placed on the placement list for assignment to a BEP facility.

(B) That the manager does not wish to participate in the business enterprise program and agrees to the termination of the manager's license.

(e) The manager's license may be suspended for thirty (30) days according to disciplinary procedures under any of the following circumstances:

(1) The manager fails to return to the facility upon completion of the leave.

(2) The manager fails to comply with subsection (d)(3).

(3) The manager fails to obtain prior approval from the state licensing agency for a leave extension allowable under this section.

(f) The state licensing agency may require specific training of a licensed manager upon returning from a leave of absence of one (1) year or more.

(g) After a leave of absence, a licensed manager requesting assignment to a BEP facility may request additional training, subject to the provisions of section 19 of this rule concerning continuing education. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-18; filed Aug 23, 2001, 2:30 p.m.: 25 IR 69)*

460 IAC 2-4-19 Continuing education

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 19. (a) In-service training activities will be conducted for licensed managers to:

(1) develop business management and marketing skills; and

(2) enhance their ability to run a profitable facility.

(b) Training requests may be approved by the state licensing agency based on:

(1) the availability of training resources; and

(2) a licensed manager's need to receive requested training.

(c) If training is provided to a licensed manager at the manager's request, the licensed manager has the right to retain the assigned BEP facility upon the completion of training.

(d) Specific training may be required of the licensed manager in any of the following situations:

(1) The assigned BEP facility changes or expands to include management responsibilities in which the licensed manager is not qualified or has not had experience or training within the past one (1) year period.

(2) Equipment is placed in the location with which the licensed manager has had no training or experience within the past one (1) year period.

(3) A licensed manager is transferred to a new location that includes management responsibilities in which the licensed manager has not had experience within the past one (1) year period.

(4) A licensed manager returns from a leave of absence of one (1) year or more.

(5) Training is required by the state licensing agency under a written action plan.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-19; filed Aug 23, 2001, 2:30 p.m.: 25 IR 70)

460 IAC 2-4-20 Termination of manager's license

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 20. (a) A manager's license terminates automatically, without further notice, if any of the following occur:

(1) Death of a licensed manager.

(2) A licensed manager's resignation or withdrawal from the business enterprise program.

(3) A licensed manager's retirement from the business enterprise program.

(b) A manager's license will be terminated if:

(1) the manager's vision improves to the extent that the manager is no longer legally blind; or

(2) extended illness or incapacity of the manager prevents the manager's personal operation of the facility, when there is no reasonable expectation, based on medical evidence, that the manager will be able to return to work.

(c) A manager's license may be terminated for cause as set out in section 27 of this rule. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-20; filed Aug 23, 2001, 2:30 p.m.: 25 IR 70)*

460 IAC 2-4-21 Disciplinary procedures for licensed managers

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 21. (a) Disciplinary actions shall include the following:

(1) Formal counseling.

(2) Written action plan.

(3) Immediate suspension without notice.

(4) Disciplinary suspension.

(5) Loss of assigned BEP facility.

(6) Termination of license.

(b) At any time discipline is imposed, a licensed manager shall be informed of the right to file a grievance under section 28 of this rule.

(c) Except as provided in section 24 of this rule (immediate suspension), a licensed manager shall be advised of the opportunity for a full evidentiary hearing before:

(1) disciplinary suspension;

(2) loss of the manager's facility; or

(3) termination of the manager's license.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-21; filed Aug 23, 2001, 2:30 p.m.: 25 IR 71)

460 IAC 2-4-22 Disciplinary procedures; formal counseling

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 22. (a) Formal counseling is a discussion, in person or by telephone, between a licensed manager and a business counselor or other staff of the state licensing agency. The discussion must be documented, in writing, in the state licensing agency's file for the manager.

(b) In formal counseling, a licensed manager will be advised of the following:

(1) That the discussion is a formal counseling session under the state licensing agency disciplinary procedures.

(2) The specific nature of the action or violation complained of.

(3) The corrective action required.

(4) The date when corrective action must be completed.

(5) The consequences of failure to comply with corrective action.

(6) The consequences of repeated violation.

(c) Formal counseling shall be used for the first violation of a rule, policy, or the terms of an agreement or permit for a BEP facility, except for any of the following, for which a higher level of discipline may result:

(1) The state licensing agency reasonably determines that public health, safety, or welfare is in danger due to the manager's operations.

(2) The state licensing agency reasonably determines that the permit for a BEP facility is in jeopardy due to the manager's operations.

(3) The state licensing agency reasonably determines that a BEP facility contract between the custodial authority of the facility and the state licensing agency is in jeopardy due to the manager's operations.

(d) The state licensing agency staff member conducting a formal counseling session shall send a written report of the session to the licensed manager. The report shall be in an accessible format designated by the licensed manager. The report shall include the information required in subsection (b). A copy of the report will be kept in the manager's file in the state licensing agency.

(e) A licensed manager shall have the right to submit written comments regarding the report to the state licensing agency. If the manager does so, the written comments will be kept in the manager's file in the state licensing agency.

(f) An action or violation that results in formal counseling may be the basis for a written action plan if the action or violation:

(1) is not corrected as requested in the formal counseling report; or

(2) that is the basis for formal counseling is repeated.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-22; filed Aug 23, 2001, 2:30 p.m.: 25 IR 71)

460 IAC 2-4-23 Disciplinary procedures; written action plan

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 23. (a) A written action plan must notify a licensed manager of the following:

(1) The specific nature of the action or violation complained of.

(2) The corrective action required.

(3) The date for completing corrective action.

(4) The consequence of failure to correct the problem.

(5) The consequence of a repeated violation.

(b) A written action plan shall be presented to a licensed manager in a meeting between the licensed manager and a business counselor or the business enterprise program director of the state licensing agency. The licensed manager may be represented at this meeting at the manager's expense.

(c) The licensed manager will be required to correct the action or violation within a specific, reasonable time period.

(d) The licensed manager must remain free of the action or violation complained of in the written action plan for a period of one hundred eighty (180) days from the date in the action plan when corrective action must be completed.

(e) A licensed manager who receives three (3) written action plans within a twelve (12) month period may be subject to disciplinary suspension.

(f) An action or violation that results in an action plan may be the basis for disciplinary suspension if the action or violation is:

(1) not corrected in accordance with the action plan; or

(2) repeated or occurs again.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-23; filed Aug 23, 2001, 2:30 p.m.: 25 IR 71)

460 IAC 2-4-24 Disciplinary procedures; immediate suspension

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 4-21.5-4; IC 12-12-5; 20 U.S.C. 107

Sec. 24. (a) The state licensing agency may seek from the director of the division the authority, pursuant to IC 4-21.5-4, to immediately suspend an operator agreement between the state licensing agency and a licensed manager, without a hearing prior to suspension, if the state licensing agency reasonably determines that:

(1) the public health, safety, or welfare is in danger due to the manager's operations;

(2) the permit for the BEP facility is in jeopardy due to the manager's operations;

(3) the BEP facility contract between the custodial authority of the facility and the state licensing agency is in jeopardy due to the manager's operations; or

(4) a licensed manager has abandoned the manager's assigned BEP facility.

(b) Pursuant to such authorization, the licensed manager's operation of the facility shall be suspended immediately. The manager shall cease operation of the facility during the period of suspension. The operation of the facility shall continue under the authority of the state licensing agency.

(c) The state licensing agency shall promptly notify the licensed manager of the immediate suspension of the operator agreement by certified mail or personal service. The notice of suspension shall inform the licensed manager of the following:

(1) The effective date of the suspension.

(2) The duration of the suspension.

(3) The violation or action that is the basis for the suspension.

(4) The consequence of failure to correct the violation or action after the suspension.

(5) The consequence of a repeated violation after the suspension.

(6) The manager's right to:

(A) file a grievance or to appeal the state licensing agency's action; and

(B) a full evidentiary hearing.

(d) An immediate inventory of all stock, equipment, and documents shall be taken and recorded. The state licensing agency shall provide a copy of the inventory to the manager whose operator agreement has been suspended.

