MINNESOTA CODE OF AGENCY RULES

RULES OF THE DEPARTMENT OF PUBLIC WELFARE

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§ 2.001 Family foster care, group family foster care.

A. Definitions.

1. Agency. Unless qualified, means the county social service agency, or human service board, or licensed voluntary child placing-child caring agency; the agency is the duly delegated representative of the Commissioner.

2. Agency requirement. Those portions of the rule binding upon the agency but not upon the provider, and so marked. Failure of the agency to meet one or more agency requirements is not a defense for the provider's failure to meet provider requirements.

3. Applicant. Individual(s) who have submitted a signed and dated application form (DPW-138) to an agency.

4. Child. Any person under the age of eighteen years.

5. Commissioner. Unless qualified, means the Commissioner of the Department of Public Welfare or any representative of the Commissioner.

6. Department. Unless qualified, means the Department of Public Welfare.

7. Foster family home (FFH). A family home licensed to provide one or more of the following types of care for children who are unrelated to the family and who are cared for twenty-four hours a day:

a. Interim home. An FFH caring for children expected to return home within one year or to be placed for adoption within two years.

b. Permanent home. An FFH caring for children (whether state wards or not) under written agreement for planned care until child reaches majority.

c. Emergency shelter home. An FFH designated primarily for time-limited emergency placements, usually lasting no longer than thirty days for any child.

d. Special services home. An FFH able to provide extraordinary care or services, by virtue of training, experience or special skills.

e. Restricted home. An FFH licensed for a specific child. An FFH licensed as a Restricted Home may not accept children other than the specifically named child(ren).

f. Group family foster home. An FFH providing care for no more than ten children, including the family's own children.

8. Handicap. Condition of mental retardation, mental illness, physical handicap, sight or hearing deficiency, or chemical dependency.

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9. License. The document issued by the Commissioner and authorizing the applicant to provide foster care.

10. Licensed capacity. Maximum number of foster children who can live in a foster home at any given time.

11. Provider. Person(s) giving care to foster child(ren) in a licensed FFH. The provider is responsible for meeting and maintaining minimum licensing requirements in cooperation with the agency.

12. Related. Any of the following persons related to the child by marriage, blood, or adoption: parent, grandparent, brother, sister, stepparent, stepsister, stepbrother, niece, nephew, uncle, aunt. It also includes a legally appointed guardian.

13. Substitute caregiver. The person(s) providing temporary care for the foster child(ren) in the absence of the foster parent(s). Arrangements for substitute care must have the approval of the agency and the foster parent(s).

14. Waiver. Written permission from either the Department or designated Agency to disregard a particular section of a licensing rule for no longer than twelve months.

B. Licensing laws and procedures.

1. A foster family home (FFH), must be licensed by the Department, with the following exclusions:

a. A home providing care and supervision only to children related to the family.

b. A home providing care and supervision for a total period of less than 30 days in any twelve-month period.

c. A home providing care and supervision only to child(ren) placed in that home by an agency for the purpose of legal adoption, unless the adoption has not been completed within two years of placement.

d. A home providing care and supervision only for one unrelated child of sixteen or seventeen years who has been independently placed by himself or his relative for purposes of education or work.

2. Application for a license shall be made to the agency on the form issued by the Department. This form shall be obtained from the public agency in the county where the applicant resides or from a licensed voluntary child placing-child caring agency.

3. The signed and completed application form, including all supporting documentation, shall be evaluated within 90 days based upon these rules and regulations. A prospective FFH meeting these standards shall be recom-

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mended to the Commissioner for issuance of an FFH license. No FFH license may be issued for more than one year. (agency requirement)

4. Every license shall specify the kind of license and the maximum number of foster children to be provided care at any one time.

5. No child shall be placed by an agency in an unlicensed home until that home has begun the required orientation, and until that home has been evaluated for compliance with the following sections of the rule: D.1.a., F.3., F.5.a,b,c,d,e. (agency requirement)

6. Every applicant for an FFH license shall be furnished by the agency with a copy of this rule and a copy of the form "Agreement between Foster Parents and Placement Agency". (agency requirement)

7. Notice of the closure of an FFH must be sent to the Department. (agency requirement)

8. The Commissioner or agency shall have access to the FFH for evaluation at any time during normal working hours and at other times by mutual agreement. For the purpose of investigating complaints concerning the health and safety of the foster children, the Commissioner or agency shall have access to the home at any time during the twenty-four hour day.

9. Any complaint concerning an FFH shall be investigated immediately. (agency requirement)

10. Any applicant whose application for a license is denied and any provider whose license is revoked or not renewed for cause may appeal to the Commissioner in accordance with Minnesota Statutes, Chapter 15. The agency shall notify by certified mail any FFH whose license is denied, suspended, revoked, or not renewed. This notification shall state the grounds for such action and shall inform the applicant or operator of his right to appeal the action. Appeals hearings shall be heard by the State Office of Hearing Examiners.

11. State law provides that any person without a license who operates an FFH required to be licensed, shall be guilty of a misdemeanor and subject to a fine of up to three hundred dollars. A home, not otherwise exempt from licensure, is required to apply for a license within 30 days of accepting an unrelated child if the child is expected to remain in the home for 30 days or longer.

12. Specific regulations may be waived with the approval of the Department according to the procedure established for such waiver, provided that the health and safety of the children is assured. The granting of a waiver shall not constitute a precedent for any other FFH. No waiver shall be valid for more than one year.

13. Foster children may be accepted into or removed from an FFH only

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under authorization of a county welfare department or a licensed agency or the court in the county where the child resides.

14. Failure, inability or refusal to comply with this rule shall be cause for denial, nonrenewal or revocation of license.

15. An FFH may not concurrently hold a license for family day care, group family day care, or group day care without the prior approval of the agency.

16. An FFH shall not be licensed through more than one agency at a time.

17. All currently licensed homes shall be furnished with a copy of this rule after it becomes effective.

C. Limitations of license.

1. A family foster home shall be limited to the following, including the home's own children: (See also Appendix B)

Reason: The abilities of parent(s) to provide care to foster children differ greatly. The maximum number of children allowed in foster homes must be flexible. But the maximums set must also allow foster family parents to devote sufficient time to each child.

a. Interim and permanent homes. Less than two years' experience as a foster home: no more than three foster children; no more than five children, total.

b. Interim and permanent homes. Two or more years' experience as a foster home: no more than five children, total.

c. Emergency shelter homes (designated). No more than seven children, total.

d. Special services homes (designated). No more than four foster children; no more than five children, total.

e. Where the foster care provider has not completed the required annual training at the time of relicensure, no further placements may be made in that home until the provider has complied with the training requirements. The license will be restricted to the children currently placed in that home. (agency requirement)

f. No FFH may care for more than two children under the age of two years, unrelated to the FFH provider(s).

