A bill for an act

relating to appropriations; appropriating money for health and human services for certain programs and grants; appropriating money for various state agencies; changing certain health, human services, and safety-related provisions; amending Minnesota Statutes 2006, sections 13.3806, by adding a subdivision; 16B.61, by adding a subdivision; 103I.101, subdivision 6; 103I.208, subdivisions 1, 2; 103I.235, subdivision 1; 144.123; 144.125; 144.2215, subdivision 1; 144.9502, subdivision 3; 144.9504, subdivision 2; 144.9507, by adding a subdivision; 144.9512; 144E.101, subdivision 6; 144E.127; 144E.35, subdivision 1; 145A.17; 156.001, by adding a subdivision; 156.02, subdivisions 1, 2; 156.04; 156.072, subdivision 2; 156.073; 156.12, subdivisions 2, 4, 6; 156.15, subdivision 2; 156.16, subdivisions 3, 10; 156.18, subdivisions 1, 2; 156.19; 198.075; 256B.0625, subdivision 14, by adding a subdivision; 256K.45, by adding a subdivision; 462A.21, subdivision 8b; 462A.33, subdivision 3; 469.021; Laws 2005, First Special Session chapter 4, article 9, section 3, subdivision 2; proposing coding for new law in Minnesota Statutes, chapters 144; 156; 325; 325E; repealing Laws 2004, chapter 288, article 6, section 27.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

HUMAN SERVICES APPROPRIATIONS

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	2008	**2009**	**Total**
General	$ 24,725,000	$ 24,225,000	$ 48,950,000
TANF	$ 750,000	$ 750,000	$ 1,500,000
Total	**$ 25,475,000**	**$ 24,975,000**	**$ 50,450,000**

Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2008" and "2009" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2008, or June 30, 2009, respectively. "The first year" is fiscal year 2008. "The second year" is fiscal year 2009. "The biennium" is fiscal years 2008 and 2009. Appropriations for the fiscal year ending June 30, 2007, are effective the day following final enactment.

	APPROPRIATIONS Available for the Year Ending June 30	
	2008	**2009**
Sec. 3. **HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ 25,475,000**	**$ 24,975,000**
Appropriations by Fund		
	2008	2009
General	24,725,000	24,225,000
TANF	750,000	750,000

Of this amount, $750,000 the first year and $750,000 the second year are onetime appropriations from the state's federal TANF block grant under Title I of Public Law 104-193. If the appropriation in either year is insufficient, the appropriation for the other year is available.

Subd. 2. **Other Children and Economic Assistance Grants**

Homeless and Runaway Youth. $3,500,000 in the first year and $3,500,000 in the second year are for the Runaway and Homeless Youth Act under Minnesota Statutes, section 256K.45. Funds shall be spent in each area of the continuum of care to ensure that programs are meeting the greatest need. The base is decreased by $2,000,000 each year in fiscal year 2010 and fiscal year 2011.

Transitional Housing and Emergency Services.

(1) $750,000 each year from the federal TANF fund is for transitional housing programs under Minnesota Statutes, section 256E.33. The TANF appropriations are onetime. The general fund base for transitional housing is increased by $422,000 each year for the fiscal 2010-2011 biennium. Up to ten percent of this appropriation may be used for housing and services which extend beyond 24 months. $300,000 in each year of this amount is for grants for safe housing pilot projects for battered women and families in Anoka County, Houston County, and Beltrami County; and

(2) $527,000 each year is added to the base for emergency services grants under Laws 1997, chapter 162, article 3, section 7. The base for emergency services grants is decreased each year by $300,000 in fiscal year 2010 and fiscal year 2011.

Foodshelf Programs. $575,000 each year is added to the base for foodshelf programs under Minnesota Statutes, section 256E.34. The base is decreased by $250,000 each year in fiscal year 2010 and fiscal year 2011.

Long-term Homeless Services. $2,440,000 each year is added to the base for the long-term homeless services under Minnesota Statutes, section 256K.26. The base is decreased by $1,000,000 each year in fiscal year 2010 and fiscal year 2011.

Minnesota Community Action Grants. $1,500,000 each year is added to the base for

the purposes of Minnesota community action grants under Minnesota Statutes, sections 256E.30 to 256E.32. The base is reduced by $500,000 each year in fiscal year 2010 and fiscal year 2011.

Tenant Hotline Services Program. $50,000 each year is added to the base for a grant to HOME Line for the tenant hotline services program. This is a onetime appropriation.

Subd. 3. **Children and Economic Assistance Administration**	100,000	100,000

Sec. 4. Minnesota Statutes 2006, section 256K.45, is amended by adding a subdivision to read:

Subd. 6. **Funding.** Any funds appropriated for this section may be expended on programs described under subdivisions 3 to 5, technical assistance, and capacity building. In addition, up to five percent of funds appropriated may be used for program administration and up to eight percent of funds appropriated may be used for the purpose of monitoring and evaluating runaway and homeless youth programs receiving funding under this section. Funding shall be directed to meet the greatest need, with a significant share of the funding focused on homeless youth providers in greater Minnesota.

Sec. 5. **DIRECTION TO COMMISSIONER.**

(a) The commissioner of human services shall offer a request for proposals to identify a research and evaluation firm with experience working with:

(1) homeless youth providers;

(2) data; and

(3) the topics of housing, homelessness, and a continuum of care for youth.

(b) The research and evaluation firm identified under paragraph (a) shall monitor and evaluate the programs receiving funding under Minnesota Statutes, section 256K.45.

ARTICLE 2
DEPARTMENT OF HEALTH APPROPRIATIONS

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	2008	2009	Total
General	$ 80,917,000	$ 75,503,000	$ 156,240,000
State Government Special Revenue	$ 26,542,000	$ 27,333,000	$ 53,875,000
Health Care Access	$ 3,648,000	$ 3,718,000	$ 7,366,000
Federal TANF	$ 11,350,000	$ 12,000,000	$ 23,350,000
Environmental Fund	$ 300,000	$ 300,000	$ 600,000
Total	**$ 122,757,000**	**$ 118,854,000**	**$ 241,611,000**

Sec. 2. **DEPARTMENT OF HEALTH APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2008" and "2009" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2008, or June 30, 2009, respectively. "The first year" is fiscal year 2008. "The second year" is fiscal year 2009. "The biennium" is fiscal years 2008 and 2009. Appropriations for the fiscal year ending June 30, 2007, are effective the day following final enactment.

	APPROPRIATIONS Available for the Year Ending June 30	
	2008	**2009**

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation**	**$ 122,757,000**	**$ 118,854,000**

Appropriations by Fund

	2008	2009
General	80,917,000	75,503,000
State Government Special Revenue	26,542,000	27,333,000
Health Care Access	3,648,000	3,718,000
Federal TANF	11,350,000	12,000,000
Environmental Fund	300,000	300,000

Subd. 2. **Community and Family Health Promotion**

Appropriations by Fund

General	46,324,000	46,060,000
State Government Special Revenue	468,000	471,000

Health Care Access	3,602,000	3,625,000
Federal TANF	8,667,000	9,002,000

TANF Appropriations. (a) $3,579,000 of the TANF funds is appropriated in each year of the biennium to the commissioner for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funding shall be distributed to community health boards based on Minnesota Statutes, section 145A.131, subdivision 1.

(b) $5,088,000 in the first year and $5,423,000 in the second year are appropriated to the commissioner of health for the family home visiting grant program. The commissioner shall distribute funds to community health boards using a formula developed in conjunction with the state Community Health Services Advisory Committee. The commissioner may use five percent of the funds appropriated in each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and may use ten percent of the funds appropriated each fiscal year to provide training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

TANF Carryforward. Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

Loan Forgiveness. $605,000 the first year and $775,000 the second year and thereafter are for the loan forgiveness program under

Minnesota Statutes, section 144.1501. This funding is in addition to the loan forgiveness program base.

MN ENABL. Base level funding for the MN ENABL program, under Minnesota Statutes, section 145.9255, is reduced by $220,000 each year of the biennium beginning July 1, 2007.

Positive Alternatives. Base level funding for the positive abortion alternatives program, under Minnesota Statutes, section 145.4235, is reduced by $1,400,000 each year of the biennium beginning July 1, 2007.

Fetal Alcohol Spectrum Disorder. (a) $900,000 each year is added to the base for fetal alcohol spectrum disorder. On July 1 each fiscal year, the portion of the general fund appropriation to the commissioner of health for fetal alcohol spectrum disorder administration and grants shall be transferred to a statewide organization that focuses solely on prevention of and intervention with fetal alcohol spectrum disorder as follows:

(1) on July 1, 2007, $2,090,000; and

(2) on July 2, 2008, and annually thereafter, $2,090,000.

(b) The money shall be used for prevention and intervention services and programs, including, but not limited to, community grants, professional education, public awareness, and diagnosis. The organization may retain $60,000 of the transferred money for administrative costs. The organization shall report to the commissioner annually

by January 15 on the services and programs funded by the appropriation.

Deaf or Hearing Loss Support. $100,000 for the first year and $100,000 for the second year is for the purpose of providing family support and assistance to families with children who are deaf or have a hearing loss. The family support provided must include direct parent-to-parent assistance and information on communication, educational, and medical options. The commissioner may contract with a nonprofit organization that has the ability to provide these services throughout the state.

Heart Disease and Stroke Prevention. $200,000 is appropriated in the first year for the heart disease and stroke prevention unit of the Department of Health to fund data collection and other activities to improve cardiovascular health and reduce the burden of heart disease and stroke in Minnesota. This is a onetime appropriation.

Family Planning Grants. $1,000,000 each year is for family planning grants under Minnesota Statutes, section 145.925.

Bright Smiles Pilot Project. (a) $384,000 in the first year and $50,000 in the second year is to fund a grant for the Bright Smiles pilot project.

(b) Of these amounts, $50,000 each year is to fund a dental health coordinator position.

(c) The commissioner of health shall establish a pilot project to fund a Bright Smiles program designed to increase access to oral health care for low-income and

immigrant children, ages birth to five years, and their families and to build the knowledge and ability of parents to care for the oral health of their children. Under this pilot project, a Bright Smiles program shall serve the medically underserved areas in Minneapolis and the Bemidji area, as determined by the commissioner of health.

(d) A grant shall be used to fund costs related to improving oral health outreach, education, screening, and access to care for families with children, ages birth to five years.

(e) Grant applicants shall submit to the commissioner a written plan that demonstrates the ability to provide the following:

(1) new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas of Minneapolis and the Bemidji area;

(2) programs for screening children entering the Minneapolis and the Bemidji area public school systems and facilitating access to care for their families;

(3) programs testing new models of care that are sensitive to cultural needs of the recipients;

(4) programs creating new educational campaigns that inform individuals of the importance of good oral health and the link between dental diseases, overall health status, and success in school; and

(5) programs testing new delivery models by creating partnerships between local early childhood and school-age education and community clinic dental providers.

(f) Qualified applicants are partnerships among early childhood experts, Minneapolis or Bemidji area public schools, and nonprofit clinics that are established to provide health services to low-income patients, provide preventive and dental care services, and utilize a sliding-scale fee or other method of providing charity care that ensures that no person is denied services because of inability to pay.

(g) Applicants shall submit to the commissioner an application and supporting documentation, in the form and manner specified by the commissioner. Applicants must be able to provide culturally appropriate outreach, screenings, and access to dental care for children, ages birth to five years, their parents, and pregnant women most at risk of poor oral health due to lack of access to dental care. Applicants must also meet the following criteria:

(1) have the potential to successfully increase access to families with children, ages birth to five years;

(2) incorporate quality program evaluation;

(3) maximize use of grant funds; and

(4) have experience in providing services to the target populations of this program.

(h) The commissioner shall evaluate the effectiveness of this pilot program on the

oral health of children and their families and report to the house of representatives and senate committees with jurisdiction over public health policy and finance by January 1, 2009, with recommendations as to how to develop programs throughout Minnesota that provide education and access to oral health care for low-income and immigrant children.

Suicide prevention programs. $600,000 each year is to fund the suicide prevention program and to administer the grants for institutions of higher education in the state of Minnesota to coordinate implementation of youth suicide early intervention and prevention strategies. The base for fiscal years 2010 and 2011 is reduced by $300,000.

Subd. 3. **Policy Quality and Compliance**

	Appropriations by Fund	
General	12,000	24,000
SGSR	94,000	188,000
HCAF	46,000	93,000

Subd. 4. **Health Protection**

	Appropriations by Fund	
General	18,393,000	13,269,000
State Government Special Revenue	25,980,000	26,674,000
Environmental	300,000	300,000

Pandemic Influenza Preparedness. Of the general fund appropriation to the commissioner, $4,088,000 in fiscal year 2008 is for preparation, planning, and response to a pandemic influenza outbreak. This appropriation is available until June 30, 2009.

Base funding for the 2010-2011 biennium is $0 each fiscal year.

Environmental Health Tracking and Biomonitoring. (a) $700,000 in each year is to the Department of Health for the environmental health tracking and biomonitoring program. The base for fiscal year 2010 and fiscal year 2011 is increased by $300,000 each year.

(b) $300,000 each year is from the environmental fund to the Pollution Control Agency for transfer to the Department of Health for the health tracking and biomonitoring program. The base for the environmental fund is $0 in fiscal year 2010 and after.

AIDS Prevention Initiative Focusing on African-born Residents. $300,000 in 2008 is for an AIDS prevention initiative focusing on African-born residents. This appropriation is a onetime appropriation and shall not become part of the base-level funding for the 2008-2009 biennium.

The commissioner of health shall award grants in accordance with Minnesota Statutes, section 145.924, paragraph (b), for a public education and awareness campaign targeting communities of African-born Minnesota residents. The grants shall be designed to promote knowledge and understanding about HIV and to increase knowledge in order to eliminate and reduce the risk for HIV infection; to encourage screening and testing for HIV; and to link individuals to public health and health care resources. The grants must be awarded to collaborative efforts that bring together nonprofit community-based

groups with demonstrated experience in addressing the public health, health care, and social service needs of African-born communities.

Water Level Standard for Atrazine. $200,000 in 2008 is for a study relating to atrazine health risk limit standards under Minnesota Statutes, section 144.355. This is a onetime appropriation.

Arsenic Health Risk Standard. $920,000 in the first year and $461,000 in the second year is to fund the study relating to arsenic health risk standards, under Minnesota Statutes, section 144.967.

Lindane and Bisphenol-A Studies. $114,000 in the first year is for the Lindane committee and the study of bisphenol-A, under Minnesota Statutes, section 325.72. This is a onetime appropriation.

Decabromodiphenyl Ether Study. $118,000 in the first year is for transfer to the commissioner of the pollution control agency for the study of decabromodiphenyl ether under Minnesota Statutes, section 325E.387. This is a onetime appropriation.

Radiation Study. $45,000 in the first year from the general fund and $15,000 in the first year from the state government special revenue fund are for the radiation study in section 60. This is a onetime appropriation.

Lead Abatement. $1,500,000 each year is for changes in lead abatement requirements. A portion of this amount may be used to reimburse local governments for costs of implementing the new requirements.

Water Treatment. $40,000 in the first year is for water treatment.

Environmental Justice Mapping. $137,000 in the first year and $53,000 in the second year is for environmental justice mapping.

HIV Information. $80,000 each year is to fund a community-based nonprofit organization with demonstrated capacity to operate a statewide HIV information and referral service using telephone, Internet, and other appropriate technologies.