(e) The state licensing agency, with the active participation of the Indiana committee of licensed managers, shall select and place a temporary operator in the facility. The costs of a temporary operator will be charged to, and paid from, the facility's gross sales.

(f) The net proceeds from the facility shall be paid on a monthly basis to the manager whose operator agreement has been suspended.

(g) After an immediate suspension of an operator agreement under this section, the manager shall have the right to a full evidentiary hearing under section 30 of this rule. To exercise that right, the manager must file a written request with the director of the division for a full evidentiary hearing. The written request must be filed within fifteen (15) business days after service of the written notice of immediate suspension of the operator agreement.

(h) If an immediate suspension under this section is found to be contrary to law after a full evidentiary hearing and after formal administrative review is complete, the licensed manager shall be reimbursed for the costs of the temporary operator. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-24; filed Aug 23, 2001, 2:30 p.m.: 25 IR 72)*

460 IAC 2-4-25 Disciplinary procedures; disciplinary suspension

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 25. (a) Disciplinary suspension of a licensed manager's operation of an assigned BEP facility for a minimum of thirty (30) calendar days may result from any of the following:

(1) Failure to comply with a written action plan.

(2) An action or a violation that is the basis of a written action plan is repeated following the written action plan.

(3) A licensed manager receives three (3) action plans within a period of twelve (12) months.

(4) A licensed manager is imprisoned after conviction of a criminal offense.

(5) A licensed manager fails, without reasonable justification, to:

(A) give the notice required under section 18 of this rule, regarding the end of a leave of absence;

(B) return to the manager's facility upon completion of an approved leave of absence; or

(C) obtain prior approval from the state licensing agency for an extension of a leave of absence allowable under section 18 of this rule.

(b) The state licensing agency shall promptly notify by certified mail or personal service a licensed manager whose license is proposed to be suspended. The notice of proposed suspension shall inform the licensed manager of the following:

(1) The action or violation that forms the basis for the proposed suspension.

(2) The duration of the proposed suspension.

(3) The consequence of a failure to correct the violation or action after the proposed suspension.

(4) The consequence of repeated violations after the proposed suspension.

(5) The manager's right to a full evidentiary hearing before suspension of the manager's license.

(c) Except as provided in section 24 of this rule (immediate suspension without notice), a licensed manager must be afforded an opportunity for a full evidentiary hearing before suspension of the manager's license.

(d) If a licensed manager's operations are suspended after a full evidentiary hearing, the manager shall cease operation of the facility during the period of suspension. The operation of the facility shall continue under the authority of the state licensing agency.

(e) An immediate inventory of all stock, equipment, and documents shall be taken and recorded. The state licensing agency shall provide the suspended manager with a copy of the inventory.

(f) The state licensing agency, with the active participation of the Indiana committee of licensed managers, shall select and place a temporary operator in the facility. The costs of a temporary operator will be charged to, and paid by, the suspended manager from the facility's gross sales.

(g) The net proceeds from the facility shall be paid to the suspended manager on a monthly basis. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-25; filed Aug 23, 2001, 2:30 p.m.: 25 IR 72; errata filed Jan 10, 2002, 11:37 a.m.: 25 IR 1645)*

460 IAC 2-4-26 Disciplinary procedures; loss of facility

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 26. (a) A licensed manager shall lose the manager's assigned BEP facility, and the facility agreement between the manager and the state licensing agency shall be terminated and canceled, if any of the following occurs:

(1) An action or violation resulted in a suspension and was not corrected.

(2) An action or violation resulted in a suspension, and the action or violation was repeated.

(3) A licensed manager has a repeated violation or failure to comply with the terms of a:

(A) permit for a BEP facility assigned to the licensed manager; or

(B) contract between the state licensing agency and the custodial authority of a BEP facility assigned to the licensed manager.

(b) The state licensing agency shall promptly notify a licensed manager by certified mail or personal service if the agency proposes to terminate the manager's operations in the manager's assigned BEP facility under this section. The notice of proposed loss of facility shall inform the licensed manager of the following:

(1) The action or violation that forms the basis for the proposed loss of the manager's assigned BEP facility.

(2) The consequence of a repeated violation after the manager's loss of the assigned BEP facility.

(3) The manager's right to a full evidentiary hearing before loss of the manager's assigned BEP facility.

(c) A licensed manager must be afforded an opportunity for a full evidentiary hearing before loss of the assigned BEP facility under this rule.

(d) The loss of a facility by a licensed manager under this section shall not restrict the manager from bidding on another available facility; however, the manager shall not be awarded the facility that was lost under this section. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-26; filed Aug 23, 2001, 2:30 p.m.: 25 IR 73)*

460 IAC 2-4-27 Disciplinary procedures; termination of license

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 27. (a) The state licensing agency may terminate a manager's license for any of the following reasons:

(1) An action or violation that resulted in a loss of a licensed manager's BEP facility is not corrected.

(2) An action or violation that resulted in a loss of a licensed manager's BEP facility is repeated.

(3) Violation of the BEP facility agreement between the state licensing agency and a licensed manager.

(4) Violation of the terms of the permit issued to the state licensing agency by the custodial authority of the BEP facility for the manager's assigned BEP facility.

(5) Violation of the terms of the BEP facility agreement between the state licensing agency and the custodial authority of the BEP facility for the manager's assigned BEP facility.

(6) Violation of this rule.

(7) Inability of a licensed manager to substantially comply with this rule for any reason.

(8) Conviction of a felony or misdemeanor that involves fraud, deceit, or misrepresentation.

(9) Continuing violation of state or local government health codes or laws, or failure to correct a violation of the health codes or laws.

(b) The state licensing agency shall promptly notify a licensed manager of a proposed license termination by certified mail or personal service. The notice shall inform a licensed manager of the following:

(1) The action or violation that is the basis for the proposed termination.

(2) The licensed manager's right to a full evidentiary hearing before termination of the manager's license.

(c) A licensed manager will be afforded an opportunity for a full evidentiary hearing before termination of the manager's license.

(d) If a manager's license is terminated, the state licensing agency shall refer the manager to the office of vocational rehabilitation services for other services. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-27; filed Aug 23, 2001, 2:30 p.m.: 25 IR 73)*

460 IAC 2-4-28 Grievance procedures for licensed managers

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 4-21.5-5; IC 12-12-5; 20 U.S.C. 107

Sec. 28. (a) At the time of licensing, a manager shall be informed of the right to, and the procedures for obtaining, administrative review, including a full evidentiary hearing, regarding a decision of the state licensing agency. A licensed manager shall be given access to this information in the manager's choice of Braille, large print, computer disk, or recorded tape.

(b) If a licensed manager disagrees with an action taken by the state licensing agency arising from the operation or administration of the BEP facility program, the licensed manager may file a written grievance with the deputy director of blind and visually impaired services within fifteen (15) business days of notification of the agency action complained of. The grievance must be filed in accordance with the procedures established in this section.

(c) Upon receiving a written grievance, the deputy director of blind and visually impaired services shall conduct informal administrative review under section 29 of this rule.

(d) If the aggrieved party is dissatisfied with the outcome of informal administrative review, the aggrieved party may file a written request with the director of DDARS for a full evidentiary hearing. The written request must be filed within fifteen (15) business days after service of the written notice of the decision from informal administrative review. The hearing must be held before an impartial hearing officer appointed by the director or the director's delegate. The hearing officer shall conduct proceedings under IC 4-21.5 and file a recommended order with the parties and the director of DDARS under section 30 of this rule.

(e) If a party is dissatisfied with the recommended order of a hearing officer, a party may file written objections with the director of DDARS within fifteen (15) business days of service of the hearing officer's recommended order. The director shall conduct proceedings and enter a final order under section 30 of this rule.

(f) If the aggrieved party is dissatisfied with the final order of the director of DDARS under subsection (e), the aggrieved party may either:

(1) request that an arbitration panel be convened by filing a written complaint with the secretary of the United States Department of Education, as authorized by 20 U.S.C. 107d-1 and 34 CFR 395.13; or

(2) seek judicial review of the final order under IC 4-21.5-5.