2. Exceptions to the maximum number of foster children will be allowed when:

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a. Siblings need placement together as determined by the agency. Maximum number: seven children.

b. The home has five or six children of its own under age 18. Maximum number: seven children.

c. A child needs to be placed again in the same home as determined by the agency. Maximum number: seven children.

3. All FFH providers must be at least 21 years of age at the time of licensure.

4. A license is not transferable to another provider or site.

5. The agency must be notified, in advance, of any changes that would affect the terms of the license, such as a change of address or additional persons in the home.

6. An FFH may not have adult roomers or boarders unrelated to the FFH provider without special permission of the agency. The FFH shall keep the agency informed about all persons living in the home and all others having regular contact with the foster child in the foster home.

D. FFH qualifications and training.

1. FFH applicants shall be kind, mature, and responsible people with a genuine liking for children. They shall possess consistent and healthy methods of handling the life-style unique to their own families. Evaluation of applicants shall consider cultural differences.

Reason: Children who must live apart from their own homes are uniquely in need of stable, understanding families. Many children needing placement are emotionally, mentally, or physically handicapped. These children need extra understanding and parenting to cope with their problems.

a. Satisfactory compliance: An FFH license shall not be issued or renewed where any person (except foster children) living in the household has any of the following characteristics:

(1) A conviction for, or admission of, or substantial evidence of an act of assault, or child battering, or child abuse, or child molesting, or child neglect.

(2) Chemical dependency, unless the individual(s) identified as chemically dependent has been chemically free for at least twelve months.

(3) Residence of the family's own children in foster care, correctional facility, or residential treatment for emotional disturbance within the previous twelve months if, in the judgment of the agency, the functioning of the family has been impaired.

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(4) A conviction for any offense involving moral turpitude within the previous five years, and at the discretion of the agency within the previous ten years.

(5) Felony conviction within the previous five years, and at the discretion of the agency within the previous ten years.

b. Satisfactory compliance: In order to protect children in foster care and assure them the maximum opportunities for growth and development, each family caring for children shall be evaluated on the following essential elements:

(1) Have established and are comfortable with their own identity to the degree that meeting their own needs does not interfere with their meeting the needs of foster children.

(2) Have optimism, a sense of humor, resiliency, and ability to enjoy life.

(3) Be in touch with their own feelings, be able to express these feelings, and have a capacity to look at themselves realistically as to the kinds of children they can accept and work with.

(4) Have health and vigor to meet the needs of children placed with them.

(5) Have meaningful extended family, neighborhood, cultural and community ties.

(6) Have the ability to deal with anger, sorrow, frustration, conflict, and other emotions in a manner which will build positive interpersonal relationships rather than in a way that could be emotionally or physically destructive to other persons.

(7) Have the ability to give positive guidance, care and training to a child according to his stage of growth, special abilities and limitations.

(8) Have the ability to use discipline in a constructive rather than destructive way.

(9) Understand, accept and seek to nurture cultural, spiritual, racial, and affectional ties of the child.

(10) Have the ability and flexibility to accept a child in placement who has special needs, treat a foster child as a member of their family, recognizing that a foster child has other family ties.

(11) Have the ability to accept the foster child's own family and maintain an understanding relationship with them.

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(12) Have the ability to work with the agency and other community resources.

(13) Have a capacity and willingness to involve themselves in ongoing educational opportunities, as well as other learning experiences.

(14) Be able to constructively resolve problems when difficulties arise.

(15) Be comfortable in relating to professional treatment personnel of all kinds, including the ability to discuss differences of viewpoint, and to be an advocate for the foster child when indicated.

(16) Have an ability to openly discuss their attitudes about persons with differing life styles and philosophies and a capacity to accept people who are different from themselves.

2. FFH applicants and agencies must be able to work in partnership.

Reason: The agency has overall responsibility for planning with the child. The service of foster parents is an integral and important part of that plan. The relationship between the FFH and the agency must be one of mutual trust and respect.

Satisfactory compliance:

a. The FFH applicant and agency must sign and abide by the terms of the Foster Parent Agreement.

b. An FFH shall be visited at least once a month by a representative of the agency for the first six months after the first placement. (agency requirement)

c. An evaluation visit shall be made by the agency at least once every twelve months for as long as the FFH provider maintains an FFH license. A copy of the written evaluation report shall be given to the FFH provider. (agency requirement)

d. The FFH has a right to know the policy, procedure, and intentions of the agency towards placement of children in that FFH. The FFH may request and receive such information from the agency at the time of licensure and at any time that FFH has been without a placement for a twelve-month period. (agency requirement)

e. Training opportunities shall be made available and accessible to all applicants and FFH providers. Substitute caregivers shall be eligible for the same training as the licensed FFH providers. (agency requirement)

f. There shall be a grievance mechanism for resolving differences between the agency and the FFH. The FFH provider shall be given a written

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statement of grievance procedures. Grievance procedures shall address those areas of disagreement not included in the appeal procedures set forth by the Department. (agency requirement)

3. Age or physical handicap of FFH providers shall be a consideration only as it affects their ability to provide adequate care to foster children or may affect an individual child's adjustment to the family.

4. The agency may request consultation from specialists in evaluating the abilities of prospective FFH providers, but must evaluate each applicant on an individual basis. (agency requirement)

5. When all adults in the FFH are employed or otherwise occupied for substantial amounts of time away from home, the plans for care and supervision of the foster children must be approved in advance by the agency.

6. The health of persons living in the FFH shall not be a hazard to the children.

Satisfactory compliance:

a. The applicant shall supply evidence to the agency:

(1) Sometime during the twelve months prior to initial licensure, each person living in the home has had a negative Mantoux test or chest X-ray.

(2) A statement from the applicant's physician dated within the six months prior to licensure that either:

(a) Members of the family have received a physical examination and are physically able to provide care to children.

or

(b) Members of the family are receiving all necessary continuing medical care and are physically able to provide care to children.