Lead Hazard Reduction. $250,000 is appropriated in the first year of the biennium for a grant to a nonprofit organization operating the CLEARCorps to conduct a pilot project to determine the incidence of lead hazards in pre-1978 rental property. Any balance in the first year does not cancel but is available in the second year.

Minnesota Birth Defects Information System. $750,000 each year is to maintain the birth defects information system that was established by Minnesota Statutes, section 144.2215.

Subd. 5. **Minority and Multicultural Health**

	Appropriations by Fund	
General	5,042,000	5,052,000
Federal TANF	2,421,000	2,421,000

TANF Appropriations. (a) $2,421,000 of the TANF funds is appropriated in each year of the biennium to the commissioner for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funding shall be distributed to tribal governments

based on Minnesota Statutes, section 145A.14, subdivision 2a, paragraph (b).

(b) $262,000 in the first year and $577,000 in the second year are appropriated to the commissioner of health for the family home visiting grant program. The commissioner shall distribute funds to tribal governments using a formula developed in conjunction with tribal governments. The commissioner may use five percent of the funds appropriated in each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and may use ten percent of the funds appropriated each fiscal year to provide training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

TANF Carryforward. Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

Subd. 6. **Administrative Support Services**

	Appropriations by Fund	
General	11,047,000	11,197,000

Disease Surveillance. $2,000,000 each fiscal year is for redesigning and implementing coordinated and modern disease surveillance systems for the department. Base level funding for the 2012-2013 biennium will be $600,000 each fiscal year for maintaining and operating the systems.

Sec. 4. **VETERANS NURSING HOMES BOARD** **$ 44,124,000 $ 46,244,000**

Repair and Betterment. Of this appropriation, $4,000,000 in fiscal year 2008 and $4,000,000 in fiscal year 2009 are to be used for repair, maintenance, rehabilitation, and betterment activities at facilities statewide.

Base Adjustment. The general fund base is decreased by $2,000,000 in fiscal year 2010 and $2,000,000 in fiscal year 2011.

Sec. 5. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation; State Government Special Revenue Fund**	**$ 14,654,000**	**$ 14,527,000**

The commissioner of finance shall not permit the allotment, encumbrance, or expenditure of money appropriated in this section in excess of the anticipated biennial revenues or accumulated surplus revenues from fees collected by the boards.

Subd. 2. **Board of Chiropractic Examiners**	450,000	447,000
Subd. 3. **Board of Dentistry**	987,000	1,009,000
Subd. 4. **Board of Dietetic and Nutrition Practice**	103,000	119,000

Base Adjustment. Of this appropriation in fiscal year 2009, $14,000 is onetime.

Subd. 5. **Board of Marriage and Family Therapy**	134,000	154,000

Base Adjustment. Of this appropriation in fiscal year 2009, $17,000 is onetime.

Subd. 6. **Board of Medical Practice**	4,120,000	3,674,000
Subd. 7. **Board of Nursing**	3,985,000	4,146,000
Subd. 8. **Board of Nursing Home Administrators**	633,000	647,000

Administrative Services Unit. Of this appropriation, $430,000 in fiscal year 2008 and $439,000 in fiscal year 2009 are for the administrative services unit. The administrative services unit may receive and expend reimbursements for services performed by other agencies.

Subd. 9. **Board of Optometry**	98,000	114,000

Base Adjustment. Of this appropriation in fiscal year 2009, $13,000 is onetime.

Subd. 10. **Board of Pharmacy**	1,375,000	1,442,000

Base Adjustment. Of this appropriation in fiscal year 2009, $29,000 is onetime.

Subd. 11. **Board of Physical Therapy**	306,000	295,000
Subd. 12. **Board of Podiatry**	54,000	63,000

Base Adjustment. Of this appropriation in fiscal year 2009, $7,000 is onetime.

Subd. 13. **Board of Psychology**	788,000	806,000
Subd. 14. **Board of Social Work**	997,000	1,022,000
Subd. 15. **Board of Veterinary Medicine**	230,000	195,000
Subd. 16. **Board of Behavioral Health and Therapy**	394,000	394,000

Sec. 6. **EMERGENCY MEDICAL SERVICES BOARD**	**$ 3,710,000**	**$ 3,745,000**

Appropriations by Fund

	2008	2009
General	3,023,000	3,041,000
State Government Special Revenue	687,000	704,000

Regional Emergency Medical Services Programs. $400,000 each year is for regional emergency medical services programs, to be distributed equally to the

eight emergency medical service regions. This amount shall be added to the base funding. Notwithstanding Minnesota Statutes, section 144E.50, 100 percent of the appropriation shall be passed on to the emergency medical service regions.

Health Professional Services Program. $687,000 in fiscal year 2008 and $704,000 in fiscal year 2009 from the state government special revenue fund are for the health professional services program.

Sec. 7. **COUNCIL ON DISABILITY** **$ 582,000 $ 590,000**

Options Too. (a) $75,000 for the first year and $75,000 for the second year are to continue the work of the Options Too disability services interagency work group established under Laws 2005, First Special Session chapter 4, article 7, section 57. Funds shall be used to monitor and assist the work group and the Options Too Steering Committee in the implementation of the recommendations in the Options Too report dated February 15, 2007.

(b) For purposes of this section, the Options Too Steering Committee shall consist of the following members:

(1) a representative from the Minnesota Housing Finance Agency;

(2) a representative from the Minnesota State Council on Disability;

(3) a representative from the Department of Veterans Affairs;

(4) a representative from the Department of Transportation;

(5) a representative from the Department of Human Services; and

(6) representatives from interested stakeholders including counties, local public housing authorities, the Metropolitan Council, disability service providers, and disability advocacy organizations who are appointed by the Minnesota State Council on Disability for two-year terms.

(c) Notwithstanding Laws 2005, First Special Session chapter 4, article 7, section 57, the interagency work group shall be administered by the Minnesota Housing Finance Agency, the Minnesota State Council on Disability, Department of Human Services, and the Department of Transportation.

(d) The Options Too Steering Committee shall report to the chairs of the health and human services policy and finance committees of the senate and house of representatives by October 15, 2007, and October 15, 2008, on the continued progress of the work group towards implementing the recommendations in the Options Too report dated February 15, 2007.

Sec. 8. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 1,567,000 $ 1,621,000**

Sec. 9. **OMBUDSMAN FOR FAMILIES** **$ 251,000 $ 257,000**

Sec. 10. Minnesota Statutes 2006, section 13.3806, is amended by adding a subdivision to read:

Subd. 21. **Birth defects registry system.** Data on individuals collected by the birth defects registry system are private data on individuals and classified pursuant to section 144.2215.

Sec. 11. Minnesota Statutes 2006, section 16B.61, is amended by adding a subdivision to read:

Subd. 3b. **Window fall prevention device code.** The commissioner of labor and industry shall adopt rules for window fall prevention devices as part of the state Building Code. Window fall prevention devices include, but are not limited to, safety screens, hardware, guards, and other devices that comply with the standards established by the commissioner of labor and industry. The rules must require compliance with standards for window fall prevention devices developed by ASTM International, contained in the International Building Code as the model language with amendments deemed necessary to coordinate with the other adopted building codes in Minnesota. The rules must establish a scope that includes the applicable building occupancies, and the types, locations, and sizes of windows that will require the installation of fall devices. The rules will be effective July 1, 2009. The commissioner shall report to the legislature on the status of the rulemaking on or before February 15, 2008.

Sec. 12. Minnesota Statutes 2006, section 103I.101, subdivision 6, is amended to read:

Subd. 6. **Fees for variances.** The commissioner shall charge a nonrefundable application fee of ~~$175~~ $215 to cover the administrative cost of processing a request for a variance or modification of rules adopted by the commissioner under this chapter.

EFFECTIVE DATE. This section is effective July 1, 2008.

Sec. 13. Minnesota Statutes 2006, section 103I.208, subdivision 1, is amended to read:

Subdivision 1. **Well notification fee.** The well notification fee to be paid by a property owner is:

(1) for a new water supply well, ~~$175~~ $215, which includes the state core function fee;

(2) for a well sealing, ~~$35~~ $50 for each well, which includes the state core function fee, except that for monitoring wells constructed on a single property, having depths within a 25 foot range, and sealed within 48 hours of start of construction, a single fee of ~~$35~~ $50; and

(3) for construction of a dewatering well, ~~$175~~ $215, which includes the state core function fee, for each dewatering well except a dewatering project comprising five or more dewatering wells shall be assessed a single fee of ~~$875~~ $1,075 for the dewatering wells recorded on the notification.

EFFECTIVE DATE. This section is effective July 1, 2008.

Sec. 14. Minnesota Statutes 2006, section 103I.208, subdivision 2, is amended to read:

Subd. 2. **Permit fee.** The permit fee to be paid by a property owner is:

(1) for a water supply well that is not in use under a maintenance permit, ~~$150~~ $175 annually;

(2) for construction of a monitoring well, ~~$175~~ $215, which includes the state core function fee;

(3) for a monitoring well that is unsealed under a maintenance permit, ~~$150~~ $175 annually;

(4) for monitoring wells used as a leak detection device at a single motor fuel retail outlet, a single petroleum bulk storage site excluding tank farms, or a single agricultural chemical facility site, the construction permit fee is ~~$175~~ $215, which includes the state core function fee, per site regardless of the number of wells constructed on the site, and the annual fee for a maintenance permit for unsealed monitoring wells is ~~$150~~ $175 per site regardless of the number of monitoring wells located on site;

(5) for a groundwater thermal exchange device, in addition to the notification fee for water supply wells, ~~$175~~ $215, which includes the state core function fee;

(6) for a vertical heat exchanger, ~~$175~~ $215;

(7) for a dewatering well that is unsealed under a maintenance permit, ~~$150~~ $175 annually for each dewatering well, except a dewatering project comprising more than five dewatering wells shall be issued a single permit for ~~$750~~ $875 annually for dewatering wells recorded on the permit; and

(8) for an elevator boring, ~~$175~~ $215 for each boring.

EFFECTIVE DATE. This section is effective July 1, 2008.

Sec. 15. Minnesota Statutes 2006, section 103I.235, subdivision 1, is amended to read:

Subdivision 1. **Disclosure of wells to buyer.** (a) Before signing an agreement to sell or transfer real property, the seller must disclose in writing to the buyer information about the status and location of all known wells on the property, by delivering to the buyer either a statement by the seller that the seller does not know of any wells on the property, or a disclosure statement indicating the legal description and county, and a map drawn from available information showing the location of each well to the extent practicable. In the disclosure statement, the seller must indicate, for each well, whether the well is in use, not in use, or sealed.

(b) At the time of closing of the sale, the disclosure statement information, name and mailing address of the buyer, and the quartile, section, township, and range in which each

well is located must be provided on a well disclosure certificate signed by the seller or a person authorized to act on behalf of the seller.

(c) A well disclosure certificate need not be provided if the seller does not know of any wells on the property and the deed or other instrument of conveyance contains the statement: "The Seller certifies that the Seller does not know of any wells on the described real property."

(d) If a deed is given pursuant to a contract for deed, the well disclosure certificate required by this subdivision shall be signed by the buyer or a person authorized to act on behalf of the buyer. If the buyer knows of no wells on the property, a well disclosure certificate is not required if the following statement appears on the deed followed by the signature of the grantee or, if there is more than one grantee, the signature of at least one of the grantees: "The Grantee certifies that the Grantee does not know of any wells on the described real property." The statement and signature of the grantee may be on the front or back of the deed or on an attached sheet and an acknowledgment of the statement by the grantee is not required for the deed to be recordable.

(e) This subdivision does not apply to the sale, exchange, or transfer of real property:

(1) that consists solely of a sale or transfer of severed mineral interests; or

(2) that consists of an individual condominium unit as described in chapters 515 and 515B.

(f) For an area owned in common under chapter 515 or 515B the association or other responsible person must report to the commissioner by July 1, 1992, the location and status of all wells in the common area. The association or other responsible person must notify the commissioner within 30 days of any change in the reported status of wells.

(g) For real property sold by the state under section 92.67, the lessee at the time of the sale is responsible for compliance with this subdivision.

(h) If the seller fails to provide a required well disclosure certificate, the buyer, or a person authorized to act on behalf of the buyer, may sign a well disclosure certificate based on the information provided on the disclosure statement required by this section or based on other available information.

(i) A county recorder or registrar of titles may not record a deed or other instrument of conveyance dated after October 31, 1990, for which a certificate of value is required under section 272.115, or any deed or other instrument of conveyance dated after October 31, 1990, from a governmental body exempt from the payment of state deed tax, unless the deed or other instrument of conveyance contains the statement made in accordance with paragraph (c) or (d) or is accompanied by the well disclosure certificate containing all the information required by paragraph (b) or (d). The county recorder or registrar of titles

must not accept a certificate unless it contains all the required information. The county recorder or registrar of titles shall note on each deed or other instrument of conveyance accompanied by a well disclosure certificate that the well disclosure certificate was received. The notation must include the statement "No wells on property" if the disclosure certificate states there are no wells on the property. The well disclosure certificate shall not be filed or recorded in the records maintained by the county recorder or registrar of titles. After noting "No wells on property" on the deed or other instrument of conveyance, the county recorder or registrar of titles shall destroy or return to the buyer the well disclosure certificate. The county recorder or registrar of titles shall collect from the buyer or the person seeking to record a deed or other instrument of conveyance, a fee of ~~$40~~ $45 for receipt of a completed well disclosure certificate. By the tenth day of each month, the county recorder or registrar of titles shall transmit the well disclosure certificates to the commissioner of health. By the tenth day after the end of each calendar quarter, the county recorder or registrar of titles shall transmit to the commissioner of health ~~$32.50~~ $37.50 of the fee for each well disclosure certificate received during the quarter. The commissioner shall maintain the well disclosure certificate for at least six years. The commissioner may store the certificate as an electronic image. A copy of that image shall be as valid as the original.

(j) No new well disclosure certificate is required under this subdivision if the buyer or seller, or a person authorized to act on behalf of the buyer or seller, certifies on the deed or other instrument of conveyance that the status and number of wells on the property have not changed since the last previously filed well disclosure certificate. The following statement, if followed by the signature of the person making the statement, is sufficient to comply with the certification requirement of this paragraph: "I am familiar with the property described in this instrument and I certify that the status and number of wells on the described real property have not changed since the last previously filed well disclosure certificate." The certification and signature may be on the front or back of the deed or on an attached sheet and an acknowledgment of the statement is not required for the deed or other instrument of conveyance to be recordable.

(k) The commissioner in consultation with county recorders shall prescribe the form for a well disclosure certificate and provide well disclosure certificate forms to county recorders and registrars of titles and other interested persons.

(l) Failure to comply with a requirement of this subdivision does not impair:

(1) the validity of a deed or other instrument of conveyance as between the parties to the deed or instrument or as to any other person who otherwise would be bound by the deed or instrument; or

(2) the record, as notice, of any deed or other instrument of conveyance accepted for filing or recording contrary to the provisions of this subdivision.

EFFECTIVE DATE. This section is effective July 1, 2008.