(g) This section applies only to licensed managers. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-28; filed Aug 23, 2001, 2:30 p.m.: 25 IR 74)*

460 IAC 2-4-29 Informal administrative review

Authority: IC 12-8-8-4 IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 29. (a) A licensed manager may file a written grievance with the deputy director of blind and visually impaired services within fifteen (15) business days of notification of the agency action complained of. The deputy director or deputy director's designee must hold an informal conference with the licensed manager within fifteen (15) business days of the receipt of the request,

or within such other period of time agreed to by the licensed manager and the deputy director.

(b) Transportation, reader, or other communication services, if needed and requested, must be arranged for the licensed manager by the state licensing agency.

(c) The deputy director of blind and visually impaired services, or the deputy director's designee, shall file a written decision from the informal conference on the licensed manager within ten (10) business days of the conference.

(d) If the licensed manager disagrees with the written decision from the informal conference with the deputy director of blind and visually impaired services, or the deputy director's designee, the licensed manager may request a full evidentiary hearing. The request must be:

(1) made in writing; and

(2) filed with the director of DDARS within fifteen (15) days after service of the deputy director's decision in subsection (c).

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-29; filed Aug 23, 2001, 2:30 p.m.: 25 IR 74)

460 IAC 2-4-30 Formal administrative review; full evidentiary hearing procedures

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 4-21.5-3; IC 12-8-8-5; IC 12-12-5; 20 U.S.C. 107

Sec. 30. (a) This section controls proceedings governed by IC 4-21.5 for which the director of DDARS is the ultimate authority.

(b) An affected person who is aggrieved by a determination of the deputy director of BVIS, or the deputy director's delegate, under section 29 of this rule may request formal administrative review and a full evidentiary hearing under IC 4-21.5 and this rule.

(c) The director of DDARS is the ultimate authority for the state licensing agency and DDARS under IC 4-21.5, under IC 12-8-8-5.

(d) As soon as practicable after the initiation of administrative review under this subsection, the director of DDARS shall appoint a hearing officer to conduct proceedings under IC 4-21.5 and this rule. The hearing officer shall be an impartial and qualified person who has no involvement either with the agency action at issue in the proceeding or with the administration or operation of the state licensing agency.

(e) A licensed manager has the right to be represented by counsel at the manager's own expense.

(f) Transportation, reader, or other communication services, if needed and requested, must be arranged for the licensed manager by the state licensing agency.

(g) The hearing shall be held during regular business hours at the state licensing agency, or at such other location as the parties agree. The hearing shall be open to the public.

(h) The hearing officer shall notify the parties, in writing, of the time and place of the hearing. The hearing officer shall also notify the licensed manager of the manager's right to be represented by counsel at his or her own expense.

(i) If the issues in the proceeding are not otherwise resolved, the hearing officer shall conduct a full evidentiary hearing. The hearing officer shall govern the conduct of a hearing and the order of proof.

(j) The hearing officer shall avoid delay, maintain order, and make sufficient record of the proceedings for a full and true disclosure of the facts and issues. To accomplish these ends, the hearing officer shall have all powers authorized by law and may make all procedural and evidentiary rulings necessary for the conduct of the hearing. Unless inconsistent with IC 4-21.5 or this rule, the hearing officer may apply the Indiana Rules of Trial Procedure or the Indiana Rules of Evidence.

(k) Both the licensed manager and the state licensing agency are entitled to present oral or documentary evidence, to submit rebuttal evidence, and to conduct such examination and cross-examination of witnesses as may be necessary for a full and true disclosure of all facts bearing on the issues.

(l) All papers and documents introduced into evidence at the hearing shall be filed with the hearing officer at the hearing, and a copy shall be provided to the other party. All such documents and other evidence submitted shall be open to examination by the parties, and opportunities shall be given to refute facts and arguments advanced on either side of the issues.

(m) A transcript shall be made of the oral evidence and shall be made available to the parties. The state licensing agency shall pay all transcript costs and shall provide the manager with one (1) copy of the transcript.

(n) The record required to be kept by a hearing officer under IC 4-21.5-3-14 commences when a proceeding is initiated and includes the items described in IC 4-21.5-3-33.

(o) The hearing officer shall issue a written recommended order within thirty (30) business days after the receipt of the official transcript. The recommended order shall be mailed promptly to the licensed manager, the state licensing agency, and the ultimate

authority of the agency.

(p) The recommended order of the hearing officer shall set forth the principal issues and relevant facts adduced at the hearing, and the applicable provisions in law, regulation, and agency policy. The order and decision shall contain findings of fact and conclusions with respect to each of the issues, and the reasons and basis therefor. The decision shall also set forth any remedial action necessary to resolve the issues in dispute.

(q) Subject to the provisions of subsections (s) through (u), after a hearing officer issues a recommended order under this section, the director or the director's designee shall issue a final order within thirty (30) business days. The final order shall:

(1) affirm;

(2) modify; or

(3) dissolve;

the hearing officer's order. The director or the director's designee may remand the matter, with or without instructions, to the hearing officer for further proceedings.

(r) In the absence of a party's objection or notice from the director of intent to review any issue related to the order under subsection (s) or (t), the director or the director's designee shall affirm the order.

(s) To preserve an objection to an order of a hearing officer for judicial review, a party who is dissatisfied with the order must not be in default under IC 4-21.5 and must object to the order, in writing, that:

(1) identifies the basis of the objection with reasonable particularity; and

(2) is filed with the director responsible for reviewing the order within fifteen (15) days after the order is served on the party.

(t) If an objection is filed, the director of DDARS or the director's designee will conduct proceedings to issue a final order. In these proceedings, the director or the director's designee shall afford each party an opportunity to present briefs. The director or the director's designee may:

(1) afford each party an opportunity to present oral argument;

(2) exercise the powers of a hearing officer to hear additional evidence under IC 4-21.5-3-25 and IC 4-21.5-3-26; or

(3) allow nonparties to participate in the proceeding in accordance with IC 4-21.5-3-25.

(u) If no objection to the order of the hearing officer is filed, the director of DDARS or the director's designee may serve written notice of the director's intent to review any issue related to the order within thirty (30) days of service of the hearing officer's recommended order. The notice shall be served on all parties. The notice must identify the issues that the director or the director's designee intends to review. In these proceedings, the director or the director's designee shall afford each party an opportunity to present briefs. The director or the director's designee may:

(1) afford each party an opportunity to present oral argument;

(2) exercise the powers of a hearing officer to hear additional evidence under IC 4-21.5-3-25 and IC 4-21.5-3-26; or

(3) allow nonparties to participate in the proceeding in accordance with IC 4-21.5-3-25.

(v) A final order disposing of the proceeding, or an order remanding an order to the hearing officer for further proceedings shall be issued within thirty (30) days after the latter of:

(1) the date that the hearing officer's order was issued;

(2) the receipt of briefs or written comments; or

(3) the close of oral arguments.

After remand of an order to a hearing officer under this subsection, the hearing officer's subsequent order is also subject to review under this section.

(w) The final order of the director of DDARS or the director's designee must:

(1) identify any differences between the director's final order and the recommended order issued by the hearing officer;

(2) include findings of fact or incorporate the findings of fact in the hearing officer's recommended order by express reference to the recommended order;

(3) inform a licensed manager that, if the licensed manager is dissatisfied with the final order issued by the director of DDARS or the director's designee, the licensed manager may request that an arbitration panel be convened by filing a complaint with the Secretary of the Department of Education, as authorized by 20 U.S.C. 107d-1 and 34 CFR 395.13; and

(4) inform a party of the right to seek judicial review of the final order pursuant to IC 4-21.5-5.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-30; filed Aug 23, 2001, 2:30 p.m.: 25 IR 75)

460 IAC 2-4-31 Business enterprise program facility equipment and inventory

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 31. (a) Requirements concerning inventory and equipment are as follows:

(1) Start-up inventory purchased by the state licensing agency as part of the vocational rehabilitation plan is the property of the licensed manager.

(2) The state is the owner of the BEP facility equipment purchased by the state licensing agency for BEP facilities under 20 U.S.C. 107b and 34 CFR 395.4.