(c) This statement may not be necessary for children who are members of the foster family if current school reports indicate good health.

b. The agency may, at its own discretion, require a physical examination of any person living in the home.

c. The FFH shall make the agency immediately aware of any communicable or infectious disease in the FFH.

d. When, in the opinion of the agency, any person in the home exhibits a mental health problem, the agency may require an evaluation of that person by a mental health specialist as a requirement for license.

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7. Family foster care providers shall participate in training to develop and enhance their skills.

Reason: The vast majority of children needing placement are children with problems. Many children are emotionally, mentally, or physically handicapped.

The intent of an ongoing training program is to build on the foster parents' initial interest in providing service and to maximize their ability to provide the highest quality services to children. The aim of this training is to transfer information about foster care and foster children.

Orientation and in-service training can, and should, take place in a variety of settings and through a variety of methods. For example: group sessions offered by local agencies or foster parent associations; regular courses offered by vocational schools, colleges, or universities; TV or correspondence courses; agricultural extension classes; organizational activities such as conferences, conventions, and seminars; special sessions offered by local school districts or mental health centers; Red Cross training; one-to-one "tutoring" by agency staff or experienced foster parents.

Satisfactory compliance:

a. Every applicant for an FFH license shall begin the minimum of six hours of orientation prior to receiving the first child in placement.

b. An FFH provider who wishes to take a "leave of absence" from foster care for up to twelve months, may have the annual training requirement waived for that twelve-month period.

c. Every FFH, except those providing exclusively Permanent Home care or Restricted Home care, shall participate in a minimum of twelve hours annual of training related to foster care. The twelve hours may be shared among the adult FFH providers in the home.

d. Training opportunities shall include, but not be limited to:

(1) Child and adolescent development

(2) Communication skills

(3) Roles and relationships in foster care

(4) Community services for children

(5) Methods of discipline

(6) Constructive problem solving

(7) The meaning of a foster child's natural parents

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(8) Basic first aid

(9) Home safety

(10) Trauma of separation and skills for handling

(11) Human sexuality

e. An FFH with five consecutive years of experience as an FFH may be exempted from mandatory annual training at the discretion of the agency.

f. In addition to regular training requirements, every FFH licensed as an Emergency - Shelter Home or a Special Services Home or a Group Family Foster Home shall participate in a minimum of six hours annually of additional training related to the special needs of these children.

8. No child shall be subjected to physical or psychological abuse.

Reason: Although families differ in their approach to discipline, harsh or threatening methods are particularly damaging to children in foster care. Discipline should be defined as an overall plan for teaching acceptable behavior; punishment is, more narrowly, negative reinforcement for unacceptable behavior. The carrying out of the individual plan for a foster child or the contract between the child and the foster parents involving specified consequences should not be construed as imposing punishment on that child.

Satisfactory compliance:

a. Methods of discipline to be used in the FFH shall be discussed with the agency during the application process. Child training and discipline shall be handled with kindness and understanding.

b. No child in care shall be subjected to unusual, severe, or cruel punishment.

c. No child in care shall be subjected to verbal abuse, derogatory remarks about himself or members of his family, or to threats to expel the child from the foster home.

d. Isolation, when used as discipline, shall not exceed ten minutes for any child under six years of age. Isolation shall not exceed one hour for a child six years of age or older. Isolation shall be in a light, well-ventilated room of at least 50 square feet, and within hearing of an adult. An adult shall periodically check, at least every 10 minutes, on a child in isolation. No child shall be isolated in a closet or a locked room.

e. No child shall be punished for bed-wetting or with regard to toilet training.

f. No child in care shall be deprived of meals, mail, or family visits as a method of discipline.

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g. Punishment shall not be delegated to another child.

h. Methods of discipline shall be periodically evaluated by the FFH and the agency.

i. Corporal punishment is prohibited. Corporal punishment includes but is not limited to hitting, slapping, spanking, pinching, shaking, kicking or biting.

9. Private data about the child or his family shall be kept private.

E. Health.

1. The FFH provider shall be prepared to cope with health emergencies.

Satisfactory compliance:

a. The FFH provider shall have a plan approved by the agency for meeting medical emergencies; this plan shall include the name and phone number of the child's physician, as provided by the agency.

b. The FFH provider shall have first-aid supplies readily available to treat minor injuries.

c. No foster child shall be given prescription medicine not specifically prescribed for him. Any medicine prescribed for a foster child shall be given exactly as prescribed and shall be given by an adult.

d. The FFH provider shall have written instructions from a licensed physician or dentist prior to the administration of any prescription medication. Medication with current prescription information on the label shall constitute such instructions.

2. FFH homes that have house pets shall ensure that such pets have had all necessary shots; FFH homes shall not have turtles, chickens, or ducks as house pets.

3. The FFH provider shall report immediately to the agency the occurrence of an unusual accident such as the death or serious injury or serious illness of a foster child. A serious injury or illness shall be defined as one requiring professional medical attention.

4. The FFH provider shall be responsible for carrying out the agreed-upon plan for medical and dental care for the foster child(ren).

5. The FFH provider shall have a means for contacting the agency twenty-four hours per day, seven days per week. (agency requirement)

F. Physical environment.

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1. Consideration shall be given to varying-life styles and different cultures when determining whether applicants meet the standards. If approval would require deviation from the regulation, the agency must request a waiver in writing from the department, taking into consideration the health and safety of child(ren) in placement. (agency requirement)

Reason: All children deserve a safe and healthy environment. But equally important is the preservation of cultural heritage. To promote the establishment of foster homes representing all cultures, the agency must consider the cultural standards.

2. There must be a safe water and milk supply.

3. The house and premises shall be reasonably clean, reasonably neat, and free from hazards that jeopardize health and safety.

Satisfactory compliance:

a. FFH premises shall be inspected by the agency. (agency requirement)

b. House and premises shall be clean, reasonably neat, and free from accumulations of dirt, rubbish, or peeling paint.

c. All medicines, chemicals, cleaning supplies, and other toxic substances shall be stored out of the reach of children. They must not be stored with or immediately beside food products.

d. The use of potentially hazardous materials and tools shall be supervised.

e. Outdoor play space shall be enclosed, if necessary, to provide protection.

f. The FFH provider shall maintain personal cleanliness while preparing food.

g. Food and cooking utensils shall be stored to protect from dust, vermin, leakage from pipes, or other contamination.

h. Food needing refrigeration shall be stored at a temperature that will prevent spoilage and bacterial growth. (40^{o} recommended.)

i. Appliances regularly used in the storage and preparation of food shall be safe and in good working order.

j. The use of homecanned fruits and vegetables is permitted.

k. Measures shall be taken to protect against the entrance into the home or breeding of vermin and insects.