Sec. 16. Minnesota Statutes 2006, section 144.123, is amended to read:

144.123 FEES FOR DIAGNOSTIC LABORATORY SERVICES; EXCEPTIONS.

Subdivision 1. **Who must pay.** Except for the limitation contained in this section, the commissioner of health shall charge a handling fee for each specimen submitted to the Department of Health for analysis for diagnostic purposes by any hospital, private laboratory, private clinic, or physician. No fee shall be charged to any entity which receives direct or indirect financial assistance from state or federal funds administered by the Department of Health, including any public health department, nonprofit community clinic, ~~venereal~~ sexually transmitted disease clinic, ~~family planning clinic,~~ or similar entity. No fee will be charged for any biological materials submitted to the Department of Health as a requirement of Minnesota Rules, part 4605.7040, or for those biological materials requested by the department to gather information for disease prevention or control purposes. The commissioner of health may establish ~~by rule~~ other exceptions to the handling fee as may be necessary to ~~gather information for epidemiologic purposes~~ protect the public's health. All fees collected pursuant to this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Subd. 2. ~~**Rules for**~~ **Fee amounts.** The commissioner of health shall ~~promulgate rules, in accordance with chapter 14, which shall specify the amount of the~~ charge a handling fee prescribed in subdivision 1. The fee shall approximate the costs to the department of handling specimens including reporting, postage, specimen kit preparation, and overhead costs. The fee prescribed in subdivision 1 shall be ~~$15~~ $25 per specimen ~~until the commissioner promulgates rules pursuant to this subdivision~~.

Sec. 17. Minnesota Statutes 2006, section 144.125, is amended to read:

144.125 TESTS OF INFANTS FOR HERITABLE AND CONGENITAL DISORDERS.

Subdivision 1. **Duty to perform testing.** It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the

birth, to arrange to have administered to every infant or child in its care tests for heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health. Testing and the recording and reporting of test results shall be performed at the times and in the manner prescribed by the commissioner of health. The commissioner shall charge ~~laboratory service fees~~ a fee so that the total of fees collected will approximate the costs of conducting the tests and implementing and maintaining a system to follow-up infants with heritable or congenital disorders. The ~~laboratory service~~ fee is ~~$61~~ $101 per specimen. Costs associated with capital expenditures and the development of new procedures may be prorated over a three-year period when calculating the amount of the fees.

Subd. 2. **Determination of tests to be administered.** The commissioner shall periodically revise the list of tests to be administered for determining the presence of a heritable or congenital disorder. Revisions to the list shall reflect advances in medical science, new and improved testing methods, or other factors that will improve the public health. In determining whether a test must be administered, the commissioner shall take into consideration the adequacy of ~~laboratory~~ analytical methods to detect the heritable or congenital disorder, the ability to treat or prevent medical conditions caused by the heritable or congenital disorder, and the severity of the medical conditions caused by the heritable or congenital disorder. The list of tests to be performed may be revised if the changes are recommended by the advisory committee established under section 144.1255, approved by the commissioner, and published in the State Register. The revision is exempt from the rulemaking requirements in chapter 14, and sections 14.385 and 14.386 do not apply.

Subd. 3. **Objection of parents to test.** Persons with a duty to perform testing under subdivision 1 shall advise parents of infants (1) that the blood or tissue samples used to perform testing thereunder as well as the results of such testing may be retained by the Department of Health, (2) the benefit of retaining the blood or tissue sample, and (3) that the following options are available to them with respect to the testing: (i) to decline to have the tests, or (ii) to elect to have the tests but to require that all blood samples and records of test results be destroyed within 24 months of the testing. If the parents of an infant object in writing to testing for heritable and congenital disorders or elect to require that blood samples and test results be destroyed, the objection or election shall be recorded on a form that is signed by a parent or legal guardian and made part of the infant's medical record. A written objection exempts an infant from the requirements of this section and section 144.128.

Sec. 18. Minnesota Statutes 2006, section 144.2215, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** Within the limits of available appropriations, the commissioner of health shall establish and maintain an information system containing data on the cause, treatment, prevention, and cure of major birth defects. The commissioner shall consult with representatives and experts in epidemiology, medicine, insurance, health maintenance organizations, genetics, consumers, and voluntary organizations in developing the system and may phase in the implementation of the system. After the parents have provided informed consent under section 144.2216, subdivision 4, the commissioner shall offer the parents with their informed consent a visit by a trained health care worker to interview the parents about:

(1) all previous home addresses, occupations, and places of work including from childhood;

(2) the time and place of any military service; and

(3) known occasions or sites of toxic exposures.

Sec. 19. **[144.355] WATER LEVEL STANDARD FOR ATRAZINE.**

(a) The Department of Health in consultation with the Pollution Control Agency shall set atrazine drinking water standards for the health risk limit in private wells and the maximum contaminant level in public water systems at three ppb to comply with the federal standard determined by the United States Environmental Protection Agency.

(b) By December 31, 2007, the Department of Health in consultation with the Pollution Control Agency shall use current scientific evidence to set the drinking water standards for the health risk limit of atrazine in private wells and the maximum contaminant level of atrazine in public water systems at a level not to exceed one ppb to reflect the requirements in section 144.0751 to adequately protect the health of a developing fetus, infant, and child which requires a higher level of care due to fetal, infant, and child development.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 20. Minnesota Statutes 2006, section 144.9502, subdivision 3, is amended to read:

Subd. 3. **Reports of blood lead analysis required.** (a) Every hospital, medical clinic, medical laboratory, other facility, or individual performing blood lead analysis shall report the results after the analysis of each specimen analyzed, for both capillary and venous specimens, and epidemiologic information required in this section to the commissioner of health, within the time frames set forth in clauses (1) and (2):

(1) within two working days by telephone, fax, or electronic transmission, with written or electronic confirmation within one month, for a venous blood lead level equal to or greater than ~~15~~ ten micrograms of lead per deciliter of whole blood; or

(2) within one month in writing or by electronic transmission, for any capillary result or for a venous blood lead level less than ~~15~~ ten micrograms of lead per deciliter of whole blood.

(b) If a blood lead analysis is performed outside of Minnesota and the facility performing the analysis does not report the blood lead analysis results and epidemiological information required in this section to the commissioner, the provider who collected the blood specimen must satisfy the reporting requirements of this section. For purposes of this section, "provider" has the meaning given in section 62D.02, subdivision 9.

(c) The commissioner shall coordinate with hospitals, medical clinics, medical laboratories, and other facilities performing blood lead analysis to develop a universal reporting form and mechanism.

Sec. 21. Minnesota Statutes 2006, section 144.9504, subdivision 2, is amended to read:

Subd. 2. **Lead risk assessment.** (a) An assessing agency shall conduct a lead risk assessment of a residence according to the venous blood lead level and time frame set forth in clauses (1) to (4) for purposes of secondary prevention:

(1) within 48 hours of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than ~~60~~ 45 micrograms of lead per deciliter of whole blood;

(2) within five working days of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than ~~45~~ 15 micrograms of lead per deciliter of whole blood;

(3) within ten working days of a child in the residence being identified to the agency as having a venous blood lead level equal to or greater than ~~15~~ ten micrograms of lead per deciliter of whole blood; or

(4) within ten working days of a pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than ten micrograms of lead per deciliter of whole blood.

(b) Within the limits of available local, state, and federal appropriations, an assessing agency may also conduct a lead risk assessment for children with any elevated blood lead level.

(c) In a building with two or more dwelling units, an assessing agency shall assess the individual unit in which the conditions of this section are met and shall inspect all

common areas accessible to a child. If a child visits one or more other sites such as another residence, or a residential or commercial child care facility, playground, or school, the assessing agency shall also inspect the other sites. The assessing agency shall have one additional day added to the time frame set forth in this subdivision to complete the lead risk assessment for each additional site.

(d) Within the limits of appropriations, the assessing agency shall identify the known addresses for the previous 12 months of the child or pregnant female with venous blood lead levels of at least ~~15~~ ten micrograms per deciliter ~~for the child or at least ten micrograms per deciliter for the pregnant female~~; notify the property owners, landlords, and tenants at those addresses that an elevated blood lead level was found in a person who resided at the property; and give them primary prevention information. Within the limits of appropriations, the assessing agency may perform a risk assessment and issue corrective orders in the properties, if it is likely that the previous address contributed to the child's or pregnant female's blood lead level. The assessing agency shall provide the notice required by this subdivision without identifying the child or pregnant female with the elevated blood lead level. The assessing agency is not required to obtain the consent of the child's parent or guardian or the consent of the pregnant female for purposes of this subdivision. This information shall be classified as private data on individuals as defined under section 13.02, subdivision 12.

(e) The assessing agency shall conduct the lead risk assessment according to rules adopted by the commissioner under section 144.9508. An assessing agency shall have lead risk assessments performed by lead risk assessors licensed by the commissioner according to rules adopted under section 144.9508. If a property owner refuses to allow a lead risk assessment, the assessing agency shall begin legal proceedings to gain entry to the property and the time frame for conducting a lead risk assessment set forth in this subdivision no longer applies. A lead risk assessor or assessing agency may observe the performance of lead hazard reduction in progress and shall enforce the provisions of this section under section 144.9509. Deteriorated painted surfaces, bare soil, and dust must be tested with appropriate analytical equipment to determine the lead content, except that deteriorated painted surfaces or bare soil need not be tested if the property owner agrees to engage in lead hazard reduction on those surfaces. The lead content of drinking water must be measured if another probable source of lead exposure is not identified. Within a standard metropolitan statistical area, an assessing agency may order lead hazard reduction of bare soil without measuring the lead content of the bare soil if the property is in a census tract in which soil sampling has been performed according to rules established by

the commissioner and at least 25 percent of the soil samples contain lead concentrations above the standard in section 144.9508.

(f) Each assessing agency shall establish an administrative appeal procedure which allows a property owner to contest the nature and conditions of any lead order issued by the assessing agency. Assessing agencies must consider appeals that propose lower cost methods that make the residence lead safe. The commissioner shall use the authority and appeal procedure granted under sections 144.989 to 144.993.

(g) Sections 144.9501 to 144.9509 neither authorize nor prohibit an assessing agency from charging a property owner for the cost of a lead risk assessment.

Sec. 22. Minnesota Statutes 2006, section 144.9507, is amended by adding a subdivision to read:

Subd. 6. **Medical assistance.** Medical assistance reimbursement for lead risk assessment services under section 256B.0625, subdivision 49, shall not be used to replace or decrease existing state or local funding for lead services and lead-related activities.

Sec. 23. Minnesota Statutes 2006, section 144.9512, is amended to read:

144.9512 LEAD ABATEMENT PROGRAM.

Subdivision 1. **Definitions.** (a) The definitions in section 144.9501 and in this subdivision apply to this section.

(b) ~~"Eligible organization" means a lead contractor, city, board of health, community health department, community action agency as defined in section 256E.30, or community development corporation.~~

~~(c)~~ "Commissioner" means the commissioner of health~~, or the commissioner of the Minnesota Housing Finance Agency as authorized by section 462A.05, subdivision 15c~~.

Subd. 2. **Grants; administration.** Within the limits of the available appropriation, the commissioner ~~must develop a swab team services program which may~~ shall make ~~demonstration and training~~ grants to ~~eligible organizations~~ a nonprofit organization currently operating the CLEARCorps lead hazard reduction project to train workers to provide swab team services ~~and swab team services~~ for residential property. ~~Grants may be awarded to nonprofit organizations to provide technical assistance and training to ensure quality and consistency within the statewide program. Grants must be awarded to help ensure full-time employment to workers providing swab team services and must be awarded for a two-year period.~~

~~Grants awarded under this section must be made in consultation with the commissioner of the Housing Finance Agency and representatives of neighborhood~~

~~groups from areas at high risk for toxic lead exposure, a labor organization, the lead coalition, community action agencies, and the legal aid society. The consulting team must review grant applications and recommend awards to eligible organizations that meet requirements for receiving a grant under this section.~~

~~Subd. 3. **Applicants.** (a) Interested eligible organizations may apply to the commissioner for grants under this section. Two or more eligible organizations may jointly apply for a grant. Priority shall be given to community action agencies in greater Minnesota and to either community action agencies or neighborhood based nonprofit organizations in cities of the first class. Of the total annual appropriation, 12.5 percent may be used for administrative purposes. The commissioner may deviate from this percentage if a grantee can justify the need for a larger administrative allowance. Of this amount, up to five percent may be used by the commissioner for state administrative purposes. Applications must provide information requested by the commissioner, including at least the information required to assess the factors listed in paragraph (d).~~

~~(b) The commissioner must consult with boards of health to provide swab team services for purposes of secondary prevention. The priority for swab teams created by grants to eligible organizations under this section must be work assigned by the commissioner of health, or by a board of health if so designated by the commissioner of health, to provide secondary prevention swab team services to fulfill the requirements of section 144.9504, subdivision 6, in response to a lead order. Swab teams assigned work under this section by the commissioner, that are not engaged daily in fulfilling the requirements of section 144.9504, subdivision 6, must deliver swab team services in response to elevated blood lead levels as defined in section 144.9501, subdivision 9, where lead orders were not issued, and for purposes of primary prevention in census tracts known to be in areas at high risk for toxic lead exposure as described in section 144.9503, subdivision 2.~~

~~(c) Any additional money must be used for grants to establish swab teams for primary prevention under section 144.9503, in census tracts in areas at high risk for toxic lead exposure as determined under section 144.9503, subdivision 2.~~

~~(d) In evaluating grant applications, the commissioner must consider the following criteria:~~

~~(1) the use of lead contractors and lead workers for residential swab team services;~~

~~(2) the participation of neighborhood groups and individuals, as swab team workers, in areas at high risk for toxic lead exposure;~~

~~(3) plans for the provision of swab team services for primary and secondary prevention as required under subdivision 4;~~

~~(4) plans for supervision, training, career development, and postprogram placement of swab team members;~~

~~(5) plans for resident and property owner education on lead safety;~~

~~(6) plans for distributing cleaning supplies to area residents and educating residents and property owners on cleaning techniques;~~

~~(7) sources of other funding and cost estimates for training, lead inspections, swab team services, equipment, monitoring, testing, and administration;~~

~~(8) measures of program effectiveness;~~

~~(9) coordination of program activities with other federal, state, and local public health, job training, apprenticeship, and housing renovation programs including programs under sections 116L.86 to 116L.881; and~~

~~(10) prior experience in providing swab team services.~~

Subd. 4. **~~Lead supervisor or certified firm~~ Eligible grant activities.** (a) ~~Eligible organizations and lead supervisors or certified firms may participate in the swab team program. An eligible organization~~ The nonprofit receiving a grant under this section must ~~assure~~ ensure that all participating lead supervisors or certified firms are licensed and that all swab team workers are certified by the Department of Health under section 144.9505. ~~Eligible organizations and lead supervisors or certified firms may distinguish between interior and exterior services in assigning duties and~~ The nonprofit organization may participate in the program by:

(1) providing on-the-job training for swab team workers;

(2) providing swab team services to meet the requirements of sections 144.9503, subdivision 4, and 144.9504, subdivision 6;

(3) providing ~~a removal and replacement component using skilled craft workers under subdivision 7~~ lead hazard reduction to meet the requirements of section 144.9501, subdivision 17;

~~(4) providing lead testing according to subdivision 8;~~

~~(5)~~ (4) providing lead dust ~~cleaning supplies~~ cleanup equipment and materials, as described in section ~~144.9507~~ 144.9503, subdivision ~~4, paragraph (c)~~ 1, to residents; ~~or~~

~~(6)~~ (5) having a swab team worker instruct residents and property owners on appropriate lead control techniques, including the lead-safe directives developed by the commissioner of health~~.~~;

(6) conducting blood lead testing events including screening children and pregnant women according to Department of Health screening guidelines;

(7) performing case management services according to Department of Health case management guidelines; or

(8) conducting mandated risk assessments under Minnesota Statutes, section 144.9504, subdivision 2.