(3) The use of BEP equipment is limited to the purposes designated by the state licensing agency for the business enterprise program.

(b) Requirements for the repair of facility equipment are as follows:

(1) A licensed manager is responsible for the periodic maintenance of equipment furnished by the state licensing agency and shall provide the care necessary to maintain the equipment in good condition and repair, excluding ordinary wear.

(2) A licensed manager who fails to maintain the BEP facility and equipment in good repair will be subject to disciplinary action.

(3) The state licensing agency shall give written notice to a licensed manager to perform or to make arrangements for, necessary maintenance or repairs within a specific, reasonable period of time. If the manager does not comply with the notice, the state licensing agency shall make arrangements for necessary maintenance or repairs.

(4) If the state licensing agency has arranged for necessary maintenance or repairs under subdivision (3), the licensed manager shall reimburse the state for the costs thereof within:

(A) thirty (30) days of the manager's receipt of the bill; or

(B) a longer time period agreed to by the licensed manager and the state licensing agency.

(c) Requirements for the replacement of facility equipment are as follows:

(1) The state licensing agency will replace worn out, severely damaged, or obsolete equipment in a BEP facility, subject to the requirements of subdivision (2).

(2) Replacement of equipment described in subdivision (1) will be based on consideration of all of the following criteria:

(A) The need for equipment replacement as determined by the state licensing agency.

(B) If requested, the manager's providing the state licensing agency with written documentation of the need for equipment replacement.

(C) A request from the custodial authority of the BEP facility.

(D) The approval of the custodial authority of the BEP facility if the equipment is not listed among the equipment allowed under the permit for the facility or the contract between the state licensing agency and the custodial authority.

(E) The availability of funding.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-31; filed Aug 23, 2001, 2:30 p.m.: 25 IR 76)

460 IAC 2-4-32 Relocation, installation, renovation of a business enterprise program facility

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 32. (a) The installation, modification, relocation, removal, or renovation of a BEP facility shall be subject to the prior approval and supervision of the state licensing agency and the custodial authority responsible for the property on which the facility is located, in consultation with the licensed manager.

(b) The cost of relocation initiated by the state licensing agency shall be paid by the state licensing agency.

(c) The cost of relocation initiated by the custodial authority shall be paid by that entity, subject, however, to the terms of the permit for the BEP facility, or to the terms of the facility agreement entered into by the custodial authority and the state licensing agency. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-32; filed Aug 23, 2001, 2:30 p.m.: 25 IR 77)*

460 IAC 2-4-33 Set-aside funds

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 33. (a) Operator-assessed set-aside funds accrue for use in the BEP for only the following purposes:

(1) Maintenance and replacement of equipment.

(2) The purchase of new equipment.

(3) Management services, including administrative costs of the Indiana committee of licensed managers.

(4) Assuring a fair minimum return to licensed managers.

(5) The establishment and maintenance of retirement or pension funds, health insurance contributions, and provision for paid sick leave and vacation time, if a majority vote of managers licensed by the state licensing agency determines that funds should be set aside for such purposes.

(b) Every operator of a BEP facility, including licensed managers, manager trainees, and temporary operators, must set aside a portion of the net proceeds from the operator's assigned BEP facility or facilities in accordance with the following:

(1) The percentage of net proceeds to be set aside will be determined and reviewed annually by the state licensing agency with the active participation of Indiana committee of licensed managers in accordance with 34 CFR 395.9.

(2) The percent of net proceeds required to be set aside will be based on the estimated amount of revenue needed by the state licensing agency to fund only the following:

(A) The maintenance and replacement of equipment.

(B) The purchase of new equipment, subject, however, to the requirement that the state licensing agency will use funds from the office of vocational rehabilitation to purchase new equipment whenever possible.

(C) Management services performed by the state licensing agency.

(D) Assuring a fair minimum return to licensed managers.

(E) The establishment and maintenance of retirement or pension funds, health insurance contributions, and provision for paid sick leave and vacation time if a majority vote of managers licensed by the state licensing agency determines that funds should be set aside for the purposes set out in this clause.

(3) The percentage determined in subdivision (2) shall become effective upon:

(A) approval by the Secretary of the United States Department of Education; and

(B) written notification to all operators of the approval by the Secretary of the United States Department of Education.

(4) The percentage approved under this subsection will remain in effect until changed in accordance with this section.

(c) Each operator shall pay the approved set-aside to the state licensing agency for any given month by the fifteenth of the following month, if assessed in accordance with this section. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-33; filed Aug 23, 2001, 2:30 p.m.: 25 IR 77)*

460 IAC 2-4-34 Allowable business expenses

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 34. (a) Each operator must file with the state licensing agency a written monthly report of the gross income, the allowable business expenses paid by the operator, and the net proceeds of the assigned BEP facility or facilities. The report must be filed in a form set by the state licensing agency.

(b) Allowable business expenses are expenses that are:

(1) paid by an operator for the operation of a BEP facility;

(2) allowed by the Internal Revenue Service; and

(3) in an amount allowed by the Internal Revenue Service.

(c) Allowable business expenses include the following expenses:

(1) The cost of goods sold. "Goods" means stock or merchandise purchased for resale in a BEP facility.

(2) Supplies, which means expendable items that are necessary for day-to-day facility operation, but are not for resale.

(3) Merchandise delivery charge, which means an additional cost, above the cost of stock or supplies, assessed for making a delivery to a BEP facility.

(4) Pest exterminating service.

(5) Janitorial service, which means a commercial firm or independent contractor to clean the facility or to remove trash. Such costs are deductible unless the state licensing agency or the custodial authority assigns this responsibility to someone other than the operator.

(6) Bookkeeping and bank fees directly related to the facility operation.

(7) Required business licenses.
(8) Telephone charges, which means the cost for any reasonably necessary business telephone service, including long distance telephone calls for BEP facility business and in fulfillment of BEP committee responsibilities.
(9) Purchase, rental, or laundry costs for uniforms and linens used in the BEP facility provided that the costs for uniforms are allowed if uniforms are worn only for work at the BEP facility.
(10) Business advertising not to exceed, in a calendar year, the greater of:
(A) one percent (1%) of the facility's gross annual income for the prior year; or
(B) three hundred dollars ($300).
(11) Premiums for insurance coverage for BEP business operations and liability for property damage and bodily injury, except that insurance premiums for state-owned equipment shall not be deductible.
(12) Rent if required by contract for space.
(13) Utilities for the facility when not included in rent.
(14) Wages, paid leave time, and other fringe benefits for an employee who is not a party to an agreement or a temporary operator agreement with the state licensing agency.
(15) Coverage for Social Security, workers' compensation, and unemployment compensation, as required by law for an employee who is not a party to an operator agreement with the state licensing agency.
(16) Sales taxes.
(17) Business-related legal fees.
(18) Short term training expenses of reasonable cost for operators and employees if the training is directly related to the job.
(19) Temporary operator fees paid in accordance with this rule.
(20) Travel expenses if required for BEP business purposes.
(21) Air conditioner filter service and fire extinguisher service.
(22) A vision exam if required in accordance with section 13(b) of this rule.
(23) Payments to the custodial authority of the assigned BEP facility if the payments are required under:
(A) the permit issued to the state licensing agency for the BEP facility; or
(B) the facility agreement between the state licensing agency and the custodial authority of the BEP facility.
(24) Payment of an expense that is the responsibility of the state licensing agency with the prior approval of the BEP business counselor or program director. The person giving such approval shall document the approval, in writing, in the facility file.
(25) Personal property taxes assessed by a governmental entity.
(26) Business dues not to exceed, in a calendar year, the greater of:
(A) one percent (1%) of the facility's gross annual income for the prior year; or
(B) three hundred dollars ($300).
(27) Charitable contributions, grants, and other donations to 501(c)(3) organizations.
(28) Entertainment expenses directly related to BEP facility operations.
(29) Postage expenses required to support BEP facility operations.
(30) Cost of equipment repairs or maintenance.
(31) Any other reasonable, necessary, and allocable expense the state licensing agency approves in writing.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-34; filed Aug 23, 2001, 2:30 p.m.: 25 IR 78)

460 IAC 2-4-35 Distribution and use of income from vending machines not designated as part of a manager's facility on federal property

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 35. (a) The state licensing agency shall disburse income received from vending machines on federal property, when those machines are not designated as part of a BEP facility, in accordance with the requirements in this section.