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4. Children in care shall be adequately supervised at all times.

5. The FFH home shall be safe from fire and structural hazards.

Satisfactory compliance:

a. An inspection for fire safety using the Fire Safety Check List shall be made jointly by the applicant and the agency before licensure and annually thereafter before relicensure. The agency may request a fire marshal inspection of any FFH. (agency requirement)

b. An FFH to be located in a mobile home must be inspected by a fire marshal or codes officer.

c. Any bedroom for a foster child located in a room fifty percent or more below ground level must be inspected by a fire marshal or codes officer. It must have two means of exit.

d. Unvented gas or oil heaters shall not be permitted.

e. No stove or heater shall be located where it would block escape in case of a fire.

f. A portable A-B-C fire extinguisher shall be provided for the kitchen and cooking areas.

g. Combustible items shall not be located near the furnace area or other sources of heat.

h. Fireplaces, space heaters, steam radiators, and hot surfaces, such as steam pipes, shall be shielded against accidental contact.

i. Every closet door latch shall be one that can be opened from the inside.

j. Any bathroom door lock shall be designed to permit the opening of the locked door from the outside in an emergency.

k. A report shall be made to the agency after the occurrence of a fire that requires the services of a fire department.

l. Emergency procedures shall be planned, written, and posted. They shall include a plan for evacuation, temporary shelter, and meeting place to determine if anyone is missing. Emergency procedures shall be reviewed at least annually by the FFH provider and agency.

m. An UL listed product of combustion detection unit (smoke or ionization), either battery or electrically operated, shall be installed in the corridor or hallway leading to the sleeping area(s) of the FFH.

6. The FFH provider shall be prepared to cope with emergencies.

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Satisfactory compliance:

a. The FFH provider shall make arrangements, approved by the agency, for substitute care during emergencies.

b. A list of emergency telephone numbers shall be prominently posted, including police, fire, doctor, hospital, ambulance, and emergency social service.

c. The FFH provider shall notify the agency as soon as it has been determined that a foster child has run away or is missing.

G. Nutrition.

1. The FFH provider shall consult with a physician about the diet for children with special dietary needs, such as infants under one year of age, children with allergies, children who are over or under weight, children who are hyperactive.

2. Well-balanced meals shall be served daily.

Reason: Balanced nutrition is basic to the attainment of good health. A child grows and develops rapidly. This growth and development is related to nutrition.

Satisfactory compliance: Each day's menu shall include servings from each of the basic four food groups as indicated in the Daily Food Guide. (Appendix A)

H. Daily activities.

Every foster child shall be treated as a member of the FFH. The foster child shall share in the privileges and responsibilities of the home as appropriate to the child's age and abilities. Activities shall foster optimum physical, social, mental, and emotional development of children. Activities that enhance the child's appreciation of his cultural heritage shall be supported and encouraged.

1. Infants.

a. Each infant must be held during bottle feedings until he is safely able to hold his own bottle.

Reason: An infant's first sense of security is closely related to his food. Being held during feeding helps him to develop a trust relationship with others. It is possible for a young infant to choke on milk or water from a propped bottle.

b. Each infant must be held, rocked, cuddled, and played with during each day of care.

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Reason: Physical closeness to others is indispensable as a first step in social relationships.

c. Infant's attempts to communicate must be responded to.

Reason: Baby sounds are the beginning of speech and language development. Socialization is encouraged when the infant receives a response to his babbling.

d. The infant must have ample opportunities for freedom of movement every day.

Reason: The infant needs large-muscle activity in order to develop properly, physically and mentally. The infant learns by exploring his environment.

Satisfactory compliance:

(1) The noncreeping infant shall spend part of each day outside of crib and playpen.

(2) The creeping infant shall have freedom to explore outside of crib or playpen. A crib or playpen shall be used only for sleeping or for short periods of time when needed for safety. During the infant's waking hours, a playpen shall be placed where the infant can see others.

e. The infant must be provided with an environment that stimulates all of his senses.

Reason: The infant develops in response to stimuli; normal development can be retarded by a lack of stimulation.

Satisfactory compliance: Infants should be provided with (commercial, homemade, or natural):

(1) Things to look at (e.g., crib mobile).

(2) Things to listen to (e.g., rattle, FFH provider's voice).

(3) Things to feel (e.g., a soft ball).

(4) Things to smell (e.g., newly baked cookies).

(5) Things to taste (e.g., clean objects that are nontoxic and too large to swallow or choke him).

2. Toddlers, preschoolers, and school-age children.

a. Each child shall be allowed as much independence as he can safely handle.

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Reason: The child needs to establish his own identity; children learn through exploring and manipulating their environment.

b. Each child shall be provided with limits consistent with his age and understanding.

Reason: The child needs to learn rules for his own and others' safety.

Satisfactory compliance: Each child shall be taught to avoid behavior that would be dangerous to himself or to others.

c. Each child shall be encouraged to communicate verbally.

Reason: Speech and language development occurs through practice and encouragement. Socialization is encouraged when the child receives a response.

d. Each child shall be given physical signs of affection as appropriate for age and maturity.

Reason: The child needs physical closeness although he may reject it at times because of his growing need for independence. This independence must be respected, but rocking, hugging, and other physical signs of affection must be offered.

e. Each child shall be provided with materials and equipment that will enhance his physical, mental, and emotional development.

Reason: Appropriate materials and equipment encourage activities among children.

Satisfactory compliance: The FFH home shall provide commercial, homemade, or natural materials and equipment of sound construction and working, that encourage and stimulate:

(1) Large-muscle activities (e.g., large blocks, cardboard cartons).

(2) Small-muscle activities (e.g., manipulative toys, craft materials).

(3) Creative activities (e.g., dress-up clothes, art supplies).

(4) Cognitive activities (e.g., puzzles, books).

(5) Social activities (e.g., games).

f. Toilet training shall be undertaken only when appropriate to each child's age and stage of development.

Satisfactory compliance:

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(1) Toilet training by the FFH provider shall be within the limits of the licensing rules.

(2) No child shall be punished for accidents occurring during toilet training. (See also D.8.)

(3) The agency shall offer consultation and training to providers about toilet training.

g. Each child shall nap or rest as appropriate to his age and stage of development.

Reason: Children's needs for naps differ even at similar ages.