~~(b) Participating lead supervisors or certified firms must:~~

~~(1) demonstrate proof of workers' compensation and general liability insurance coverage;~~

~~(2) be knowledgeable about lead abatement requirements established by the Department of Housing and Urban Development and the Occupational Safety and Health Administration and lead hazard reduction requirements and lead-safe directives of the commissioner of health;~~

~~(3) demonstrate experience with on-the-job training programs;~~

~~(4) demonstrate an ability to recruit employees from areas at high risk for toxic lead exposure; and~~

~~(5) demonstrate experience in working with low-income clients.~~

Subd. 5. **Swab team workers.** Each worker engaged in swab team services established under this section must have blood lead concentrations below 15 micrograms of lead per deciliter of whole blood as determined by a baseline blood lead screening. ~~Any~~ The nonprofit organization receiving a grant under this section is responsible for lead screening and must ~~assure~~ ensure that all swab team workers meet the standards established in this subdivision. ~~Grantees~~ The nonprofit organization must use appropriate workplace procedures including following the lead-safe directives developed by the commissioner of health to reduce risk of elevated blood lead levels. ~~Grantees~~ The nonprofit organization and participating contractors must report all employee blood lead levels that exceed 15 micrograms of lead per deciliter of whole blood to the commissioner of health.

~~Subd. 6. **On-the-job training component.** (a) Programs established under this section must provide on-the-job training for swab team workers.~~

~~(b) Swab team workers must receive monetary compensation equal to the prevailing wage as defined in section 177.42, subdivision 6, for comparable jobs in the licensed contractor's principal business.~~

~~Subd. 7. **Removal and replacement component.** (a) Within the limits of the available appropriation and if a need is identified by a lead inspector, the commissioner may establish a component for removal and replacement of deteriorated paint in residential properties according to the following criteria:~~

~~(1) components within a residence must have both deteriorated lead-based paint and substrate damage beyond repair or rotting wooden framework to be eligible for removal and replacement;~~

~~(2) all removal and replacement must be done using least-cost methods and following lead-safe directives;~~

~~(3) whenever windows and doors or other components covered with deteriorated lead-based paint have sound substrate or are not rotting, those components should be repaired, sent out for stripping, planed down to remove deteriorated lead-based paint, or covered with protective guards instead of being replaced, provided that such an activity is the least-cost method of providing the swab team service;~~

~~(4) removal and replacement or repair must be done by lead contractors using skilled craft workers or trained swab team members; and~~

~~(5) all craft work that requires a state license must be supervised by a person with a state license in the craft work being supervised. The grant recipient may contract for this supervision.~~

~~(b) The program design must:~~

~~(1) identify the need for on-the-job training of swab team workers to be removal and replacement workers; and~~

~~(2) describe plans to involve appropriate groups in designing methods to meet the need for training swab team workers.~~

~~Subd. 8.~~ **~~Testing and evaluation.~~** ~~(a) Testing of the environment is not necessary by swab teams whose work is assigned by the commissioner of health or a designated board of health under section 144.9504. The commissioner of health or designated board of health must share the analytical testing data collected on each residence for purposes of secondary prevention under section 144.9504 with the swab team workers in order to provide constructive feedback on their work and to the commissioner for the purposes set forth in paragraph (c).~~

~~(b) For purposes of primary prevention evaluation, the following samples must be collected: pretesting and posttesting of one noncarpeted floor dust lead sample and a notation of the extent and location of bare soil and of deteriorated lead-based paint. The analytical testing data collected on each residence for purposes of primary prevention under section 144.9503 must be shared with the swab team workers in order to provide constructive feedback on their work and to the commissioner for the purposes set forth in paragraph (c).~~

~~(c) The commissioner of health must establish a program to collect appropriate data as required under paragraphs (a) and (b), in order to conduct an ongoing evaluation of swab team services for primary and secondary prevention. Within the limits of available appropriations, the commissioner of health must conduct on up to 1,000 residences which have received primary or secondary prevention swab team services, a postremediation~~

~~evaluation, on at least a quarterly basis for a period of at least two years for each residence. The evaluation must note the condition of the paint within the residence, the extent of bare soil on the grounds, and collect and analyze one noncarpeted floor dust lead sample. The data collected must be evaluated to determine the efficacy of providing swab team services as a method of reducing lead exposure in young children. In evaluating this data, the commissioner of health must consider city size, community location, historic traffic flow, soil lead level of the property by area or census tract, distance to industrial point sources that emit lead, season of the year, age of the housing, age and number of children living at the residence, the presence of pets that move in and out of the residence, and other relevant factors as the commissioner of health may determine.~~

Subd. 9. **Program benefits.** As a condition of providing swab team services under this section, ~~an~~ the nonprofit organization may require a property owner to not increase rents on a property solely as a result of a substantial improvement made with public funds under the programs in this section.

Subd. 10. **Requirements of ~~organizations receiving grants~~ the nonprofit organization.** ~~An eligible~~ The nonprofit organization that is awarded a ~~training and demonstration~~ grant under this section must prepare and submit a quarterly progress report to the commissioner beginning three months after receipt of the grant.

Sec. 24. **[144.966] EARLY HEARING DETECTION AND INTERVENTION ACT.**

Subdivision 1. **Definitions.** (a) "Child" means a person 18 years of age or younger.

(b) "False positive rate" means the proportion of infants identified as having a significant hearing loss by the screening process who are ultimately found to not have a significant hearing loss.

(c) "False negative rate" means the proportion of infants not identified as having a significant hearing loss by the screening process who are ultimately found to have a significant hearing loss.

(d) "Hearing screening test" means automated auditory brain stem response, otoacoustic emissions, or another appropriate screening test approved by the Department of Health.

(e) "Hospital" means a birthing health care facility or birthing center licensed in this state that provides obstetrical services.

(f) "Infant" means a child who is not a newborn and has not attained the age of one year.

(g) "Newborn" means an infant 28 days old or younger.

(h) "Parent" means a natural parent, stepparent, adoptive parent, guardian, or custodian of a newborn or infant.

Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The commissioner of health shall appoint a Newborn Hearing Screening Advisory Committee to advise and assist the Department of Health and the Department of Education in:

(1) developing protocols and timelines for screening, rescreening, and diagnostic audiological assessment and early medical, audiological, and educational intervention services for children who are deaf or hard-of-hearing;

(2) designing protocols for tracking children from birth through age three that may have passed newborn screening but are at risk for delayed or late onset of permanent hearing loss;

(3) designing a technical assistance program to support facilities implementing the screening program and facilities conducting rescreening and diagnostic audiological assessment;

(4) designing implementation and evaluation of a system of follow-up and tracking; and

(5) evaluating program outcomes to increase effectiveness and efficiency and ensure culturally appropriate services for children with a confirmed hearing loss and their families.

(b) Membership of the committee shall include at least one member from each of the following groups with no less than two of the members being deaf or hard-of-hearing:

(1) a representative from a consumer organization representing culturally deaf persons;

(2) a parent with a child with hearing loss representing a parent organization;

(3) a consumer from an organization representing oral communication options;

(4) a consumer from an organization representing cued speech communication options;

(5) an audiologist who has experience in evaluation and intervention of infants and young children;

(6) a speech-language pathologist who has experience in evaluation and intervention of infants and young children;

(7) two primary care providers who have experience in the care of infants and young children, one of which shall be a pediatrician;

(8) a representative from the early hearing detection intervention teams;

(9) a representative from the Department of Education resource center for the deaf and hard-of-hearing or their designee;

(10) a representative of the Minnesota Commission Serving Deaf and Hard of Hearing People;

(11) a representative from the Department of Human Services Deaf and Hard of Hearing Services Division;

(12) one or more of the Part C coordinators from the Department of Education, the Department of Health, or the Department of Human Services or their designee;

(13) the Department of Health early hearing detection and intervention coordinator;

(14) two birth hospital representatives from one rural and one urban hospital;

(15) a pediatric geneticist;

(16) an otolaryngologist;

(17) a representative from the Newborn Screening Advisory Committee under this subdivision; and

(18) a representative of the Department of Education regional low-incidence facilitators.

The Department of Health member shall chair the first meeting of the committee. At the first meeting, the committee shall elect a chairperson from its membership. The committee shall meet at the call of the chairperson, at least four times a year. The committee shall adopt written bylaws to govern its activities. The Department of Health shall provide technical and administrative support services as required by the committee. These services shall include technical support from individuals qualified to administer infant hearing screening, rescreening, and diagnostic audiological assessments.

Members of the committee shall receive no compensation for their service, but shall be reimbursed for expenses incurred as a result of their duties as members of the committee.

Subd. 3. **Newborn and infant hearing screening programs.** All hospitals shall establish a Universal Newborn Hearing and Infant Screening (UNHS) program. Each UNHS program shall:

(1) in advance of any hearing screening testing, provide to the newborn's or infant's parents information concerning the nature of the screening procedure, applicable costs of the screening procedure, the potential risks and effects of hearing loss, and the benefits of early detection and intervention;

(2) comply with parental consent under section 144.125, subdivision 3;

(3) develop policies and procedures for screening and rescreening based on Department of Health recommendations;

(4) provide appropriate training and monitoring of individuals responsible for performing hearing screening tests as recommended by the Department of Health;

(5) test the newborn's hearing prior to discharge, or, if the newborn is expected to remain in the hospital for a prolonged period, testing shall be performed prior to three months of age, or when medically feasible;

(6) develop and implement procedures for documenting the results of all hearing screening tests;

(7) inform the baby's parents or parent, primary care physician, and the Department of Health according to recommendations of the Department of Health of the results of the hearing screening test or rescreening if conducted, or if the newborn or infant was not successfully tested. The hospital that discharges the baby to home is responsible for the screening; and

(8) collect performance data specified by the Department of Health.

Subd. 4. **Notification and information.** (a) Notification to the parents, primary care provider, and Department of Health shall occur prior to discharge or no later than ten days following the date of testing. Notification shall include information recommended by the Department of Health.

(b) A physician, nurse, midwife, or other health professional attending a birth outside a hospital or institution shall provide information, orally and in writing, as established by the Department of Health, to parents regarding places where the parents may have their infants' hearing screened and the importance of such screening.

(c) The professional conducting the diagnostic procedure to confirm the hearing loss must report the results to the parents, primary care provider, and Department of Health according to the Department of Health recommendations.

Subd. 5. **Oversight responsibility.** The Department of Health shall exercise oversight responsibility for UNHS programs, including establishing a performance data set and reviewing performance data collected by each hospital.

Subd. 6. **Civil and criminal immunity and penalties.** (a) No physician or hospital shall be civilly or criminally liable for failure to conduct hearing screening testing.

(b) No physician, midwife, nurse, other health professional, or hospital acting in compliance with this section shall be civilly or criminally liable for any acts conforming with this section, including furnishing information required according to this section.

Subd. 7. **Laboratory service fees.** The commissioner shall charge laboratory service fees according to section 16A.1285 so that the total of fees collected will approximate the costs of implementing and maintaining a system to follow up infants, provide technical assistance, a tracking system, data management, and evaluation.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 25. **[144.967] ARSENIC HEALTH RISK STANDARD.**

Subdivision 1. **Arsenic health risk standard established.** The commissioner of health in cooperation with the commissioners of agriculture and the Pollution Control Agency responsible for monitoring land and water cleanup and soil contamination information shall determine a health risk standard for human exposure to arsenic. The commissioner of health shall ensure that the established arsenic health risk standard is included in all information provided to the public.

Subd. 2. **Information.** The commissioner of health, in consultation with the commissioners of agriculture and the Pollution Control Agency with jurisdiction over soil and water contamination, shall establish a central information source available to the public to provide accurate information on arsenic soil and water contamination in residential areas.

Subd. 3. **Testing for arsenic.** (a) The commissioner of health shall ensure access to medical testing for arsenical pesticide exposure to persons living within one mile of the CMC Heartland Lite Yard Superfund site who are not covered by health insurance or medical assistance.

(b) Through an agreement with the United States Environmental Protection Agency, the commissioner shall ensure soil testing is available to households within one mile of the CMC Heartland Lite Yard Superfund site at no cost to the residents.

Subd. 4. **Evaluation.** The commissioner of health shall evaluate the cumulative health impact burdens of environmental toxins in the residential communities impacted by arsenic-contaminated soil from the CMC Heartland Lite Yard Superfund site. The first priority shall be to evaluate health burdens to those communities experiencing health disparities as documented by the Minority and Multicultural Health Division of the Minnesota Department of Health.

Sec. 26. **[144.995] DEFINITIONS.**

(a) For purposes of sections 144.995 to 144.998, the terms in this section have the meanings given.

(b) "Advisory panel" means the Environmental Health Tracking and Biomonitoring Advisory Panel established under section 144.998.

(c) "Biomonitoring" means the process by which chemicals and their metabolites are identified and measured within a biospecimen.

(d) "Biospecimen" means a sample of human fluid, serum, or tissue that is reasonably available as a medium to measure the presence and concentration of chemicals or their metabolites in a human body.

(e) "Commissioner" means the commissioner of the Department of Health.

(f) "Community" means geographically or nongeographically-based populations that may participate in the biomonitoring program. A "nongeographical community" includes, but is not limited to, populations that may share a common chemical exposure through similar occupations, populations experiencing a common health outcome that may be linked to chemical exposures, or populations that may experience similar chemical exposures because of comparable consumption, lifestyle, product use, or subpopulations that share ethnicity, age, or gender.

(g) "Department" means the Department of Health.

(h) "Designated chemicals" means those chemicals that are known to, or strongly suspected of, adversely impacting human health or development, based upon scientific, peer-reviewed animal, human, or in vitro studies, and baseline human exposure data, and consists of chemical families or metabolites that are included in the federal Centers for Disease Control and Prevention studies that are known collectively as the National Reports on Human Exposure to Environmental Chemicals program and any substances specified under section 144.998, subdivision 3, clause (6).

(i) "Environmental hazard" means a chemical, metal, or other substance for which scientific, peer-reviewed studies of humans, animals, or cells have demonstrated that the chemical is known or reasonably anticipated to adversely impact human health.

(j) "Environmental health tracking" means collection, integration, analysis, and dissemination of data on human exposures to chemicals in the environment and on diseases potentially caused or aggravated by those chemicals.

Sec. 27. **[144.996] ENVIRONMENTAL HEALTH TRACKING; BIOMONITORING.**

Subdivision 1. **Environmental health tracking.** In cooperation with the commissioner of the Pollution Control Agency, the commissioner shall establish an environmental health tracking program to:

(1) coordinate data collection activities with the Pollution Control Agency, Department of Agriculture, University of Minnesota, and any other relevant state agency and work to promote the sharing of and access to health and environmental databases in order to develop an environmental health tracking system for Minnesota, consistent with applicable data practices laws;

(2) facilitate the dissemination of public health tracking data to the public and researchers in accessible format and provide technical assistance on interpreting the data;

(3) develop written data sharing agreements with the Minnesota Pollution Control Agency, Department of Agriculture, and other relevant state agencies and organizations, and develop additional procedures as needed to protect individual privacy;

(4) develop a strategic plan that includes a mission statement, the identification of core priorities for research and epidemiologic surveillance, the identification of internal and external stakeholders, and a work plan describing future program development;

(5) organize, analyze, and interpret available data, in order to:

(i) characterize statewide and localized trends and geographic patterns of prevalence and incidence of chronic diseases, including, but not limited to, cancer, respiratory diseases, reproductive problems, birth defects, neurologic diseases, and developmental disorders;

(ii) recommend to the commissioner methods to improve data collection on statewide population rates of chronic diseases and the occurrence of environmental hazards and exposures;

(iii) characterize statewide and localized trends and geographic patterns in the occurrence of environmental hazards and exposures;

(iv) assess the level of correlation with disease rate data and indicators of exposure such as biomonitoring data, and other health and environmental data;

(v) incorporate newly collected and existing health tracking and biomonitoring data into efforts to identify communities with elevated rates of chronic disease, higher likelihood of exposure to environmental pollutants, or both;

(vi) analyze occurrence of environmental hazards, exposures, and diseases with relation to socioeconomic status, race, and ethnicity;

(vii) develop and implement targeted plans to conduct more intensive health tracking and biomonitoring among communities;

(viii) work with the Pollution Control Agency, the Department of Agriculture, and other relevant state agency personnel and organizations to develop, implement, and evaluate preventive measures to reduce elevated rates of diseases and exposures identified through activities performed under sections 144.995 to 144.998; and

(ix) provide baseline data and present descriptive information relevant to policy formation that are consistent with existing goals of the department; and

(6) submit a biennial report to the legislature by January 15, beginning January 15, 2009, on the status of environmental health tracking activities and related research programs, and making recommendations regarding the continuation and improvement of the programs.