(b) The state licensing agency shall disburse that income to a licensed manager or managers operating a BEP facility on the same federal property. However, the total amount of income disbursed to a licensed manager shall not exceed the maximum amount allowed under 34 CFR 395.32 and 34 CFR 395.8(a).

(c) If the income from such vending machines exceeds the maximum amount that may be disbursed to a licensed manager under subsection (a), the additional income shall accrue to the state licensing agency for the following purposes:

(1) The income shall be used first for:

(A) the establishment and maintenance of retirement or pension plans;

(B) health insurance contributions; or

(C) the provision of paid sick leave and vacation time for licensed managers in the state;

if a majority vote of managers licensed by the state licensing agency determines that funds should be used for such purposes.

(2) Any vending machine income not necessary for the purposes set out in subdivision (1), shall be used by the state licensing agency for the following purposes:

(A) The maintenance and replacement of equipment.

(B) The purchase of new equipment.

(C) Management services.

(D) Assuring a fair minimum return to licensed vendors.

(3) Any assessment or set-aside charged to licensed managers shall be reduced pro rata in an amount equal to the total of such remaining vending machine income.

(d) If there is no licensed manager operating a BEP facility on the same federal property, the income shall accrue to the state licensing agency for the purposes set out in subsection (c).

(e) The state licensing agency shall disburse vending machine income under this section on at least a quarterly basis. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-35; filed Aug 23, 2001, 2:30 p.m.: 25 IR 79)*

460 IAC 2-4-36 Operation of facility; business requirements

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 36. (a) A licensed manager must comply with the business requirements set forth in this section. Failure to comply with these business requirements will result in disciplinary action under section 21 of this rule.

(b) A licensed manager and the manager's employees shall not discriminate against any person in furnishing, or by refusing to furnish, to such person the use of any BEP facility, including any and all goods, services, privileges, accommodations and activities provided by the facility, on the basis of sex, race, age, creed, color, national origin, physical or mental disability, or political affiliation.

(c) A licensed manager is responsible for the operations and profitability of the assigned BEP facility.

(d) A licensed manager must comply with the terms of:

(1) the agreement between the state licensing agency and the licensed manager; and

(2) either:

(A) the permit issued to the state licensing agency for the BEP facility; or

(B) the facility agreement between the custodial authority of the facility and the state licensing agency.

(e) A licensed manager is a self-employed person and must comply with all applicable federal, state, and local laws, regulations, and ordinances, including, but not limited to, those applicable to taxes, worker's compensation, unemployment insurance, and Social Security.

(f) A licensed manager must operate the BEP facility in compliance with applicable health, sanitation, and building codes and ordinances.

(g) The accounting records for a BEP facility shall be kept separate from the accounting records for any other business venture.

(h) A BEP facility shall not be used for the operation of any business venture except a business operated under IC 12-12-5, this rule, or the facility agreement between the licensed manager and the state licensing agency. BEP money, product, equipment, and assets shall not be used in, or commingled with the assets of, any other business venture.

(i) A licensed manager must:

(1) accurately complete all reports and forms approved by the state licensing agency and developed with the active participation of the Indiana committee of licensed managers; and

(2) submit the reports and forms to the state licensing agency within established time frames.

(j) A licensed manager must file the following reports with the state licensing agency on forms prescribed by BVIS:

(1) A written monthly report of the gross income, the allowable business expenses paid, and the net income of the assigned BEP facility or facilities. The report for any month is due and must be filed with the state licensing agency by the close of

business on the fifteenth day of the following month, except that, if the fifteenth day is on a Saturday, a Sunday, a legal holiday as defined by state statute, or a day when state offices are closed during regular business hours, the report shall be due on the following business day.

(2) Each January, a detailed annual inventory of facility merchandise, submitted with the monthly operating report required in subsection (j)(1) above. Unless it is a first inventory for a manager at a facility, the inventory must be reconciled with the facility inventory of the year before. Opening inventory will usually be the same as the closing inventory of the year before. Any difference must be explained in an attachment to the inventory.

(k) A licensed manager must establish procedures to:

(1) maintain inventory control;

(2) maintain adequate inventory; and

(3) ensure correct charges by the suppliers of articles sold at the BEP facility.

(l) Because one (1) purpose of the business enterprise program is to demonstrate the competence of blind persons, a licensed manager must maintain a physical presence and personal involvement in the daily management and operation of the BEP facility.

(m) A licensed manager shall employ other persons as necessary for the following purposes:

(1) The effective and efficient operation of the BEP facility.

(2) Compliance with all contractual obligations.

(3) Maintaining continuous operation of the facility.

(n) A licensed manager must assure that the terms of employment of any employee are commensurate with the terms of employment of other persons engaged in similar work in the local economy.

(o) A licensed manager is responsible for the conduct of the manager's employees and must ensure that any employee is aware of and complies with the business practices set out in this rule. The manager is responsible for correcting actions of an employee and enforcing the business practices that apply to an employee.

(p) If a licensed manager becomes or is unable to personally operate the BEP facility and to perform under provisions of the agreement between the manager and the state licensing agency, the manager must:

(1) notify the state licensing agency promptly; and

(2) select an individual, approved in advance by the state licensing agency, and make arrangements for that individual, to operate the facility in the operator's absence.

If a manager fails or is unable to comply with this subsection, the state licensing agency shall have the right to place a temporary operator in the BEP facility and to assess the costs of the temporary operator to the manager.

(q) A licensed manager shall:

(1) obtain each policy of insurance required, in the amount required, pursuant to the operating agreement with the state licensing agency;

(2) upon approval of the state licensing agency, obtain any additional policies of insurance considered necessary for the BEP facility;

(3) ensure that each policy of insurance names DDARS as an additional insured;

(4) provide the state licensing agency with a copy of each policy of insurance, if requested; and

(5) immediately notify the state licensing agency if either an insurer or the licensed manager cancels any required insurance.

(r) A licensed manager must ensure that each BEP facility will be open during the days and hours:

(1) specified in:

(A) the permit issued to the state licensing agency for the BEP facility; or

(B) the agreement between the state licensing agency and the custodial authority of the BEP facility; or

(2) otherwise agreed upon by the state licensing agency, the manager, and the custodial authority of the BEP facility.

(s) Articles sold at a BEP facility may consist of newspapers, periodicals, publications, confections, tobacco products, foods, beverages, and any other articles or services suitable for a particular location as determined by the state licensing agency, in consultation with the custodial authority and the licensed manager. However, the state licensing agency, in consultation with the custodial authority and the licensed manager, may exclude the sale of various types of merchandise or products at a particular site.

(t) A licensed manager has the right to make the ultimate decision as to particular brands of articles sold.

(u) A licensed manager shall select suppliers of merchandise to be sold at the assigned BEP facility.

(v) A licensed manager has full responsibility for all financial arrangements necessary to obtain merchandise for the BEP facility, except for the initial stock.

(w) A licensed manager must pay all bills, including purchases for goods or services, in a timely manner.

(x) The possession, consumption, or use of alcoholic beverages or illegal drugs at a BEP facility by a licensed manager or by an employee of the manager is not permitted. A licensed manager or an employee of a manager shall not work under the influence of alcohol or illegal drugs at a BEP facility. No alcoholic beverages or illegal drugs shall be allowed at a BEP facility.

(y) A licensed manager must maintain fresh stock and must not sell out-of-date product.

(z) A licensed manager must assure that services are provided to customers and the public in a courteous and professional manner at all times. Any contact with the custodial authority or management of the BEP facility must be conducted in a professional and courteous manner. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-36; filed Aug 23, 2001, 2:30 p.m.: 25 IR 79)*

460 IAC 2-4-37 Business performance of a business enterprise program facility

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 37. (a) A BEP facility must produce a reasonable amount of net proceeds in order to:

(1) provide a significant economic opportunity for a licensed manager or manager trainee;

(2) provide for a productive use of program assets; and

(3) be suitable as a BEP facility.