3. Adolescents.

Reason: The view of adolescence on which the following is based is that of adolescence being a segment of continuing human development. Adolescents are persons with specific qualities and characteristics who have a participatory and responsible role to play, tasks to perform, skills to develop at that particular time of life. The degree or extent to which an adolescent experiences such responsible participation will determine and maximize human development.

Conditions for healthy development should provide young people with opportunities:

a. To participate as citizens, as members of a household, as workers, as responsible members of society.

Reason: Adolescents are growing, developing persons in a particular age group - not pre-adults, pre-parents, or pre-workers, but human beings participating in the activities of the world around them.

Satisfactory compliance: The agency and the foster child shall discuss house rules with the foster parent(s). The foster child(ren) are expected to live by these house rules.

b. To gain experience in decision-making.

Reason: In our complex society, youth must develop the capacity to make decisions in many areas: school interests, work interests, use of discretionary time, the kind of friends they want to cultivate, etc.

Satisfactory compliance: Each child shall be provided practical learning opportunities.

c. To interact with peers and acquire a sense of belonging.

Reason: Adolescents are moving toward wider interdependence with their

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peers, need to have a sense of belonging to their own age groups, as well as to adults. They need to acquire the ability to handle their sexuality, to develop and maintain friendship, to experience closeness.

Satisfactory compliance: Each child shall have the opportunity to participate in a variety of activities.

d. To reflect on self in relation to others and to discover self by looking outward, as well as inward.

Reason: Adolescents encounter conflicting values in a rapidly changing world and should have the opportunity to thrash out their reactions, consider the pluses and minuses, and try to determine where they themselves stand.

Satisfactory compliance: Each child shall be encouraged to participate in open discussion, with adults exposing, but not imposing, their value systems on the child.

e. To discuss conflicting values and formulate their own value system.

Reason: There is almost no increase in the level of moral maturity beyond that reached during adolescence.

Satisfactory compliance: Each child shall be provided opportunity for significant experiences and careful examination and reflection of those experiences for their moral development.

f. To experiment with their own identity, with relationships to other people, with ideas: to try out various roles without having to commit themselves irrevocably.

Reason: Adolescents should be able to try out various roles without being obligated to pursue a given course.

Satisfactory compliance: Each child shall be allowed opportunities to experiment, within the constraints of law, with his own identity in a nonjudgmental atmosphere.

g. To develop a feeling of accountability in the context of a relationship among equals.

Reason: Genuine participation and genuine responsibility go hand in hand. A basic tenet of our social system is: for every right, there is a corresponding responsibility, resulting in the commitment necessary in a mature society.

Satisfactory compliance: Each child shall be provided opportunities for participation and accountability in a family relationship.

h. To cultivate a capacity to enjoy life.

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Reason: Maturity includes enjoyment, being creative, frivolous, doing things on one's own, learning to interact with all kinds of people.

Satisfactory compliance: Each child should have a family accepting of other person's life styles and values, having flexibility and a sense of humor, and a sense of the joy of living.

4. Special activities related to a child's religious or cultural heritage shall be available to him.

5. Special activities related to a child's natural family shall be available to him, based on the agency's plan.

I. Records.

1. The agency shall establish and maintain an individual record for the foster family home. (agency requirement)

Reason: The foster home record serves as the basis of evaluation both of foster home quality and of agency practice. Recommendations to the Department about the foster home must be substantiated through the agency's records.

Satisfactory compliance: The agency record shall contain:

a. A copy of the application for licensure signed by the applicant. (DPW-138)

b. A Foster Parent Agreement Form signed by both the applicant and the agency. (DPW-139)

c. A physician's statement concerning the physical health of persons in the FFH.

d. A current completed Fire Safety Check List (DPW-644) plus a written report from the fire marshal on any special fire hazards (if required by agency).

e. The prelicensing home study.

f. References from persons who can evaluate the applicant(s) as potential foster care providers. If the applicant(s) have been licensed through another agency within the previous five years, the agency shall request a reference from that agency.

g. An annual evaluation of the FFH, done jointly by provider and agency, covering services provided by both FFH and agency. It shall be based on a complete review of this rule and on the years placement experiences. Any disagreement about the evaluation between the FFH and the agency shall also be entered into the record.

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h. Documentation for any waiver of licensing regulations.

i. Record of training received by the foster parents.

2. Individual case records for children placed in foster care shall be kept separately from the licensing record. (agency requirement)

3. FFH data classified as private shall be maintained as private. FFH providers shall have access to private data concerning themselves. (agency requirement)

J. Special services home (additional requirements).

Reason: Children with special needs require a special understanding. FFH providers who undertake to care for these children must possess more than ordinary abilities. Such children require extraordinary care.

Opportunities for achieving the special knowledge and skills can include observation of children with special needs, meeting with other foster parents who have cared for children with special needs, discussions with specialists and community resource people, and attending conferences.

1. Prior to licensure for special services, the FFH provider must have structured opportunities for achieving knowledge and skills necessary and pertinent to specific special need or handicap:

a. Three years' experience as a licensed FFH plus twelve hours of training related to children with special needs.

or

b. One year experience in working with children with special needs, which may include their own children, plus six hours of training related to children with special needs.

or

c. Twenty-five hours of training related to children with special needs.

2. Within thirty days after placement of a child with special needs in an FFH, a written individualized program plan must be developed by the FFH provider and the agency. This plan shall be evaluated and updated regularly, but no less often than every six months. (agency requirement)

Reason: The growth and development of children with special needs or handicaps must be planned and evaluated regularly.

Satisfactory compliance:

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a. At least the FFH provider and agency must participate in program planning. The school district shall be invited to participate, and given reasonable notice.

b. Other agencies and community resources shall be called upon as indicated by the particular needs of the individual child.

c. The individual program plan must be available for use by the FFH provider, the agency, and the school district.

d. There shall be a regular evaluation of the child's progress at intervals mutually agreed upon by provider agency. Progress shall be recorded by the agency.

e. The individualized program plan shall contain specific, objective, time-limited goals. These goals shall be dated. The goals shall be updated as needed at the times of evaluation. Goals shall relate to the care and welfare of the foster child.

3. Community resources and services must be made known to and utilized by the FFH, as indicated by the needs of the children.

4. A plan for regular time-off for providers shall be developed by the agency and the FFH provider. (agency requirement)

5. The environment and structure of the home shall be appropriate to the needs of the foster child(ren).

K. Group family foster homes (additional requirements):

Reason: Not all foster homes fit into neat categories. There are families with many children of their own. There is a need to develop innovative ways of caring for children away from their own families—such as emergency shelters and teen-age peer groups. It is both necessary and desirable to provide flexibility and room for innovation in the field of foster care, while still ensuring the basic needs of children.