Subd. 2. **Biomonitoring.** The commissioner shall:

(1) conduct biomonitoring of communities on a voluntary basis by collecting and analyzing biospecimens, as appropriate, to assess environmental exposures to designated chemicals;

(2) conduct biomonitoring of pregnant women and minors on a voluntary basis, when scientifically appropriate;

(3) communicate findings to the public, and plan ensuing stages of biomonitoring and disease tracking work to further develop and refine the integrated analysis;

(4) share analytical results with the advisory panel and work with the panel to interpret results, communicate findings to the public, and plan ensuing stages of biomonitoring work; and

(5) submit a biennial report to the legislature by January 15, beginning January 15, 2009, on the status of the biomonitoring program and any recommendations for improvement.

Subd. 3. **Health data.** Data collected under the biomonitoring program are health data under section 13.3805.

Sec. 28. **[144.997] BIOMONITORING PILOT PROGRAM.**

Subdivision 1. **Pilot program.** With advice from the advisory panel, the commissioner shall develop a biomonitoring pilot program. The program shall collect one biospecimen from each of the voluntary participants. The biospecimen selected must be the biospecimen that most accurately represents body concentration of the chemical of interest. Each biospecimen from the voluntary participants must be analyzed for one type or class of related chemicals or metals, based on recommendations from the advisory panel. The panel shall determine the chemical or class of chemicals that community members were most likely exposed to. The program shall collect and assess biospecimens in accordance with the following:

(1) 30 voluntary participants from each of three communities that the advisory panel identifies as likely to have been exposed to a designated chemical;

(2) 100 voluntary participants from each of two communities: (i) that the advisory panel identifies as likely to have been exposed to arsenic and (ii) that the advisory panel identifies as likely to have been exposed to mercury; and

(3) 100 voluntary participants from each of two communities that the advisory panel identifies as likely to have been exposed to perfluorinated chemicals.

Subd. 2. **Base program.** Following the conclusion of the pilot program and within the appropriations available, the program shall:

(1) collect and assess biospecimens from at least as many voluntary participants and communities as identified in subdivision 1, clause (1); and

(2) work with the advisory panel to assess the usefulness of continuing biomonitoring among members of communities assessed during the initial phase of the program, and to identify other communities and other designated chemicals to be assessed via biomonitoring.

Subd. 3. **Participation.** (a) Participation in the biomonitoring program by providing biospecimens is voluntary and requires written, informed consent. Minors may participate in the program if a written consent is signed by the minor's parent or legal guardian. The written consent must include the information required to be provided under this subdivision to all voluntary participants.

(b) All participants shall be evaluated for the presence of the designated chemical of interest as a component of the biomonitoring process. Participants shall be provided with information and fact sheets about the program's activities and its findings. Individual participants shall, if requested, receive their complete results. Any results provided to participants shall be subject to the Department of Health Institutional Review Board protocols and guidelines. When either physiological or chemical data obtained from a participant indicate a significant known health risk, program staff experienced in communicating biomonitoring results shall consult with the individual and recommend follow-up steps, as appropriate. Program administrators shall receive training in administering the program in an ethical, culturally sensitive, participatory, and community-based manner.

Subd. 4. **Program guidelines.** (a) The commissioner, in consultation with the advisory panel, shall develop:

(1) protocols or program guidelines that address the science and practice of biomonitoring to be utilized and procedures for changing those protocols to incorporate new and more accurate or efficient technologies as they become available. The protocols shall be developed utilizing a peer-review process in a manner that is participatory and community-based in design, implementation, and evaluation;

(2) guidelines for ensuring the privacy of information; informed consent; follow-up counseling and support; and communicating findings to participants, communities, and the general public. The informed consent used for the program must meet the informed consent protocols developed by the National Institutes of Health;

(3) educational and outreach materials that are culturally appropriate for dissemination to program participants and communities. Priority shall be given to the development of materials specifically designed to ensure that parents are informed about

all of the benefits of breastfeeding so that the program does not result in an unjustified fear of toxins in breast milk, which might inadvertently lead parents to avoid breastfeeding. The materials shall communicate relevant scientific findings; data on the accumulation of pollutants to community health; and the required responses by local, state, and other governmental entities in regulating toxicant exposures;

(4) a training program that is culturally sensitive specifically for health care providers, health educators, and other program administrators;

(5) a designation process for state and private laboratories that are qualified to analyze biospecimens and report the findings; and

(6) a method for informing affected communities and local governments representing those communities concerning biomonitoring activities and for receiving comments from citizens concerning those activities.

(b) The commissioner may enter into contractual agreements with health clinics, community-based organizations, or experts in a particular field to perform any of the activities described under this section.

Sec. 29. **[144.998] ENVIRONMENTAL HEALTH TRACKING AND BIOMONITORING ADVISORY PANEL.**

Subdivision 1. **Creation.** The commissioner shall establish the Environmental Health Tracking and Biomonitoring Advisory Panel. The commissioner shall appoint, from the panel's membership, a chair. The panel shall meet as often as it deems necessary but, at a minimum, on a quarterly basis. Members of the panel shall serve without compensation but shall be reimbursed for travel and other necessary expenses incurred through performance of their duties. Members appointed under this subdivision are appointed for a three-year term and may be reappointed.

Subd. 2. **Members.** The commissioner shall appoint eight members who have backgrounds or training in designing, implementing, and interpreting health tracking and biomonitoring studies or in related fields of science, including epidemiology, biostatistics, environmental health, laboratory sciences, occupational health, industrial hygiene, toxicology, and public health, including:

(1) two scientists who represent nongovernmental organizations with a focus on environmental health, environmental justice, children's health, or on specific chronic diseases; and

(2) one scientist who is a representative of the University of Minnesota.

In addition, the commissioner shall appoint one member representing each of the following departments or divisions: the department's health promotion and chronic disease division, the Pollution Control Agency, and the Department of Agriculture.

Subd. 3. **Duties.** The advisory panel shall make recommendations to the commissioner and the legislature on:

(1) priorities for health tracking;

(2) priorities for biomonitoring that are based on sound science and practice, and that will advance the state of public health in Minnesota;

(3) specific chronic diseases to study under the environmental health tracking system;

(4) specific environmental pollutant exposures to study under the environmental health tracking system;

(5) specific communities and geographic areas on which to focus environmental health tracking and biomonitoring efforts;

(6) specific chemicals and metals to study under the biomonitoring program that meet the following criteria:

(i) the degree of potential exposure to the public or specific subgroups, including, but not limited to, occupational;

(ii) the likelihood of a chemical being a carcinogen or toxicant based on peer-reviewed health data, the chemical structure, or the toxicology of chemically related compounds;

(iii) the limits of laboratory detection for the chemical, including the ability to detect the chemical at low enough levels that could be expected in the general population;

(iv) exposure or potential exposure to the public or specific subgroups;

(v) the known or suspected health effects resulting from the same level of exposure based on peer-reviewed scientific studies;

(vi) the need to assess the efficacy of public health actions to reduce exposure to a chemical;

(vii) the availability of a biomonitoring analytical method with adequate accuracy, precision, sensitivity, specificity, and speed;

(viii) the availability of adequate biospecimen samples; and

(ix) other criteria that the panel may agree to; and

(7) other aspects of the design, implementation, and evaluation of the environmental health tracking and biomonitoring system, including, but not limited to:

(i) identifying possible community partners and sources of additional public or private funding;

(ii) developing outreach and educational methods and materials; and

(iii) disseminating environmental health tracking and biomonitoring findings to the public.

Subd. 4. **Liability.** No member of the panel shall be held civilly or criminally liable for an act or omission by that person if the act or omission was in good faith and within the scope of the member's responsibilities under sections 144.995 to 144.998.

Sec. 30. Minnesota Statutes 2006, section 144E.101, subdivision 6, is amended to read:

Subd. 6. **Basic life support.** (a) Except as provided in paragraph (e), a basic life support ambulance shall be staffed by at least two ambulance service personnel, at least one of which must be an EMT, who provide a level of care so as to ensure that:

(1) life-threatening situations and potentially serious injuries are recognized;

(2) patients are protected from additional hazards;

(3) basic treatment to reduce the seriousness of emergency situations is administered; and

(4) patients are transported to an appropriate medical facility for treatment.

(b) A basic life support service shall provide basic airway management.

(c) By January 1, 2001, a basic life support service shall provide automatic defibrillation, as provided in section 144E.103, subdivision 1, paragraph (b).

(d) A basic life support service licensee's medical director may authorize the ambulance service personnel to carry and to use medical antishock trousers and to perform intravenous infusion if the ambulance service personnel have been properly trained.

(e) Upon application from an ambulance service that includes evidence demonstrating hardship, the board may grant a ~~temporary~~ variance from the staff requirements in paragraph (a) and may authorize a basic life support ambulance to be staffed by one EMT and one first responder. The variance shall apply to basic life support ambulances operated by the ambulance service ~~for up to one year from the date of the variance's issuance~~ until the ambulance service renews its license. When a variance expires, an ambulance service may apply for a new variance under this paragraph. For purposes of this paragraph, "ambulance service" means either an ambulance service whose primary service area is located outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or an ambulance service based in a community with a population of less than 1,000.

Sec. 31. Minnesota Statutes 2006, section 144E.127, is amended to read:

144E.127 INTERHOSPITAL; INTERFACILITY TRANSFER.

Subdivision 1. **Interhospital transfers.** When transporting a patient from one licensed hospital to another, a licensee may substitute for one of the required ambulance service personnel, a physician, a registered nurse, or physician's assistant who has been trained to use the equipment in the ambulance and is knowledgeable of the licensee's ambulance service protocols.

Subd. 2. **Interfacility transfers.** In an interfacility transport, a licensee whose primary service area is located outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or an ambulance service based in a community with a population of less than 1,000, may substitute one EMT with a registered first responder if an EMT or EMT-paramedic, physician, registered nurse, or physician's assistant is in the patient compartment. If using a physician, registered nurse, or physician's assistant as the sole provider in the patient compartment, the individual must be trained to use the equipment in the ambulance and be knowledgeable of the ambulance service protocols.

Sec. 32. Minnesota Statutes 2006, section 144E.35, subdivision 1, is amended to read:

Subdivision 1. **Repayment for volunteer training.** ~~Any political subdivision, or nonprofit hospital or nonprofit corporation operating~~ A licensed ambulance service shall be reimbursed by the board for the necessary expense of the initial training of a volunteer ambulance attendant upon successful completion by the attendant of a basic emergency care course, or a continuing education course for basic emergency care, or both, which has been approved by the board, pursuant to section 144E.285. Reimbursement may include tuition, transportation, food, lodging, hourly payment for the time spent in the training course, and other necessary expenditures, except that in no instance shall a volunteer ambulance attendant be reimbursed more than ~~$450~~ $600 for successful completion of a basic course, and ~~$225~~ $275 for successful completion of a continuing education course.

Sec. 33. Minnesota Statutes 2006, section 145A.17, is amended to read:

145A.17 FAMILY HOME VISITING PROGRAMS.

Subdivision 1. **Establishment; goals.** The commissioner shall establish a program to fund family home visiting programs designed to foster ~~a~~ healthy ~~beginning for children in families at or below 200 percent of the federal poverty guidelines~~ beginnings, improve pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency for children and families. The commissioner shall promote partnerships, collaboration, and multidisciplinary visiting done by teams of

professionals and paraprofessionals from the fields of public health nursing, social work, and early childhood education. A program funded under this section must serve families at or below 200 percent of the federal poverty guidelines, and other families determined to be at risk, including but not limited to being at risk for child abuse, child neglect, or juvenile delinquency. Programs must ~~give priority for services to families considered to be in need of services, including but not limited to~~ begin prenatally whenever possible and must be targeted to families with:

(1) adolescent parents;

(2) a history of alcohol or other drug abuse;

(3) a history of child abuse, domestic abuse, or other types of violence;

(4) a history of domestic abuse, rape, or other forms of victimization;

(5) reduced cognitive functioning;

(6) a lack of knowledge of child growth and development stages;

(7) low resiliency to adversities and environmental stresses; ~~or~~

(8) insufficient financial resources to meet family needs;

(9) a history of homelessness;

(10) a risk of long-term welfare dependence or family instability due to employment barriers; or

(11) other risk factors as determined by the commissioner.

Subd. 3. **Requirements for programs; process.** (a) ~~Before a community health board or tribal government may receive an allocation under subdivision 2, a community health board or tribal government must submit a proposal to the commissioner that includes identification, based on a community assessment, of the populations at or below 200 percent of the federal poverty guidelines that will be served and the other populations that will be served. Each program that receives funds must~~ Community health boards and tribal governments that receive funding under this section must submit a plan to the commissioner describing a multidisciplinary approach to targeted home visiting for families. The plan must be submitted on forms provided by the commissioner. At a minimum, the plan must include the following:

(1) a description of outreach strategies to families prenatally or at birth;

(2) provisions for the seamless delivery of health, safety, and early learning services;

(3) methods to promote continuity of services when families move within the state;

(4) a description of the community demographics;

(5) a plan for meeting outcome measures; and

(6) a proposed work plan that includes:

(i) coordination to ensure nonduplication of services for children and families;

(ii) a description of the strategies to ensure that children and families at greatest risk receive appropriate services; and

(iii) collaboration with multidisciplinary partners including public health, ECFE, Head Start, community health workers, social workers, community home visiting programs, school districts, and other relevant partners. Letters of intent from multidisciplinary partners must be submitted with the plan.

(b) Each program that receives funds must accomplish the following program requirements:

(1) use ~~either~~ a ~~broad~~ community-based ~~or selective community-based~~ strategy to provide preventive and early intervention home visiting services;

(2) offer a home visit by a trained home visitor. If a home visit is accepted, the first home visit must occur prenatally or as soon after birth as possible and must include a public health nursing assessment by a public health nurse;

(3) offer, at a minimum, information on infant care, child growth and development, positive parenting, preventing diseases, preventing exposure to environmental hazards, and support services available in the community;

(4) provide information on and referrals to health care services, if needed, including information on and assistance in applying for health care coverage for which the child or family may be eligible; and provide information on preventive services, developmental assessments, and the availability of public assistance programs as appropriate;

(5) provide youth development programs when appropriate;

(6) recruit home visitors who will represent, to the extent possible, the races, cultures, and languages spoken by families that may be served;

(7) train and supervise home visitors in accordance with the requirements established under subdivision 4;

(8) maximize resources and minimize duplication by coordinating ~~activities~~ or contracting with local social and human services organizations, education organizations, and other appropriate governmental entities and community-based organizations and agencies; ~~and~~

(9) utilize appropriate racial and ethnic approaches to providing home visiting services; and

(10) connect eligible families, as needed, to additional resources available in the community, including, but not limited to, early care and education programs, health or mental health services, family literacy programs, employment agencies, social services, and child care resources and referral agencies.