(b) The state licensing agency, with the active participation of the Indiana committee of licensed managers, shall select criteria to determine whether a BEP facility produces a reasonable amount of net proceeds. The criteria includes, but is not limited to, the following:

(1) The criteria set out in section 14(a)(2) of this rule.

(2) An operator's need for assistance in performing any operational responsibility under this rule.

(c) The state licensing agency will perform periodic evaluations of each BEP facility to determine whether a facility is producing a reasonable amount of net proceeds. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-37; filed Aug 23, 2001, 2:30 p.m.: 25 IR 81)*

460 IAC 2-4-38 Indiana committee of licensed managers

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 38. (a) The Indiana committee of licensed managers shall be fully representative, to the extent possible, of all licensed managers in the Indiana program on the basis of geography, facility type, and designation as a federal or nonfederal facility. The committee shall consist of a total of nine (9) members selected from the following categories in the number or numbers indicated:

(1) By geographic location of a licensed manager's primary facility located:

(A) north of I-70 and west of US 31, one (1) committee member;

(B) north of I-70 and east of US 31, one (1) committee member; and

(C) south of I-70, one (1) committee member.

(2) By facility type of a licensed manager's primary facility:

(A) highway vending, one (1) committee member;

(B) non-highway vending, one (1) committee member;

(C) snack bar, cafeteria, and other type of facility, one (1) committee member.

(3) By designation of a licensed manager's primary facility as a federal or nonfederal facility:

(A) federal facility, one (1) committee member; and

(B) nonfederal facility, two (2) committee members.

(b) Requirements for the election of committee members are as follows:

(1) All members of the committee shall be elected every two (2) years at a conference sponsored by the state licensing agency.

(2) Only licensed managers may nominate, vote for, and elect members to the committee.

(3) A licensed manager may vote for and elect only committee members to serve in the same three (3) categories as the licensed manager's primary facility. For example, if the primary facility of a licensed manager is located south of I-70, is a snack bar, and is a nonfederal facility, the licensed manager may vote for and elect committee members only in those three (3) categories.

(4) The participation of a licensed manager in the election of committee members shall not be conditioned upon the payment of dues or any fees.

(c) The state licensing agency shall notify all licensed managers, in writing, at least thirty (30) days before the election of the committee at a biennial conference. The notice must include the following information:

(1) The date, time, and place of the election of members of the Indiana committee of licensed managers.

(2) The three (3) categories in which a licensed manager may vote as determined from a primary facilities list enclosed in the notice.

(3) The process whereby the manager may contact the state licensing agency within ten (10) days of receipt of the notice if the manager believes that the primary facilities list contains an error concerning the manager's primary facility or the categories in which the manager may vote.

(4) Notice that a licensed manager may submit written nominations prior to the conference for any position on the committee, and the process for doing so.

(5) Notice that nominations for all positions on the committee will also be taken from the floor at the election.

(d) Official committee action requirements are as follows:

(1) A quorum of the committee shall consist of five (5) members.

(2) Motions shall be passed by a majority of those members present.

(e) The duties of the committee are as follows:

(1) To actively participate with the state licensing agency in major administrative decisions and policy and program development decisions affecting the business enterprise program.

(2) To receive and transmit grievances of licensed managers to the state licensing agency, and to serve as advocate for licensed managers in connection with the grievances.

(3) To actively participate with the state licensing agency in decisions regarding the transfer and promotion of licensed managers.

(4) To actively participate with the state licensing agency in the development of training and retraining programs for licensed managers.

(5) To sponsor meetings and instructional conferences for licensed managers with the state licensing agency.

(6) To keep confidential any confidential information concerning program participants that is disclosed to committee members during the exercise of their duties under this section.

(f) The payment of any expenses incurred by the committee in conjunction with the duties of the committee shall be subject to the prior approval of the state licensing agency. Committee members will be reimbursed in accordance with state travel and administrative policies. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-38; filed Aug 23, 2001, 2:30 p.m.: 25 IR 81; errata filed Jan 10, 2002, 11:37 a.m.: 25 IR 1645)*

460 IAC 2-4-39 Accessibility of written materials

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-12-5; 20 U.S.C. 107

Sec. 39. (a) A licensed manager and a manager trainee may designate a preferred format for receiving access to written materials or communications from the agency. Available formats are as follows:

(1) Braille.

(2) Large print.

(3) Computer disk.

(4) Recorded tape.

(b) If reasonably possible, the state licensing agency shall provide a licensed manager and a manager trainee with access to written materials or communications in the preferred format requested under subsection (a). *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-4-39; filed Aug 23, 2001, 2:30 p.m.: 25 IR 82)*

Rule 5. Interpreter Standards for the Deaf and Hard of Hearing in Educational Settings

460 IAC 2-5-1 Scope

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-12-7-5
Affected: IC 12-12-7

Sec. 1. (a) This rule establishes state certification standards for behavior, competency, and proficiency in interpretation, transliteration, and oral transliteration in a public or private primary or secondary school setting.

(b) This rule applies to a person who:

(1) applies for state certification;

(2) works in a public or private school in grades preschool through secondary school in Indiana with a deaf or hard of hearing student; and

(3) is hired as an interpreter or transliterator.

This includes any interpreter/transliterator who uses American Sign Language or who uses any code or method of communication used by deaf or hard of hearing students, including, but not limited to, cued speech, signed English, signing exact English, seeing essential English, conceptually accurate signed English (CASE), or oral methods of communication.

(c) This rule does not apply to certified teachers with endorsement to teach deaf children unless the person is hired by a public or private school to work as an interpreter/transliterator. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-5-1; filed Jun 27, 2002, 1:40 p.m.: 25 IR 3765)*

460 IAC 2-5-2 Definitions

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-12-7-5
Affected: IC 12-12-7

Sec. 2. (a) The definitions and acronyms in this section apply throughout this rule.

(b) "ASL" means American Sign Language.

(c) "BIS" means board of interpreter standards.

(d) "CEU" means continuing education unit.

(e) "Code of ethics" means the rules of professional behavior for interpreters and transliterators approved by the board of interpreter standards.

(f) "Cued Speech" means a system for visual representation of spoken language using eight (8) handshapes and four (4) hand locations near the face to supplement speech.

(g) "DDARS" means the division of disability, aging, and rehabilitative services.

(h) "Deaf or hard of hearing person" means the persons for and between whom the interpreter is facilitating communication and includes both hearing and deaf consumers.

(i) "DHHS" means deaf and hard of hearing services.

(j) "EIPA" means educational interpreter performance assessment.

(k) "Educational interpreter" means a person who is able to perform conventional interpreting or transliterating, together with required skills for working in the educational setting.

(l) "Hard of hearing" means a person who has mild to moderate hearing loss.

(m) "Hearing impaired" means an educational label that is used to refer to all deaf and hard of hearing students.

(n) "Individualized education program (IEP)" means a document developed by a case conference committee which identifies educational goals and objectives needed to appropriately address the educational needs of a student with a disability.

(o) "Interpreter" means interpreters, transliterators, and oral transliterators and includes a person who works with a deaf or hard of hearing child or otherwise hearing impaired student to facilitate communication by rendering the complete message for the student and others because they do not share the same language and culture.

(p) "Interpreting " means the process of conveying a message from one (1) language into another.

(q) "Manually coded English" means a signed message that attempts to convey the meaning of the English speaker while maintaining the English form and word order.

(r) "NAD" means National Association of the Deaf.

(s) "New interpreter" means an interpreter who has no proof of work as an interpreter in a school setting.

(t) "Oral transliteration" means the process of understanding the speech and/or mouth movements of deaf, hard of hearing, or otherwise hearing impaired persons and repeating the message in spoken English and includes the process of paraphrasing/

transliterating a message spoken in English to a more visible form with natural lip movements so a deaf or hard of hearing person can read the lips of the oral transliterator.

(u) "RID" means Registry of Interpreters for the Deaf.

(v) "SEE II" means Signing Exact English II.