1. The group family foster home, in conjunction with the agency, shall define, in writing, a description of the ages and kinds of children to be served, as well as the scope of services to be provided by the group family foster home.

2. The group family foster home and agency shall have a written and signed agreement containing: (agency responsibility)

a. Admission and discharge policy for the children.

b. Individualized program plans for the children and designated responsibility for developing and implementing these plans.

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c. The time limits of the agreement.

d. The responsibilities of the agency and the GFFH.

e. The rate to be paid the home for its services, including any special payments for clothing, medical expenses, and special services.

f. The responsibility for arranging for all necessary services and resources in the community.

g. The arrangements for substitute providers for emergency situations, vacations, illness, and for regular time-off.

h. The arrangements for providing administrative, consultative, and social services for the GFFH.

3. There shall be a minimum of one adult in residence for every five children in the group family foster home.

4. The group family foster home shall care for no more than ten children, including their own children.

5. Physical facility.

a. There shall be thirty-five square feet of living space per child, excluding bathrooms, halls, bedrooms, kitchen, and laundry or furnace room.

b. The dining area must be able to comfortably accommodate, at one time, all the children plus the family.

c. Every sleeping room accommodating one foster child shall have at least eighty square feet of floor space.

d. Every sleeping room accommodating more than one foster child shall have at least sixty square feet of floor space per child.

e. No sleeping room shall accommodate more than four children.

f. Each child shall have adequate space for his clothing and personal possessions.

6. The application for licensure shall be signed by both the agency and the applicant.

7. A group family foster home may not care for more than two unrelated children who are nonambulatory, nonmobile, severely mentally retarded, or profoundly mentally retarded at any one time.

Effective Date: December 24, 1977.

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APPENDIX A

DAILY FOOD GUIDE

FOOD	SERVING PER DAY	AVERAGE SIZE SERVING BY AGE*				
		1-3 yrs	3-6 yrs	6-9 yrs	9-12 yrs	12-18 yrs
MILK GROUP:						
Milk	2-3 servings	½-1 cup	½-1 cup	1 cup	1 cup	1 cup
Cheese and ice cream occasionally						
MEAT GROUP:						
Meat, poultry, fish, and, as alternatives, dried beans or peas or peanut butter	1-2 servings	1-3 oz.	2-4 oz.	4-5 oz.	4-6 oz.	4-6 oz.
Egg	3-4/wk	1	1	1	1	1
VEGETABLE & FRUIT GROUP:						
Dark green vegetables and deep yellow vegetables and fruits for Vitamin A	1 serving	2-3 tblsp.	2-4 tblsp.	¼ cup	½ cup	½ cup
Fruit for Vitamin C - citrus, tomato, cabbage	1 serving	1/3-2/3 cup	1/3-2/3 cup	½ cup	½ cup	½ cup
Other fruits and vegetables	2 servings	¼-1/3 cup	¼-½ cup	½ cup	½ cup	½ cup
BREAD AND CEREAL GROUP:						
Bread and cereal, whole grain or enriched	4 servings	½-1 slice ¼ cup cereal	½-1½ slices ½ cup cereal	2-3 slices ½ cup cereal	2-3 slices ¾ cup cereal	2-3 slices 1 cup cereal

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APPENDIX A (Cont.)

FOOD	SERVING PER DAY	AVERAGE SIZE SERVING BY AGE*				
		1-3 yrs	3-6 yrs	6-9 yrs	9-12 yrs	12-18 yrs
OTHER						
Butter or margarine	as spread or seasoning				2 tblsp.	2-4 tblsp.

*Size of serving will differ with individual children; some may want smaller amounts and some larger.

Source: USDA, Consumer & Food Economics Research Division - 1963 Minnesota Department of Health.

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APPENDIX B

FOSTER CARE

TYPE OF HOME	EXPERIENCE	ANNUAL TRAINING	NUMBER OF "OWN" CHILDREN	NUMBER OF FOSTER CHILDREN	TOTAL NUMBER OF CHILDREN
1. Interim & permanent (3 foster - 5 total)	Licensed less than 2 years	12 hours	0-2	3 Absolute	5
			3	2 limit in	5
			4	1 this	5
Exclusively Permanent or Restricted		No Requirement	5	2 category	7
			6	1	7
2. Interim & Permanent (5 children total)	Licensed 2 or more years	12 hours	0	5	5
			1	4	5
			2	3	5
Exclusively Permanent or Restricted		No Requirement	3	2	5
			4	1	5
			5	2	7
			6	1	7
3. Emergency Shelter (7 children total)		12 hours 6 hours (Special needs)			7

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APPENDIX B (Cont.)

TYPE OF HOME	EXPERIENCE	ANNUAL TRAINING	NUMBER OF "OWN" CHILDREN	NUMBER OF FOSTER CHILDREN	TOTAL NUMBER OF CHILDREN
4. Special Services (Handicapped or Extraordinary Care) (4 foster - 5 total)	a) Licensed 3 years + 12 hrs. related training OR b) Experience - 1 year with handicapped + 6 hours related training OR c) 25 hrs. related training	12 hours 6 hours (Special needs)	0 1 2 3 4	4 4 3 2 1	4 5 5 5 5
5. Group Family (10 children total)		12 hours 6 hours (Special needs)	(No more than 2 children with severe handicaps at one time)		10

EXCEPTIONS: a) Siblings need placement together. Maximum Number: Seven children total.
b) Home has five or six children of its own under age 18. Maximum Number: Seven children total.
c) Child needs to be placed again in the same home. Maximum Number: Seven children total.

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§ 2.002 Standards for family-day-care homes and group-family-day-care homes.

A. Definitions:

Agency–Unless qualified, means the local county welfare department; the agency is the duly delegated representative of the Commissioner.

Commissioner–Unless qualified, means the Commissioner of the Department of Public Welfare.

Day-Care–The care of children outside of their own homes for a part of the 24 hour day by persons unrelated to them by blood or marriage. Day Care includes family day care, group family day care, and group day care centers.

Department–Unless qualified, means the Department of Public Welfare.

Family-Day-Care-Home (FDC)–A program providing day care for no more than five children at one time, including the family day care provider's own children under school age.

Family-Day-Care Provider–The individual giving care to children in a family-day-care-home. The family day care provider is the person held accountable for the operation of the family day care home or group-family-day-care home under this rule.