(c) When available, programs that receive funds under this section must offer or provide the family with a referral to center-based or group meetings that meet at least once per month for those families identified with additional needs. The meetings must focus on further enhancing the information, activities, and skill-building addressed during home visitation; offering opportunities for parents to meet with and support each other; and offering infants and toddlers a safe, nurturing, and stimulating environment for socialization and supervised play with qualified teachers.

~~(b)~~ (d) Funds available under this section shall not be used for medical services. The commissioner shall establish an administrative cost limit for recipients of funds. The outcome measures established under subdivision 6 must be specified to recipients of funds at the time the funds are distributed.

~~(c)~~ (e) Data collected on individuals served by the home visiting programs must remain confidential and must not be disclosed by providers of home visiting services without a specific informed written consent that identifies disclosures to be made. Upon request, agencies providing home visiting services must provide recipients with information on disclosures, including the names of entities and individuals receiving the information and the general purpose of the disclosure. Prospective and current recipients of home visiting services must be told and informed in writing that written consent for disclosure of data is not required for access to home visiting services.

Subd. 4. **Training.** The commissioner shall establish training requirements for home visitors and minimum requirements for supervision ~~by a public health nurse~~. The requirements for nurses must be consistent with chapter 148. The commissioner must provide training for home visitors. Training must include ~~child development, positive parenting techniques, screening and referrals for child abuse and neglect, and diverse cultural practices in child rearing and family systems~~ the following:

(1) effective relationships for engaging and retaining families and ensuring family health, safety, and early learning;

(2) effective methods of implementing parent education, conducting home visiting, and promoting quality early childhood development;

(3) early childhood development from birth to age five;

(4) diverse cultural practices in child rearing and family systems;

(5) recruiting, supervising, and retaining qualified staff;

(6) increasing services for underserved populations; and

(7) relevant issues related to child welfare and protective services, with information provided being consistent with state child welfare agency training.

Subd. 5. **Technical assistance.** The commissioner shall provide administrative and technical assistance to each program, including assistance in data collection and other activities related to conducting short- and long-term evaluations of the programs as required under subdivision 7. The commissioner may request research and evaluation support from the University of Minnesota.

Subd. 6. **Outcome and performance measures.** The commissioner shall establish ~~outcomes~~ measures to determine the impact of family home visiting programs funded under this section on the following areas:

(1) appropriate utilization of preventive health care;

(2) rates of substantiated child abuse and neglect;

(3) rates of unintentional child injuries;

(4) rates of children who are screened and who pass early childhood screening; ~~and~~

(5) rates of children accessing early care and educational services;

(6) program retention rates;

(7) number of home visits provided compared to the number of home visits planned;

(8) participant satisfaction;

(9) rates of at-risk populations reached; and

(10) any additional qualitative goals and quantitative measures established by the commissioner.

Subd. 7. **Evaluation.** Using the qualitative goals and quantitative outcome and performance measures established under subdivisions 1 and 6, the commissioner shall conduct ongoing evaluations of the programs funded under this section. Community health boards and tribal governments shall cooperate with the commissioner in the evaluations and shall provide the commissioner with the information necessary to conduct the evaluations. As part of the ongoing evaluations, the commissioner shall rate the impact of the programs on the outcome measures listed in subdivision 6, and shall periodically determine whether home visiting programs are the best way to achieve the qualitative goals established under subdivisions 1 and 6. If the commissioner determines that home visiting programs are not the best way to achieve these goals, the commissioner shall provide the legislature with alternative methods for achieving them.

Subd. 8. **Report.** By January 15, 2002, and January 15 of each even-numbered year thereafter, the commissioner shall submit a report to the legislature on the family home visiting programs funded under this section and on the results of the evaluations conducted under subdivision 7.

Subd. 9. **No supplanting of existing funds.** Funding available under this section may be used only to supplement, not to replace, nonstate funds being used for home visiting services as of July 1, 2001.

Sec. 34. Minnesota Statutes 2006, section 156.001, is amended by adding a subdivision to read:

Subd. 10a. **Program for the Assessment of Veterinary Education Equivalence; PAVE certificate.** A "Program for the Assessment of Veterinary Education Equivalence" or "PAVE" certificate is issued by the American Association of Veterinary State Boards, indicating that the holder has demonstrated knowledge and skill equivalent to that possessed by a graduate of an accredited or approved college of veterinary medicine.

Sec. 35. **[156.015] FEES.**

Subdivision 1. **Verification of licensure.** The board may charge a fee of $25 per license verification to a licensee for verification of licensure status provided to other veterinary licensing boards.

Subd. 2. **Continuing education review.** The board may charge a fee of $50 per submission to a sponsor for review and approval of individual continuing education seminars, courses, wet labs, and lectures. This fee does not apply to continuing education sponsors that already meet the criteria for preapproval under Minnesota Rules, part 9100.1000, subpart 3, item A.

Sec. 36. Minnesota Statutes 2006, section 156.02, subdivision 1, is amended to read:

Subdivision 1. **License application.** Application for a license to practice veterinary medicine in this state shall be made in writing to the Board of Veterinary Medicine upon a form furnished by the board, accompanied by satisfactory evidence that the applicant is at least 18 years of age, is of good moral character, and has one of the following:

(1) a diploma conferring the degree of doctor of veterinary medicine, or an equivalent degree, from an accredited or approved college of veterinary medicine;

(2) an ECFVG or PAVE certificate; or

(3) a certificate from the dean of an accredited or approved college of veterinary medicine stating that the applicant is a student in good standing expecting to be graduated at the completion of the current academic year of the college in which the applicant is enrolled.

The application shall contain the information and material required by subdivision 2 and any other information that the board may, in its sound judgment, require. The

application shall be filed with the board at least 60 days before the date of the examination. If the board deems it advisable, it may require that such application be verified by the oath of the applicant.

Sec. 37. Minnesota Statutes 2006, section 156.02, subdivision 2, is amended to read:

Subd. 2. **Required with application.** Every application shall contain the following information and material:

(1) the application fee set by the board in the form of a check or money order payable to the board, which fee is not returnable in the event permission to take the examination is denied for good cause;

(2) a copy of a diploma from an accredited or approved college of veterinary medicine or a certificate from the dean or secretary of an accredited or approved college of veterinary medicine showing the time spent in the school and the date when the applicant was duly and regularly graduated or will duly and regularly graduate or verification of ECFVG or PAVE certification;

(3) affidavits of at least two veterinarians and three adults who are not related to the applicant setting forth how long a time, when, and under what circumstances they have known the applicant, and any other facts as may be proper to enable the board to determine the qualifications of the applicant; and

(4) if the applicant has served in the armed forces, a copy of discharge papers.

Sec. 38. Minnesota Statutes 2006, section 156.04, is amended to read:

156.04 BOARD TO ISSUE LICENSE.

The Board of Veterinary Medicine shall issue to every applicant who has successfully passed the required examination, who has received a diploma conferring the degree of doctor of veterinary medicine or an equivalent degree from an accredited or approved college of veterinary medicine or an ECFVG or PAVE certificate, and who shall have been adjudged to be duly qualified to practice veterinary medicine, a license to practice.

Sec. 39. Minnesota Statutes 2006, section 156.072, subdivision 2, is amended to read:

Subd. 2. **Required with application.** Such doctor of veterinary medicine shall accompany the application by the following:

(1) a copy of a diploma from an accredited or approved college of veterinary medicine or certification from the dean, registrar, or secretary of an accredited or approved college of veterinary medicine attesting to the applicant's graduation from an accredited

or approved college of veterinary medicine, or a certificate of satisfactory completion of the ECFVG or PAVE program.

(2) affidavits of two licensed practicing doctors of veterinary medicine residing in the United States or Canadian licensing jurisdiction in which the applicant is currently practicing, attesting that they are well acquainted with the applicant, that the applicant is a person of good moral character, and has been actively engaged in practicing or teaching in such jurisdiction for the period above prescribed;

(3) a certificate from the regulatory agency having jurisdiction over the conduct of practice of veterinary medicine that such applicant is in good standing and is not the subject of disciplinary action or pending disciplinary action;

(4) a certificate from all other jurisdictions in which the applicant holds a currently active license or held a license within the past ten years, stating that the applicant is and was in good standing and has not been subject to disciplinary action;

(5) in lieu of clauses (3) and (4), certification from the Veterinary Information Verification Agency that the applicant's licensure is in good standing;

(6) a fee as set by the board in form of check or money order payable to the board, no part of which shall be refunded should the application be denied;

(7) score reports on previously taken national examinations in veterinary medicine, certified by the Veterinary Information Verification Agency; and

(8) if requesting waiver of examination, provide evidence of meeting licensure requirements in the state of the applicant's original licensure that were substantially equal to the requirements for licensure in Minnesota in existence at that time.

Sec. 40. Minnesota Statutes 2006, section 156.073, is amended to read:

156.073 TEMPORARY PERMIT.

The board may issue without examination a temporary permit to practice veterinary medicine in this state to a person who has submitted an application approved by the board for license pending examination, and holds a doctor of veterinary medicine degree or an equivalent degree from an approved or accredited college of veterinary medicine or an ECFVG or PAVE certification. The temporary permit shall expire the day after publication of the notice of results of the first examination given after the permit is issued. No temporary permit may be issued to any applicant who has previously failed the national examination and is currently not licensed in any licensing jurisdiction of the United States or Canada or to any person whose license has been revoked or suspended or who is currently subject to a disciplinary order in any licensing jurisdiction of the United States or Canada.

Sec. 41. Minnesota Statutes 2006, section 156.12, subdivision 2, is amended to read:

Subd. 2. **Authorized activities.** No provision of this chapter shall be construed to prohibit:

(a) a person from rendering necessary gratuitous assistance in the treatment of any animal when the assistance does not amount to prescribing, testing for, or diagnosing, operating, or vaccinating and when the attendance of a licensed veterinarian cannot be procured;

(b) a person who is a regular student in an accredited or approved college of veterinary medicine from performing duties or actions assigned by instructors or preceptors or working under the direct supervision of a licensed veterinarian;

(c) a veterinarian regularly licensed in another jurisdiction from consulting with a licensed veterinarian in this state;

(d) the owner of an animal and the owner's regular employee from caring for and administering to the animal belonging to the owner, except where the ownership of the animal was transferred for purposes of circumventing this chapter;

(e) veterinarians who are in compliance with subdivision 6 and who are employed by the University of Minnesota from performing their duties with the College of Veterinary Medicine, College of Agriculture, Agricultural Experiment Station, Agricultural Extension Service, Medical School, School of Public Health, or other unit within the university; or a person from lecturing or giving instructions or demonstrations at the university or in connection with a continuing education course or seminar to veterinarians or pathologists at the University of Minnesota Veterinary Diagnostic Laboratory;

(f) any person from selling or applying any pesticide, insecticide or herbicide;

(g) any person from engaging in bona fide scientific research or investigations which reasonably requires experimentation involving animals;

(h) any employee of a licensed veterinarian from performing duties other than diagnosis, prescription or surgical correction under the direction and supervision of the veterinarian, who shall be responsible for the performance of the employee;

(i) a graduate of a foreign college of veterinary medicine from working under the direct personal instruction, control, or supervision of a veterinarian faculty member of the College of Veterinary Medicine, University of Minnesota in order to complete the requirements necessary to obtain an ECFVG <u>or PAVE</u> certificate.

Sec. 42. Minnesota Statutes 2006, section 156.12, subdivision 4, is amended to read:

Subd. 4. **Titles.** It is unlawful for a person who has not received a professional degree from an accredited or approved college of veterinary medicine, or ECFVG <u>or PAVE</u>

certification, to use any of the following titles or designations: Veterinary, veterinarian, animal doctor, animal surgeon, animal dentist, animal chiropractor, animal acupuncturist, or any other title, designation, word, letter, abbreviation, sign, card, or device tending to indicate that the person is qualified to practice veterinary medicine.

Sec. 43. Minnesota Statutes 2006, section 156.12, subdivision 6, is amended to read:

Subd. 6. **Faculty licensure.** (a) Veterinary Medical Center clinicians at the College of Veterinary Medicine, University of Minnesota, who are engaged in the practice of veterinary medicine as defined in subdivision 1 and who treat animals owned by clients of the Veterinary Medical Center must possess the same license required by other veterinary practitioners in the state of Minnesota except for persons covered by paragraphs (b) and (c).

(b) A specialty practitioner in a hard-to-fill faculty position who has been employed at the College of Veterinary Medicine, University of Minnesota, for five years or more prior to 2003 or is specialty board certified by the American Veterinary Medical Association or the European Board of Veterinary Specialization may be granted a specialty faculty Veterinary Medical Center clinician license which will allow the licensee to practice veterinary medicine in the state of Minnesota in the specialty area of the licensee's training and only within the scope of employment at the Veterinary Medical Center.

(c) A specialty practitioner in a hard-to-fill faculty position at the College of Veterinary Medicine, University of Minnesota, who has graduated from a board-approved foreign veterinary school may be granted a temporary faculty Veterinary Medical Center clinician license. The temporary faculty Veterinary Medical Center clinician license expires in two years and allows the licensee to practice veterinary medicine as defined in subdivision 1 and treat animals owned by clients of the Veterinary Medical Center. The temporary faculty Veterinary Medical Center clinician license allows the licensee to practice veterinary medicine in the state of Minnesota in the specialty area of the licensee's training and only within the scope of employment at the Veterinary Medical Center while under the direct supervision of a veterinarian currently licensed and actively practicing veterinary medicine in Minnesota, as defined in section 156.04. The direct supervising veterinarian shall not have any current or past conditions, restrictions, or probationary status imposed on the veterinarian's license by the board within the past five years. The holder of a temporary faculty Veterinary Medical Center clinician license who is enrolled in a PhD program may apply for up to two additional consecutive two-year extensions of an expiring temporary faculty Veterinary Medical Center clinician license. Any other holder of a temporary faculty Veterinary Medical Center clinician license may apply for one two-year extension of the expiring temporary faculty Veterinary Medical Center

clinician license. Temporary faculty Veterinary Medical Center clinician licenses that are allowed to expire may not be renewed. The board shall grant an extension to a licensee who demonstrates suitable progress toward completing the requirements of their academic program, specialty board certification, or full licensure in Minnesota by a graduate of a foreign veterinary college.

(d) Temporary and specialty faculty Veterinary Medical Center clinician licensees must abide by all the laws governing the practice of veterinary medicine in the state of Minnesota and are subject to the same disciplinary action as any other veterinarian licensed in the state of Minnesota.

(e) The fee for a license issued under this subdivision is the same as for a regular license to practice veterinary medicine in Minnesota. License payment deadlines, late payment fees, and other license requirements are also the same as for regular licenses.

Sec. 44. Minnesota Statutes 2006, section 156.15, subdivision 2, is amended to read:

Subd. 2. **Service.** Service of an order under this section is effective if the order is served on the person or counsel of record personally or by ~~certified~~ United States mail to the most recent address provided to the board for the person or counsel of record.