(w) "Setting" means the context within which an interpreting assignment takes place.

(x) "Signed English" means a system devised as a semantic representation of English where ASL signs are used in English word order with fourteen (14) sign makers being added to represent a portion of the inflectional system of English.

(y) "State certification" means certified by DHHS.

(z) "TECUnit" means Testing, Evaluation and Certification Unit, Inc., an organization that certifies Cued Speech transliterators.

(aa) "Transliteration" refers to the process of conveying information from a spoken English message to an invented code that is signed or vice versa. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-5-2; filed Jun 27, 2002, 1:40 p.m.: 25 IR 3765)*

460 IAC 2-5-3 Registration requirements

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-12-7-5
Affected: IC 12-12-7

Sec. 3. In order to receive state certification as an interpreter, working interpreters/transliterators in Indiana must be registered with deaf and hard of hearing services (DHHS) in the manner prescribed by DHHS. DHHS is the agency responsible for standards related to sign language interpreters in Indiana and has been designated as the agency to make the determination that an interpreter can be certified to interpret in an educational setting. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-5-3; filed Jun 27, 2002, 1:40 p.m.: 25 IR 3766)*

460 IAC 2-5-4 Certificate

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-12-7-5
Affected: IC 12-12-7

Sec. 4. After being certified by the state, an interpreter shall be issued a certificate signed by the DHHS deputy director and DDARS director evidencing such certification. An interpreter shall also be issued an identification card signed by the DHHS deputy director and DDARS director, a copy of which the interpreter shall present when requested as proof of certification. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-5-4; filed Jun 27, 2002, 1:40 p.m.: 25 IR 3766)*

460 IAC 2-5-5 Certification requirements for new interpreters and transliterators

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-12-7-5
Affected: IC 12-12-7

Sec. 5. (a) In addition to any other requirements that a school district or school corporation establishes, to receive state certification as an interpreter, a person who interprets/transliterates in a public or private school in Indiana working with a deaf or hard of hearing student is required to have the appropriate national certification or performance assessment score listed in subsection (b). This section applies to all new interpreters and transliterators after July 1, 2010.

(b) The five (5) types of certificates and corresponding requirements include:

(1) American Sign Language:	Hold the RID certificate of interpretation (CI) or the NAD Level IV or V for educational situations requiring an ASL/English interpreter.
(2) Manually coded English (MCE): (unspecified MCE)	Hold the RID certificate of transliteration (CT) for educational situations requiring transliteration.
(3) Oral transliteration:	Hold the RID oral transliteration certificate (OTC) for educational situations requiring an oral transliterator. This certificate requires a special written and performance exam.

(4) Cued speech:	Hold certification from TECUnit and pass the RID written generalist test for educational situations requiring a cued speech transliterator.
(5) Signing exact English (SEE-II):	Pass the educational interpreter performance assessment (EIPA) instrument specific to SEE-II at level 3.5 and pass the RID written generalist test. These are the requirements for educational situations needing a SEE-II transliterator.

(c) Interpreters or transliterators holding applicable national certifications must maintain these certifications in good standing in order to maintain their certification by the state, including fulfilling continuing education requirements.

(d) An interpreter or transliterator certified by the state shall renew the certification every two (2) years in the manner prescribed by DHHS. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-5-5; filed Jun 27, 2002, 1:40 p.m.: 25 IR 3767)*

460 IAC 2-5-6 Certificate requirements for practicing interpreters and transliterators

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-12-7-5
Affected: IC 12-12-7

Sec. 6. (a) To receive state certification as an interpreter or transliterator, an individual who has documentation proving paid work as an educational interpreter prior to July 1, 2010, shall meet the following criteria:

(1) Beginning July 1, 2002, the interpreter or transliterator must earn annually one (1) CEU of skill development in the type of interpreting or transliterating that corresponds to the certificate held by the interpreter.

(2) Beginning July 1, 2002, the interpreter or transliterator must earn annually one (1) CEU from one (1) of the following seven (7) content areas:

(A) Deaf culture and history.
(B) Language development and acquisition in children.
(C) Child development.
(D) Foundations in interpreting theory and practice.
(E) Code of ethics for educational interpreters.
(F) Principles and practices of special education; or
(G) Audiological issues for students and adults.

(b) An interpreter or transliterator certified by the state shall renew such certification every two (2) years in the manner prescribed by DHHS.

(c) After July 1, 2010, a newly hired interpreter or transliterator cannot use this section in later years to qualify. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-5-6; filed Jun 27, 2002, 1:40 p.m.: 25 IR 3767)*

460 IAC 2-5-7 Limited state certification requirements for graduates of interpreter training programs

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-12-7-5
Affected: IC 12-12-7

Sec. 7. (a) To receive limited state certification as an interpreter or transliterator, an individual who has a degree in Sign Language Interpreting from an accredited institution after July 1, 2010, may meet each of the following criteria to hold a limited certificate:

(1) When granted the limited certificate, the interpreter/transliterator must earn annually one (1) CEU of skill development in the type of interpreting/transliterating that corresponds to the limited certificate held by the interpreter/transliterator.

(2) When granted the limited certificate, the interpreter/transliterator must annually earn one (1) CEU from one (1) of the following seven (7) content areas:

(A) Deaf culture and history.
(B) Language development and acquisition in children.
(C) Child development.
(D) Foundations in interpreting theory and practice.
(E) Code of ethics for educational interpreters.

(F) Principles and practices of special education; or

(G) Audiological issues for students and adults.

(3) The interpreter or transliterator must apply for and pass the RID written generalist test for the limited certificate.

(b) The interpreter or transliterator can renew the limited state certificate each year for up to five (5) years in the manner prescribed by DHHS.

(c) A person may use this section for only the first five (5) years immediately following graduation from an accredited sign language interpreter preparation program. There shall be no renewals or extensions of this section. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-5-7; filed Jun 27, 2002, 1:40 p.m.: 25 IR 3767)*

460 IAC 2-5-8 Interpreter code of ethics

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-12-7-5
Affected: IC 12-12-7

Sec. 8. (a) To maintain state certification as an interpreter or transliterator, an individual must follow the ethical standards taken from the RID code of ethics.

(1) Interpreters and transliterators shall keep all assignment-related information strictly confidential.

(2) Interpreters and transliterators shall render the message faithfully, always conveying the content and spirit of the speaker, using language most readily understood by the person(s) whom they serve.

(3) Interpreters and transliterators shall not counsel, advise, or interject personal opinions.

(4) Interpreters and transliterators shall accept assignments using discretion with regard to skill, setting, and the consumers involved.

(5) Interpreters and transliterators shall request compensation for services in a professional and judicious manner.

(6) Interpreters and transliterators shall function in a manner appropriate to the situation.

(7) Interpreters and transliterators shall strive to further knowledge and skills through participation in workshops, professional meetings, interaction with professional colleagues, and reading of current literature in the field.

(8) Interpreters and transliterators shall strive to maintain high professional standards in compliance with the code of ethics.

(b) Questions by consumers, interpreters, and transliterators relating to interpreting these ethical standards in an educational setting can be answered by contacting DHHS. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-5-8; filed Jun 27, 2002, 1:40 p.m.: 25 IR 3768)*

460 IAC 2-5-9 Grievances

Authority: IC 12-8-8-4; IC 12-9-2-3; IC 12-12-7-5
Affected: IC 12-12-7

Sec. 9. The grievance committee created under 460 IAC 2-3-13 shall have jurisdiction over grievances arising out of this rule, and any grievances shall be referred to that committee. All grievance procedures, actions, enforcement, discipline, and appeals shall be handled according to the provisions of 460 IAC 2-3-15 through 460 IAC 2-3-20. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 2-5-9; filed Jun 27, 2002, 1:40 p.m.: 25 IR 3768)*

ARTICLE 3. DIVISION ON MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES: ALTERNATE RESIDENTIAL CARE (EXPIRED)

(Expired under IC 4-22-2.5, effective January 1, 2002.)