Group-Family-Day-Care (GFDC)–A program providing day care for more than five but fewer than eleven children at any one time, including the provider's or helper's own children under school age.

Helper–An individual who is at least 13 years of age who assists a family-day-care provider or a group-family-day-care provider with the care of children.

Infant–Child aged six weeks through 15 months.

Intermediate School Child–Child aged nine years through twelve years.

Licensed Capacity–Maximum number of children who can be in attendance in a family-day-care home or group-family-day-care-home at any given time.

Licensing Representative–A duly delegated representative of the Commissioner.

Preschool Child–Child aged 31 months through five years.

Primary School Child–Child aged six years through eight years.

Toddler–Child aged 16 months through 30 months.

Waiver–Temporary (or permanent) written permission to disregard a particular licensing rule.

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B. Licensing laws and procedures:

1. A family-day-care-home (FDC), in order to provide care during any part of the 24-hour day, must be licensed by the department, with the following exclusions:

a. A FDC providing care only to children related to the FDC operator by blood or marriage.

b. A FDC providing care to children from one other family only.

c. A FDC providing care to children for less than 30 days in any twelve month period.

2. Application for a license shall be made on the form issued by the department. This form can be obtained from the county welfare department (agency) in the county where the applicant resides.

3. The applicant for a FDC license shall apply through a duly delegated representative of the commissioner.

4. The applicant for a FDC license shall be furnished with a copy of the appropriate rules and regulations.

5. Upon receipt of a signed and completed application form, the agency shall evaluate the prospective FDC based upon these rules and regulations. A prospective FDC which meets minimum standards shall be recommended to the Commissioner for issuance of a FDC license. This license may be either provisional or regular.

a. A non-renewable provisional license shall be issued for a period of up to one year where, in the opinion of the agency or the department, the FDC does not fully comply with licensing standards.

b. A regular license shall be issued for a period of up to two years where, in the opinion of the agency and the department, the FDC fully complies with licensing standards.

6. The license, whether provisional or regular, shall specify the number of children to be provided care.

7. An evaluation visit shall be made by the agency at least once every twelve months for as long as the FDC provider maintains a FDC license.

8. The Commissioner or his duly designated representative shall have access to the FDC for inspection at any time during the hours in which day care is being provided.

9. Any FDC applicant or licensee whose application for a license is denied and any FDC provider whose license is revoked or not renewed may

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appeal to the Commissioner within 30 days in accordance with Minnesota Statutes, Chapter 15, 1969. The agency shall notify by certified mail any facility whose license is denied, revoked, or not renewed. This notification shall state the grounds for such action and shall inform the applicant or operator of his right to appeal the action.

10. State law provides that every person who operates a facility required to be licensed pursuant to Minn. Stat. §§ 257.081 through 257.123, without a license or who violates any provision of those sections shall be guilty of a misdemeanor. Any person who offers or advertises a facility required to be licensed pursuant to Minn. Stat. §§ 257.081 through 257.123, prior to obtaining such a license or who offers or advertises any facility in violation of any provision of Minn. Stat. §§ 257.081 through 257.123 shall be guilty of a misdemeanor.

11. Regulations may be waived for not more than one year with the approval of the department according to the procedure established for such waiver, provided that the health and safety of children is assured. The granting of a waiver shall not constitute a precedent.

C. Limitations of license:

1. No FDC provider shall discriminate in relation to admissions, terminations, or treatment of children on the basis of race, creed, color, national origin, religion, or sex.

2. The FDC home shall be licensed for no more than five children under school-age, including the provider's children under school-age.

Satisfactory Compliance:

a. No family day care provider shall care for more than three infants and toddlers under two and one-half years of age at any one time; or more than two infants under fifteen months of age at any one time.

b. Part-time children may be counted as one full-time child if they are not in care at the same time.

c. In addition to the licensed capacity, two school-age children may be in care if:

(1) Care is generally limited to no more than three hours per day, and

(2) exceptions to this limit amount to no more than 30 days per school year.

d. Other child care arrangements shall have the prior approval of the agency.

3. Twenty-four hour care may not be provided for day care children

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unless the FDC provider has the approval of the agency. Such care may not be provided for more than 30 days in any month period.

4. A FDC provider must have reached at least the age of 18 years at the time of licensure.

5. The FDC license is not transferable to another operator or site.

6. The agency must be notified of any changes that would affect the terms of the license.

7. Any changes in the terms of the license (maximum number or age grouping) must have prior written approval of the agency.

8. When an FDC provider decides to terminate services as an FDC provider, notice of the closing must be sent to the agency.

D. Staff qualifications and training:

1. FDC applicants and others living in the household shall be kind and responsible people with a genuine liking for children. They shall possess consistent and healthy methods for handling the life style unique to their own families.

Reason: Children in family-day-care-programs are under the care of the day care providers for a large portion of the day and therefore are strongly influenced by the emotional climate and the values within that day-care home. Children are often too young or too frightened to speak out against physical or emotional abuse or neglect.

Satisfactory Compliance:

An FDC license shall not be issued where any person living in the household has any of the following characteristics:

a. A conviction for, admission of, or substantial evidence of an act of child battering or child abuse or child molesting.

b. Use of alcohol or drugs such that its effects are apparent during the hours that children are in care.

c. A placement of the family's own children in foster care or residential treatment for emotional disturbance within the previous 12 months unless the primary reason for such placement was:

(1) The physical illness of the parent.

(2) or The mental retardation or physically handicapping of the child.

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(3) or The temporary foster placement of an infant being relinquished for adoption.

d. A conviction for any felony or offense involving moral turpitude.

2. The FDC provider shall be able and willing to work cooperatively with the agency and with the parents of children in care.

Satisfactory Compliance:

a. The FDC provider shall keep the parent aware of the child's progress and development.

b. All required reports and information shall be submitted to the agency on time.

3. All adults in the FDC home during the time child care is given shall be reasonably healthy and free from contagious or infectious disease.

Satisfactory Compliance:

The FDC provider shall supply evidence to the Agency that:

a. During the six months prior to application, each adult in contact with the FDC children has had a negative Mantoux test or chest X-ray.

b. A statement from the provider's physician dated within the six months prior to the application that either:

(1) The provider has received a physical examination and is physically and emotionally able to provide day care to young children.

(2) or The provider is receiving all necessary continuing medical care and is physically and emotionally able to provide day care to young children.