Sec. 45. Minnesota Statutes 2006, section 156.16, subdivision 3, is amended to read:

Subd. 3. **Dispensing.** "Dispensing" means distribution of veterinary prescription drugs or over-the-counter drugs for extra-label use or human drugs for extra-label use by a person licensed as a pharmacist by the Board of Pharmacy or a person licensed by the Board of Veterinary Medicine.

Sec. 46. Minnesota Statutes 2006, section 156.16, subdivision 10, is amended to read:

Subd. 10. **Prescription.** "Prescription" means an order from a veterinarian to a pharmacist or another veterinarian authorizing the dispensing of ~~a~~ veterinary prescription ~~drug~~ drugs, human drugs for extra-label use, or over-the counter drugs for extra-label use to a client for use on or in a patient.

Sec. 47. Minnesota Statutes 2006, section 156.18, subdivision 1, is amended to read:

Subdivision 1. **Prescription.** (a) A person may not dispense a veterinary prescription drug to a client without a prescription or other veterinary authorization. A person may not make extra-label use of an animal or human drug for an animal without a prescription from a veterinarian. A veterinarian or the veterinarian's authorized employee may dispense ~~a~~ veterinary prescription ~~drug to~~ drugs, human drugs for extra-label use, or

an over-the-counter drug for extra-label use by a client ~~or oversee the extra-label use of a veterinary drug directly by a client~~ without a separate written prescription, providing there is documentation of the prescription in the medical record and there is an existing veterinarian-client-patient relationship. The prescribing veterinarian must monitor the use of veterinary prescription drugs, human drugs for extra-label use, or over-the-counter drugs for extra-label use by a client.

(b) A veterinarian may dispense prescription veterinary drugs and prescribe and dispense extra-label use drugs to a client without personally examining the animal if a bona fide veterinarian-client-patient relationship exists and in the judgment of the veterinarian the client has sufficient knowledge to use the drugs properly.

(c) A veterinarian may issue a prescription or other veterinary authorization by oral or written communication to the dispenser, or by computer connection. If the communication is oral, the veterinarian must enter it into the patient's record. The dispenser must record the veterinarian's prescription or other veterinary authorization within 72 hours.

(d) A prescription or other veterinary authorization must include:

(1) the name, address, and, if written, the signature of the prescriber;

(2) the name and address of the client;

(3) identification of the species for which the drug is prescribed or ordered;

(4) the name, strength, and quantity of the drug;

(5) the date of issue;

(6) directions for use; ~~and~~

(7) withdrawal time~~.~~, if applicable; and

(8) number of authorized refills.

(e) A veterinarian may, in the course of professional practice and an existing veterinarian-client-patient relationship, prepare medicaments that combine drugs approved by the United States Food and Drug Administration and other legally obtained ingredients with appropriate vehicles.

(f) A veterinarian or a bona fide employee of a veterinarian may dispense veterinary prescription drugs to a person on the basis of a prescription issued by a licensed veterinarian. The provisions of paragraphs (c) and (d) apply.

(g) This section does not limit the authority of the Minnesota Racing Commission to regulate veterinarians providing services at a licensed racetrack.

Sec. 48. Minnesota Statutes 2006, section 156.18, subdivision 2, is amended to read:

Subd. 2. **Label of dispensed veterinary drugs.** (a) A veterinarian or the veterinarian's authorized agent or employee dispensing a veterinary prescription drug

~~or prescribing the extra-label use of an over-the-counter drug~~, an over-the-counter drug for extra-label use, or a human drug for extra-label use must provide written information which includes the name and address of the veterinarian, date of filling, species of patient, name or names of drug, strength of drug or drugs, directions for use, withdrawal time, and cautionary statements, if any, appropriate for the drug.

(b) If the veterinary drug has been prepared, mixed, formulated, or packaged by the dispenser, all of the information required in paragraph (a) must be provided on a label affixed to the container.

(c) If the veterinary drug is in the manufacturer's original package, the information required in paragraph (a) must be supplied in writing but need not be affixed to the container. Information required in paragraph (a) that is provided by the manufacturer on the original package does not need to be repeated in the separate written information. Written information required by this paragraph may be written on the sales invoice.

Sec. 49. Minnesota Statutes 2006, section 156.19, is amended to read:

156.19 EXTRA-LABEL USE.

A person, other than a veterinarian or ~~a person working under the control~~ an employee of a veterinarian, must not make extra-label use of a veterinary drug in or on a food-producing animal, unless permitted by the prescription of a veterinarian. A veterinarian may prescribe the extra-label use of a ~~veterinary~~ drug if:

(1) the veterinarian makes a careful medical diagnosis within the context of a valid veterinarian-client-patient relationship;

(2) the veterinarian determines that there is no marketed drug specifically labeled to treat the condition diagnosed, or that drug therapy as recommended by the labeling has, in the judgment of the attending veterinarian, been found to be clinically ineffective;

(3) the veterinarian recommends procedures to ensure that the identity of the treated animal will be carefully maintained; ~~and~~

(4) the veterinarian prescribes a significantly extended time period for drug withdrawal before marketing meat, milk, or eggs~~.~~; and

(5) the veterinarian has met the criteria established in Code of Federal Regulations, title 21, part 530, which define the extra-label use of medication in or on animals.

Sec. 50. Minnesota Statutes 2006, section 198.075, is amended to read:

198.075 MINNESOTA VETERANS HOME EMPLOYEES; EXCLUDED FROM COMMISSARY PRIVILEGES.

Except as provided in this section, no commissary privileges including food, laundry service, janitorial service, and household supplies shall be furnished to any employee of the Minnesota veterans homes. An employee of the Minnesota veterans homes who works a second shift that is consecutive with a regularly scheduled shift may be allowed one free meal at the veterans home on the day of that extra shift.

Sec. 51. Minnesota Statutes 2006, section 256B.0625, subdivision 14, is amended to read:

Subd. 14. **Diagnostic, screening, and preventive services.** (a) Medical assistance covers diagnostic, screening, and preventive services.

(b) "Preventive services" include services related to pregnancy, including:

(1) services for those conditions which may complicate a pregnancy and which may be available to a pregnant woman determined to be at risk of poor pregnancy outcome;

(2) prenatal HIV risk assessment, education, counseling, and testing; and

(3) alcohol abuse assessment, education, and counseling on the effects of alcohol usage while pregnant. Preventive services available to a woman at risk of poor pregnancy outcome may differ in an amount, duration, or scope from those available to other individuals eligible for medical assistance.

(c) "Screening services" include, but are not limited to, blood lead tests. Screening services also include, for children with blood lead levels equal to or greater than five micrograms of lead per deciliter of whole blood, environmental investigations to determine the source of lead exposure. Reimbursement is limited to a health professional's time and activities during an on-site investigation of a child's home or primary residence.

Sec. 52. Minnesota Statutes 2006, section 256B.0625, is amended by adding a subdivision to read:

Subd. 49. **Lead risk assessments.** (a) Effective October 1, 2007, or six months after federal approval, whichever is later, medical assistance covers lead risk assessments provided by a lead risk assessor who is licensed by the commissioner of health under section 144.9505 and employed by an assessing agency as defined in section 144.9501. Medical assistance covers a onetime on-site investigation of a recipient's home or primary residence to determine the existence of lead so long as the recipient is under the age of 21 and has a venous blood lead level specified in section 144.9504, subdivision 2, paragraph (a).

(b) Medical assistance reimbursement covers the lead risk assessor's time to complete the following activities:

(1) gathering samples;

(2) interviewing family members;

(3) gathering data, including meter readings; and

(4) providing a report with the results of the investigation and options for reducing lead-based paint hazards.

Medical assistance coverage of lead risk assessment does not include testing of environmental substances such as water, paint, or soil or any other laboratory services. Medical assistance coverage of lead risk assessments is not included in the capitated services for children enrolled in health plans through the prepaid medical assistance program and the MinnesotaCare program.

(c) Payment for lead risk assessment must be cost-based and must meet the criteria for federal financial participation under the Medicaid program. The rate must be based on allowable expenditures from cost information gathered. Under section 144.9507, subdivision 5, federal medical assistance funds may not replace existing funding for lead-related activities. The nonfederal share of costs for services provided under this subdivision must be from state or local funds and is the responsibility of the agency providing the risk assessment. Eligible expenditures for the nonfederal share of costs may not be made from federal funds or funds used to match other federal funds. Any federal disallowances are the responsibility of the agency providing risk assessment services.

Sec. 53. **[325.172] BISPHENOL-A IN PRODUCTS FOR CHILDREN.**

Subdivision. 1. **Bisphenol-A and phthalates committee.** The commissioner of health shall create a committee under the direction of the environmental health division of the Department of Health to study the scientific literature and make recommendations to the legislature on the health impact of bisphenol-A and phthalates on children in products intended for use by young children, including, but not limited to, toys, pacifiers, baby bottles, and teethers, and report back by January 15, 2008. The committee shall also identify least harmful alternatives. Of the seven committee members at least one shall be a representative of the Department of Health, one shall be a representative of environmental health sciences research, one shall be a representative of the Minnesota Nurses Association, one shall be a representative of environmental health consumer advocates, one shall be a member of a children's product manufacturer's association, and one shall be a representative of the University of Minnesota, chemical plastics research department.

Subd. 2. **Definitions.** For the purposes of this section, the following terms have the meanings given them:

(a) "Toy" means all products designed or intended by the manufacturer to be used by children when they play.

(b) "Child care article" means all products designed or intended by the manufacturer to facilitate sleep, relaxation, or the feeding of children or to help children with sucking or teething.

Sec. 54. **[325E.385] PRODUCTS CONTAINING POLYBROMINATED DIPHENYL ETHER.**

Subdivision 1. **Definitions.** For the purposes of sections 325E.386 to 325E.388, the terms in this section have the meanings given them.

Subd. 2. **Commercial decabromodiphenyl ether.** "Commercial decabromodiphenyl ether" means the chemical mixture of decabromodiphenyl ether, including associated polybrominated diphenyl ether impurities not intentionally added.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of the Pollution Control Agency.

Subd. 4. **Manufacturer.** "Manufacturer" means any person, firm, association, partnership, corporation, governmental entity, organization, or joint venture that produces a product containing polybrominated diphenyl ethers or an importer or domestic distributor of a noncomestible product containing polybrominated diphenyl ethers.

Subd. 5. **Polybrominated diphenyl ethers or PBDE's.** "Polybrominated diphenyl ethers" or "PBDE's" means chemical forms that consist of diphenyl ethers bound with bromine atoms. Polybrominated diphenyl ethers include, but are not limited to, the three primary forms of the commercial mixtures known as pentabromodiphenyl ether, octabromodiphenyl ether, and decabromodiphenyl ether.

Subd. 6. **Retailer.** "Retailer" means a person who offers a product for sale at retail through any means, including, but not limited to, remote offerings such as sales outlets, catalogs, or the Internet, but does not include a sale that is a wholesale transaction with a distributor or a retailer.

Subd. 7. **Used product.** "Used product" means any product that has been previously owned, purchased, or sold in commerce. Used product does not include any product manufactured after January 1, 2008.

Sec. 55. **[325E.386] PRODUCTS CONTAINING CERTAIN POLYBROMINATED DIPHENYL ETHERS BANNED; EXEMPTIONS.**

Subdivision 1. **Penta- and octabromodiphenyl ethers.** Except as provided in subdivision 3, beginning January 1, 2008, a person may not manufacture, process, or

distribute in commerce a product or flame-retardant part of a product containing more than one-tenth of one percent of pentabromodiphenyl ether or octabromodiphenyl ether by mass.

Subd. 2. **Exemptions.** The following products containing polybrominated diphenyl ethers are exempt from subdivision 1:

(1) the sale or distribution of any used transportation vehicle with component parts containing polybrominated diphenyl ethers;

(2) the sale or distribution of any used transportation vehicle parts or new transportation vehicle parts manufactured before January 1, 2008, that contain polybrominated diphenyl ethers;

(3) the manufacture, sale, repair, distribution, maintenance, refurbishment, or modification of equipment containing polybrominated diphenyl ethers and used primarily for military or federally funded space program applications. This exemption does not cover consumer-based goods with broad applicability;

(4) the sale or distribution by a business, charity, public entity, or private party of any used product containing polybrominated diphenyl ethers;

(5) the manufacture, sale, or distribution of new carpet cushion made from recycled foam containing more than one-tenth of one percent penta polybrominated diphenyl ether; or

(6) medical devices.

In-state retailers in possession of products on January 1, 2008, that are banned for sale under subdivision 1 may exhaust their stock through sales to the public. Nothing in this section restricts the ability of a manufacturer, importer, or distributor from transporting products containing polybrominated diphenyl ethers through the state, or storing such products in the state for later distribution outside the state.

Sec. 56. **[325E.387] REVIEW OF DECABROMODIPHENYL ETHER.**

Subdivision 1. **Commissioner duties.** The commissioner in consultation with the commissioners of health and public safety shall review uses of commercial decabromodiphenyl ether, availability of technically feasible and safer alternatives, fire safety and any evidence regarding the potential harm to public health and the environment posed by commercial decabromodiphenyl ether and the alternatives. The commissioner must consult with key stakeholders. The commissioner must also review the findings from similar state and federal agencies and must report their findings and recommendations to the appropriate committees of the legislature no later than January 15, 2008.

Subd. 2. **State procurement.** By January 1, 2008, the commissioner of administration shall make available for purchase and use by all state agencies only equipment, supplies, and other products that do not contain polybrominated diphenyl ethers, unless exempted under section 325E.386, subdivision 2.

Sec. 57. **[325E.388] PENALTIES.**

A manufacturer who violates sections 325E.386 to 325E.388 is subject to a civil penalty not to exceed $1,000 for each violation in the case of a first offense. A manufacturer is subject to a civil penalty not to exceed $5,000 for each repeat offense. Penalties collected under this section must be used by the commissioner to implement and enforce this section.

Sec. 58. Laws 2005, First Special Session chapter 4, article 9, section 3, subdivision 2, is amended to read:

Subd. 2. **Community and Family Health Improvement**

Summary by Fund		
General	40,413,000	40,382,000
State Government Special Revenue	141,000	128,000
Health Care Access	3,510,000	3,516,000
Federal TANF	6,000,000	6,000,000

~~**Family Planning Base Reduction.** Base level funding for the family planning special projects grant program is reduced by $1,877,000 each year of the biennium beginning July 1, 2007, provided that this reduction shall only take place upon full implementation of the family planning project section of the 1115 waiver. Notwithstanding Minnesota Statutes, section 145.925, the commissioner shall give priority to community health care clinics providing family planning services that either serve a high number of women who do not qualify for medical assistance or are unable to participate in the medical assistance program~~

~~as a medical assistance provider when allocating the remaining appropriations. Notwithstanding section 15, this paragraph shall not expire.~~

Shaken Baby Video. Of the state government special revenue fund appropriation, $13,000 in 2006 is appropriated to the commissioner of health to provide a video to hospitals on shaken baby syndrome. The commissioner of health shall assess a fee to hospitals to cover the cost of the approved shaken baby video and the revenue received is to be deposited in the state government special revenue fund.