ARTICLE 3.5. RATES FOR ADULT DAY SERVICES PROVIDED BY COMMUNITY MENTAL RETARDATION AND OTHER DEVELOPMENTAL DISABILITIES CENTERS

Rule 1. Definitions, Purpose, and Applicability

460 IAC 3.5-1-1 Definitions

Authority: IC 12-8-8-4
Affected: IC 12-7-2-39; IC 12-7-2-61; IC 12-9-2-6

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

(1) "Adult" means an individual with a developmental disability who is sixteen (16) years of age or older and who no longer is participating in a secondary education program.

(2) "Adult day services" means the following services that providers, under contract with the division, provide to adult individuals with developmental disabilities:

(A) supported employment follow-along;
(B) community-based sheltered work;
(C) sheltered work;
(D) group habilitation;
(E) individual habilitation;
(F) group occupational therapy;
(G) individual occupational therapy;
(H) group physical therapy;
(I) individual physical therapy;
(J) group speech therapy;
(K) individual speech therapy; and
(L) transportation.

(3) "Developmental disability" has the meaning set forth in IC 12-7-2-61.

(4) "Division" means the division of disability, aging, and rehabilitative services.

(5) "Provider" means community mental retardation and other developmental disabilities centers, as defined in IC 12-7-2-39, under contract with the division to provide adult day services to individuals with developmental disabilities.

(6) "Round trip" means transportation of an adult from the adult's place of residence to the provider and back.

(7) "Unit of service" means a measurable unit of an adult day service for which a rate of reimbursement is established under this article.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 3.5-1-1; filed Mar 18, 1996, 11:00 a.m.: 19 IR 2040)

460 IAC 3.5-1-2 Purpose and applicability

Authority: IC 12-8-8-4
Affected: IC 12-7-2-39; IC 12-7-2-61; IC 12-9-2-6

Sec. 2. The purpose of this article is to establish unit of service reimbursement rates for providers contracting with the division to provide adult day services to individuals with developmental disabilities. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 3.5-1-2; filed Mar 18, 1996, 11:00 a.m.: 19 IR 2041)*

Rule 2. Unit of Service Reimbursement Rates

460 IAC 3.5-2-1 Unit of service reimbursement rates

Authority: IC 12-8-8-4
Affected: IC 12-7-2-39; IC 12-7-2-61; IC 12-9-2-6

Sec. 1. (a) The units of adult day services specified in this section shall be reimbursed by the division at the following corresponding rates:

Adult Day Service	Unit of Service	Unit Rate
Supported employment follow-along	1 hour	$36.95
Community-based sheltered work	1 hour	$5.67
Sheltered work	1 hour	$2.75

Group habilitation	1 hour	$5.34
Individual habilitation	1 hour	$28.82
Group occupational therapy	15 minutes	$5.04
Individual occupational therapy	15 minutes	$20.13
Group physical therapy	15 minutes	$5.87
Individual physical therapy	15 minutes	$23.49
Group speech therapy	15 minutes	$4.24
Individual speech therapy	15 minutes	$16.97
Transportation	1 round trip	$8.91

(b) For the following rates, at least eighty percent (80%) of the unit rate increase from the previously published unit rate must be paid by the provider to the hourly wages of direct care staff:

Adult Day Service	Unit of Service Rate	Previous Unit Rate	New Unit Rate
Community-based sheltered work	1 hour	$5.43	$5.67
Group habilitation	1 hour	$5.11	$5.34
Individual habilitation	1 hour	$27.58	$28.82

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 3.5-2-1; filed Mar 18, 1996, 11:00 a.m.: 19 IR 2041; filed Feb 11, 2002, 4:27 p.m.: 25 IR 2226)

460 IAC 3.5-2-2 Annual review of adult day service reimbursement rates

Authority: IC 12-8-8-4
Affected: IC 12-7-2-39; IC 12-7-2-61; IC 12-9-2-6

Sec. 2. The division shall annually review the adult day service reimbursement rates established by this article. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 3.5-2-2; filed Mar 18, 1996, 11:00 a.m.: 19 IR 2041)*

ARTICLE 4. STATE INSTITUTIONS (EXPIRED)

(Expired under IC 4-22-2.5, effective January 1, 2002.)

ARTICLE 5. PUBLIC ASSISTANCE

NOTE: 460 IAC 5 was transferred from 470 IAC 8.1-3. Wherever in any promulgated text there appears a reference to 470 IAC 8.1-3, substitute 460 IAC 5-1.

Rule 1. Room and Board Assistance Program

460 IAC 5-1-1 Definitions (Expired)

Sec. 1. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 5-1-2 Interview of applicants and recipients (Expired)

Sec. 2. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 5-1-3 Place of application (Expired)

Sec. 3. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 5-1-4 Age requirement (Expired)

Sec. 4. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 5-1-5 Visual eligibility (Expired)

Sec. 5. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 5-1-6 Disability determination (Expired)

Sec. 6. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 5-1-7 United States citizenship or alienage requirement (Expired)

Sec. 7. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 5-1-8 Personal property ownership; limitations (Expired)

Sec. 8. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 5-1-9 Real property ownership; limitations (Expired)

Sec. 9. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 5-1-10 Life care contracts (Expired)

Sec. 10. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 5-1-11 Income of applicant or recipient; calculation (Expired)

Sec. 11. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 5-1-12 Income of spouse; inclusion (Expired)

Sec. 12. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 5-1-13 Income eligibility

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-6

Sec. 13. (a) An applicant's or recipient's income eligibility for room and board assistance shall be determined by the procedures in this section.

(b) The following requirements apply to a single applicant or recipient:

(1) Determine the applicant's or recipient's countable income under section 11 of this rule.

(2) Subtract from the total amount determined in subdivision (1), fifty dollars ($50) for the personal needs of the applicant or recipient.

(3) Subtract the established room and board rate from the amount determined in subdivision (2).

(4) If the remainder is less than zero dollars ($0), the applicant or recipient is eligible for room and board assistance.

(5) If the remainder is zero dollars ($0) or more, the applicant or recipient is ineligible for room and board assistance.

(c) The following requirements apply to married applicants or recipients residing in the room and board facility:

(1) Determine separately each spouse's countable income under section 11 of this rule.

(2) Subtract from each spouse's total amount determined in subdivision (1), fifty dollars ($50) for the spouse's personal needs.

(3) Subtract the established room and board rate from the amount determined in subdivision (2) for each spouse.

(4) If each spouse's remainder is less than zero dollars ($0), each spouse is eligible for room and board assistance.

(5) If one (1) spouse is ineligible, subtract the amount of his average monthly medical expenses from his remainder determined in subdivision (3).
(6) Add the remainder determined in subdivision (5) to the eligible spouse's countable income *[sic.]* subdivision (1).
(7) Subtract from the total amount determined in subdivision (6), fifty dollars ($50) for personal needs.
(8) Subtract the established room and board rate from the amount determined in subdivision (7).
(9) If the remainder is less than zero dollars ($0), the spouse is eligible for room and board assistance.
(10) If the remainder is zero dollars ($0) or more, both spouses are ineligible for room and board assistance.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 5-1-13; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1007, eff Apr 1, 1984; filed Sep 22, 1988, 2:30 p.m.: 12 IR 294; filed Feb 23, 1998, 11:30 a.m.: 21 IR 2385; filed Mar 13, 2000, 7:50 a.m.: 23 IR 1992) NOTE: Transferred from the Division of Family and Children (470 IAC 8.1-3-13) to the Division of Aging and Rehabilitative Services (460 IAC 5-1-13) by P.L.9-1991, SECTION 130, effective January 1, 1992.

460 IAC 5-1-14 Rate of payment (Repealed)

Sec. 14. *(Repealed by Division of Aging and Rehabilitative Services; filed Jun 3, 1992, 9:00 a.m.: 15 IR 2211)*

460 IAC 5-1-15 Payment of room and board assistance (Expired)

Sec. 15. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 5-1-16 Replacement of lost or stolen warrants (Expired)

Sec. 16. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

460 IAC 5-1-17 Accounting for personal needs funds (Expired)

Sec. 17. *(Expired under IC 4-22-2.5, effective January 1, 2002.)*

*