Sec. 59. **FUNDING FOR ENVIRONMENTAL JUSTICE MAPPING.**

The commissioner of health, in conjunction with the commissioner of the Pollution Control Agency, shall apply for federal funding to renew and expand the state's environmental justice mapping capacity in order to promote public health tracking. The commissioner shall coordinate the project with the Pollution Control Agency and the Department of Agriculture in order to explore possible links between environmental health and toxic exposures and to help create a system for environmental public health tracking. The commissioner shall also make recommendations to the legislature for additional sources of funding within the state.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 60. **LEGISLATIVE FINDINGS AND PURPOSE.**

The legislature hereby finds that hearing loss occurs in newborn infants more frequently than any other health condition for which newborn infant screening is required. Early detection of hearing loss in a child and early intervention and treatment has been demonstrated to be highly effective in facilitating a child's healthy development in a manner consistent with the child's age, language acquisition, and cognitive ability. Without early hearing detection and intervention, children with hearing loss experience serious delays in language acquisition and social and cognitive development. With appropriate testing and identification of newborn infants, hearing loss screening will

facilitate early intervention and treatment and will serve the public purpose of promoting the healthy development of children.

For these reasons, the legislature hereby determines that it is beneficial and in the best interests of the development of the children of the state of Minnesota that newborn infants' hearing be screened.

Sec. 61. **INFORMATION SHARING.**

By August 1, 2007, the commissioner of health, the Pollution Control Agency, the commissioner of agriculture, and the University of Minnesota are requested to jointly develop and sign a memorandum of understanding declaring their intent to share new and existing environmental hazard, exposure, and health outcome data, consistent with applicable data practices laws, and to cooperate and communicate effectively to ensure sufficient clarity and understanding of the data between these organizations.

Sec. 62. **COMMISSIONER OF HEALTH REPORT; ROUTINE RADIATION EMISSIONS.**

The commissioner of health, within the limits of available appropriations, in cooperation with the utilities that own the Monticello and Prairie Island nuclear plants, shall issue a report detailing where routine radiation releases go and the health impacts of the radiation emissions on affected communities. By April 1, 2008, the report must be distributed to house and senate committees having jurisdiction over public health and to all communities that are part of the emergency response planning.

Sec. 63. **FRAGRANCE-FREE SCHOOLS EDUCATION PILOT PROJECT.**

Subdivision 1. **Purpose.** Recognizing that scented products may trigger asthma or chemical sensitivity reactions in students and school staff, which can contribute to learning and breathing problems, the commissioner of health shall develop a fragrance-free schools education pilot project.

Subd. 2. **Education.** The commissioner of health, in collaboration with the commissioner of education and the Minneapolis Board of Education, shall establish a working group composed of at least three students, two teachers, one school administrator, and one member of the Minneapolis Board of Education to recommend an education campaign in Minneapolis public schools to inform students and parents about the potentially harmful effects of the use of fragrance products on sensitive students and school personnel in Minneapolis schools. The commissioner shall report findings to the legislature by February 1, 2008.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 64. **LINDANE COMMITTEE.**

The commissioner of health shall create a committee of stakeholders, including at least one environmental health research scientist and at least one parent consumer advocate, to review the scientific literature and make recommendations to the legislature on the health impact of Lindane on children and report back by January 15, 2008.

Sec. 65. **MEDICAL ASSISTANCE COVERAGE FOR ARSENIC TESTING.**

The commissioner of human services shall ensure that testing for arsenic under section 1, subdivision 3, is covered under medical assistance.

Sec. 66. **BLOOD LEAD TESTING STUDY.**

The commissioner of health, in consultation with the Department of Human Services; cities of the first class; health care providers; and other interested parties shall conduct a study to evaluate blood lead testing methods used to confirm elevated blood lead status. The study shall examine and/or develop:

(1) the false positive rate of capillary tests for children less than 72 months old;

(2) current protocols for conducting capillary testing, including filter paper methodology;

(3) existing guidelines and regulations from other states and federal agencies regarding lead testing;

(4) recommendations regarding the use of capillary tests to initiate environmental investigations and case management, including number and timing of tests and fiscal implications for state and local lead programs; and

(5) recommendations regarding reducing the state mandatory intervention to ten micrograms of lead per deciliter of whole blood.

The commissioner shall submit the results of the study and any recommendations, including any necessary legislative changes, to the legislature by February 15, 2008.

Sec. 67. **WINDOW SAFETY EDUCATION.**

The commissioner of health shall create in the department's current educational safety program a component targeted at parents and caregivers of young children to provide awareness of the need to take precautions to prevent children from falling through open windows. The commissioner of health shall consult with representatives of the residential building industry, the window products industry, the child safety

advocacy community, and the Department of Labor and Industry to create the window safety program component. The program must include the gathering of data about falls from windows that result in severe injury in order to measure the effectiveness of the safety program. The commissioner of health may consult with other child safety advocacy groups, experts, and interested parties in the development and implementation of the window safety program. The commissioner of health shall prepare and submit a final report on the window safety program to the legislature by March 1, 2011. The commissioner shall prepare and submit a yearly progress report to the legislature by March 1 of each year beginning in 2008 until the submission of the final report. The final report must include a summary of the safety program, the impact of the program on children falling from windows, and any recommendations for further study or action.

Sec. 68. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall change the range reference "144.9501 to 144.9509" to "144.9501 to 144.9512" wherever the reference appears in Minnesota Statutes and Minnesota Rules.

Sec. 69. **REPEALER.**

Laws 2004, chapter 288, article 6, section 27, is repealed.

ARTICLE 3
HOUSING

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

		2008		**2009**		**Total**
General	$	67,896,000	$	49,040,000	$	116,936,000
TANF	$	3,075,000	$	3,075,000	$	6,150,000
Total	**$**	**70,971,000**	**$**	**52,115,000**	**$**	**123,086,000**

Sec. 2. **HOUSING.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2008" and "2009" used in this act mean that the appropriations listed under them are available for the fiscal year ending June 30, 2008, or June 30, 2009, respectively. "The

first year" is fiscal year 2008. "The second year" is fiscal year 2009. "The biennium" is fiscal years 2008 and 2009. Appropriations for the fiscal year ending June 30, 2007, are effective the day following final enactment.

	APPROPRIATIONS Available for the Year Ending June 30	
	2008	2009

Sec. 3. **HOUSING FINANCE AGENCY**

Subdivision 1. **Total Appropriation** **$ 70,971,000 $ 52,115,000**

Appropriations by Fund	2008	2009
General	67,896,000	49,040,000
TANF	3,075,000	3,075,000

This appropriation is for transfer to the housing development fund. The amounts that may be spent from this appropriation for certain programs are specified in the following subdivisions. Except as otherwise indicated, this transfer is part of the agency's permanent budget base.

Of this amount, $3,075,000 the first year and $3,075,000 the second year are onetime appropriations from the state's federal TANF block grant under Title I of Public Law Number 104-193 to the commissioner of human services, to reimburse the housing development fund for assistance under the programs for families receiving TANF assistance under the MFIP program. The commissioner of human services shall make monthly reimbursements to the housing development fund. The commissioner of human services shall not make any reimbursement which the commissioner determines would be subject to a penalty under Code of Federal Regulations, section

262.1. If the appropriation in either year is insufficient, the appropriation for the other year is available.

Subd. 2. **Economic Development and Housing Challenge**

(a) $21,308,000 the first year and $9,622,000 the second year are for the economic development and housing challenge program under Minnesota Statutes, section 462A.33, for housing that:

(i) conserves energy and utilizes sustainable, healthy building materials;

(ii) preserves sensitive natural areas and open spaces and minimizes the need for new infrastructure;

(iii) is accessible to jobs and services through integration with transportation or transit systems; and

(iv) expands the mix of housing choices in a community by diversifying the levels of housing affordability.

The agency may fund demonstration projects that have unique approaches to achieving the housing described above.

(b) The base is reduced by $3,407,000 each year in fiscal year 2010 and fiscal year 2011.

Subd. 3. **Housing Trust Fund**

$15,195,000 the first year and $11,945,000 the second year are for the housing trust fund account created under Minnesota Statutes, section 462A.201, for the purposes of that section. Of this amount, $1,500,000 the first year and $1,500,000 in the second year is a onetime appropriation from the state's federal

TANF block grant. The base is reduced by $3,390,000 each year in fiscal year 2010 and fiscal year 2011.

Subd. 4. **Bridges Rental Assistance for Mentally Ill**

$3,400,000 the first year and $3,400,000 the second year are for a rental housing assistance program for persons with a mental illness or families with an adult member with a mental illness under Minnesota Statutes, section 462A.2097.

Subd. 5. **Family Homeless Prevention**

$7,565,000 the first year and $7,565,000 the second year are for family homeless prevention and assistance programs under Minnesota Statutes, section 462A.204. Of this amount, $1,575,000 in the first year and $1,575,000 in the second year is a onetime appropriation from the state's federal TANF block grant. The base is reduced by $3,800,000 each year in fiscal year 2010 and fiscal year 2011.

Subd. 6. **Home Ownership Assistance Fund**

$1,885,000 the first year and $1,885,000 the second year are for the home ownership assistance program under Minnesota Statutes, section 462A.21, subdivision 8. The base is reduced by $1,000,000 each year in fiscal year 2010 and fiscal year 2011.

Subd. 7. **Affordable Rental Investment Fund**

$11,496,000 the first year and $8,996,000 the second year are for the affordable rental investment fund program under Minnesota Statutes, section 462A.21, subdivision 8b.

Of this amount, $2,500,000 the first year is a onetime appropriation.

This appropriation is to finance the acquisition, rehabilitation, and debt restructuring of federally assisted rental property and for making equity take-out loans under Minnesota Statutes, section 462A.05, subdivision 39. The owner of the federally assisted rental property must agree to participate in the applicable federally assisted housing program and to extend any existing low-income affordability restrictions on the housing for the maximum term permitted. The owner must also enter into an agreement that gives local units of government, housing and redevelopment authorities, and nonprofit housing organizations the right of first refusal if the rental property is offered for sale. Priority must be given among comparable federally assisted rental properties to properties with the longest remaining term under an agreement for federal rental assistance. Priority must also be given among comparable rental housing developments to developments that are or will be owned by local government units, a housing and redevelopment authority, or a nonprofit housing organization.

This appropriation may also be used to finance the acquisition, rehabilitation, and debt restructuring of existing supportive housing properties. For purposes of this subdivision, "supportive housing" means affordable rental housing with links to services necessary for individuals, youth, and

families with children to maintain housing stability.

Of this amount, $2,500,000 is appropriated for the purposes of financing the rehabilitation and operating costs to preserve public housing. For purposes of this subdivision, "public housing" is housing for low-income persons and households financed by the federal government and owned and operated by public housing authorities and agencies. Eligible public housing authorities must have a public housing assessment system rating of standard or above. Priority among comparable proposals must be given to proposals that maximize federal or local resources to finance the capital and operating costs.

Subd. 8. **Housing Rehabilitation and Accessibility**

$5,657,000 the first year and $4,287,000 the second year are for the housing rehabilitation and accessibility program under Minnesota Statutes, section 462A.05, subdivisions 14a and 15a. The base is reduced by $629,000 each year in fiscal year 2010 and fiscal year 2011.

Subd. 9. **Urban Indian Housing Program**

$187,000 in the first year and $187,000 in the second year are for the urban Indian housing program under Minnesota Statutes, section 462A.07, subdivision 15. The base is reduced by $52,000 each year in fiscal year 2010 and fiscal year 2011.

Subd. 10. **Tribal Indian Housing Program**

$1,683,000 in the first year and $1,683,000 in the second year are for the tribal Indian housing program under Minnesota Statutes, section 462A.07, subdivision 14. The base is reduced by $468,000 each year in fiscal year 2010 and fiscal year 2011.

Subd. 11. **Home Ownership Education, Counseling, and Training**

$2,135,000 the first year and $2,135,000 the second year are appropriated for the home ownership education, counseling, and training program under Minnesota Statutes, section 462A.209. The base is reduced by $1,460,000 each year in fiscal year 2010 and fiscal year 2011. Of this amount, $..... the first year is for:

(1) foreclosure prevention and assistance activities in communities that have mortgage foreclosure rates that exceed the statewide average foreclosure rate for the most recent quarter for which data is available; and

(2) home buyer education and counseling activities by organizations that have experience working with emerging markets or partner with organizations with experience working with emerging markets and that have demonstrated a commitment to increasing the homeownership rate of emerging markets.

Subd. 12. **Capacity Building Grants**

$820,000 for the biennium is for capacity building grants under Minnesota Statutes section 462A.21, subdivision 3b, to be used for continuum of care planning in greater Minnesota. This appropriation is the agency's base budget for this program.

Subd. 13. **Grant for Hennepin County.**

$50,000 is a onetime appropriation in the first year for a grant to Hennepin County for collaboration with the Center for Urban and Regional Affairs at the University of Minnesota for the development of a predictive, data-driven model that can be used to identify at-risk properties in order to target resources to prevent foreclosure.

Sec. 4. Minnesota Statutes 2006, section 462A.21, subdivision 8b, is amended to read:

Subd. 8b. **Family rental housing.** It may establish a family rental housing assistance program to provide loans or direct rental subsidies for housing for families with incomes of up to 80 percent of state median income, or to provide grants for the operating cost of public housing. Priority must be given to those developments with resident families with the lowest income. The development may be financed by the agency or other public or private lenders. Direct rental subsidies must be administered by the agency for the benefit of eligible families. Financial assistance provided under this subdivision to recipients of aid to families with dependent children must be in the form of vendor payments whenever possible. Loans, grants, and direct rental subsidies under this subdivision may be made only with specific appropriations by the legislature. The limitations on eligible mortgagors contained in section 462A.03, subdivision 13, do not apply to loans for the rehabilitation of existing housing under this subdivision.

Sec. 5. Minnesota Statutes 2006, section 462A.33, subdivision 3, is amended to read:

Subd. 3. **Contribution requirement.** Fifty percent of the funds appropriated for this section must be used for challenge grants or loans ~~which meet the requirements of this subdivision~~ for housing proposals with financial or in-kind contributions from nonstate resources that reduce the need for deferred loan or grant funds from state resources. ~~These~~ Challenge grants or loans must be used for economically viable homeownership or rental housing proposals that~~:~~

~~(1) include a financial or in-kind contribution from an area employer and either a unit of local government or a private philanthropic, religious, or charitable organization; and~~

~~(2)~~ address the housing needs of the local work force.

Among comparable proposals, preference must be given to proposals that include contributions from nonstate resources for the greatest portion of the total development

cost. Comparable proposals with contributions from local units of government or private philanthropic, religious, or charitable organizations must be given preference in awarding grants or loans.

For the purpose of this subdivision, ~~an employer~~ a contribution may consist partially or wholly of the premium paid for federal housing tax credits.

~~Preference for grants and loans shall also be given to comparable proposals that include a financial or in-kind contribution from a unit of local government, an area employer, and a private philanthropic, religious, or charitable organization.~~

Sec. 6. Minnesota Statutes 2006, section 469.021, is amended to read:

469.021 PREFERENCES.

As between applicants equally in need and eligible for occupancy of a dwelling and at the rent involved, preference shall be given to disabled veterans, persons with disabilities, and families of service persons who died in service and to families of veterans. In admitting families of low income to dwelling accommodations in any housing project an authority shall, as far as is reasonably practicable, give consideration to applications from families ~~to which aid for dependent children is payable~~ receiving assistance under chapter 256J, and to resident families to whom public assistance or supplemental security income for the aged, blind, and disabled is payable, when those families are otherwise eligible.

Sec. 7. **MORTGAGE FORECLOSURE REDUCTION.**

The commissioner of the Minnesota Housing Finance Agency, in consultation with the commissioner of commerce, the attorney general, the Minnesota Mortgage Bankers' Association, Legal Services of Minnesota, and the Minnesota Sheriffs' Association shall evaluate the provisions of Minnesota Statutes, sections 580.04 and 580.041, to determine if corrective actions could be taken by the 2008 legislature to reduce mortgage foreclosures in the state.