4. The operator must demonstrate willingness to acquire knowledge of the basic needs of children.

Satisfactory Compliance:

Within two years after the agency is prepared to offer training to FDC providers, each licensed FDC provider shall participate in a minimum of six hours of training. Newly licensed providers shall participate in a minimum of six hours of training within one year after the date of initial licensure, provided that the agency is prepared to make such training available.

5. No child shall be subjected to corporal or psychological abuse.

Reason: Although families differ in their approach to discipline, harsh or threatening methods are not appropriate for children in day care.

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Satisfactory Compliance:

a. Methods of discipline used by the FDC provider shall be discussed with the child's parent at the time of enrollment.

b. No child shall be hit, shaken, pinched, or roughly handled by the FDC provider.

c. No child shall be insulted or belittled by the FDC provider.

d. Exclusion, when used as discipline, shall not exceed ten minutes for any child and shall be within hearing of an adult in a lighted, well-ventilated room. No child shall be isolated in a locked room or closet.

e. No child shall be punished for lapses in toilet training.

f. Deprivation of meals and snacks shall not be used as forms of punishment unless the misbehavior occurs during meal or snack.

g. No discipline or punishment shall be delegated to another child.

h. No derogatory remarks about a child or his family shall be made.

6. Personal information about the child or his family shall not be shared with the community.

E. Health:

1. At the time of admission, the FDC provider shall obtain from the parent a health history of the child, including information on special diet, allergies, immunization record, source of regular health care, and any other problems of the child.

2. Special consideration must be given when providing care to a handicapped child.

Satisfactory Compliance:

a. A physician's statement indicating the nature of the handicap and any special methods that must be employed in caring for the handicapped child.

b. A careful exploration with the parent of the handicapped child, including complete explanations of care and treatment, at the time of admission or occurrence of the handicap.

c. Written instructions from the physician and/or parent indicating any special therapy, program or behavior techniques required by the handicapped child.

d. Regular Conferences with the parent.

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3. No FDC provider shall be required to accept a sick child for care. The provider may, however, accept a sick child where care can be given without unduly endangering the health of others.

Reason: Caring for a sick child imposes extra burdens on the FDC provider that the parent and agency cannot require. If a sick child is to be cared for, appropriate health practices must be assured.

Satisfactory Compliance:

a. Provider shall have a plan approved by the agency for isolating a sick child when necessary from other children receiving care.

b. Parents of children in care shall be notified that it is the practice of the provider to offer care to sick children.

c. The parent of a sick child placed in the FDC provider's care shall give complete instructions to the provider about care for his child.

d. The sick child, if isolated from other children, shall still be under the control and supervision of the provider. The sick child must be within hearing of the FDC provider or a helper.

4. The FDC provider shall be prepared to cope with health emergencies.

Satisfactory Compliance:

a. The FDC provider shall have a plan approved by the agency and by the child's parents for meeting medical emergencies; this plan shall include the name and phone number of the child's physician.

b. The FDC provider shall have first aid supplies readily available to treat minor injuries.

c. The FDC provider shall obtain written permission from the child's parents prior to the administration of any medication-prescription or non-prescription.

d. The FDC provider shall have written instructions from a licensed physician or dentist prior to the administration of any prescription medication. Medication with current prescription information on the label shall constitute such instructions.

5. Separate towels, wash cloths, drinking cups, combs and other personal articles must be used for each child. (Paper towels are permitted.)

6. Clean and separate bed linen shall be provided for each child in care.

7. FDC homes that have pets shall provide evidence that such pets have

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had all necessary shots; FDC homes shall not have turtles, chickens, or ducks as house pets.

8. FDC provider shall submit to the agency a special report within 48 hours after the occurrence of an unusual accident such as the death or serious injury of a child. A serious injury shall be defined as one which requires the hospitalization of the child. A report shall also be made within 48 hours after the occurrence of a fire that requires the services of a fire department.

9. When a positive diagnosis of a serious communicable or infectious disease is made, the parents of all exposed children shall be notified immediately. Such children shall be watched for symptoms of the disease.

10. The FDC provider and any helper shall wash thoroughly after changing diapers or using toilet facilities and before handling food.

11. Diapers shall be changed when they become soiled or wet. A child who has soiled shall be washed with a separate cloth or towel before diapering.

12. Children shall be offered frequent opportunities for toileting.

13. An adequate supply of clean diapers shall be available. Diapers may be provided by the parent. All diapers shall be stored in a sanitary manner.

14. Soiled diapers shall be kept in a closed container. This container shall be renewed or cleaned daily and shall not be accessible to the children.

F. Physical environment:

1. The day-care-home must have adequate toilet facilities, disposal, and proper lighting and ventilation, as determined by the commissioner in consultation with the Department of Health.

Satisfactory Compliance:

a. Complete disposal of waste means toilet must flush thoroughly.

b. Outdoor toilets are permissible if local regulations allow.

2. There must be a safe water and milk supply.

Satisfactory Compliance:

a. Sample shall be taken of water from wells and tested by the State Health Department.

b. All milk must be pasteurized.

3. Basements, if warm and dry, light and well ventilated, may be used for short periods of active play but must not be used for sleeping.

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Satisfactory Compliance:

a. Furnace and hot water heater must be separated by a door, partition or barrier from play areas.

b. Basements partly above ground level that are clean, warm and dry may be used for play periods; basements shall not be used for sleeping.

c. Cellars wholly below ground level shall not be used.

4. All stairways shall be guarded for the toddler and crawler.

Reason: Stairways present a substantial accident hazard to toddler and crawler.

Satisfactory Compliance:

a. The area between guard rail and stair tread shall be enclosed on stairs used by the children.

b. Stairways used by children shall have handrails.

c. Gates shall be used at both top and bottom of stairs accessible to the children where care is being provided to crawlers or toddlers.

d. Stairways shall be kept clear.

5. The house and premises shall be clean, reasonable neat, and free from hazards that jeopardize health and safety.

Satisfactory Compliance:

a. FDC premises shall be inspected by a representative of the Commissioner.

b. House and premises shall be clean, reasonably neat, and free from accumulations of dirt, rubbish, or peeling paint.

c. All medicines, chemicals, cleaning supplies, and other toxic substances shall be stored out of the reach of children. They must not be stored with or immediately adjacent to food products.

d. Electric receptacles accessible to the children shall be covered or protected when not in use.

e. Scissors, knives, matches, thin plastic bags, and other potential hazards to children shall be kept out of their reach. The use of potentially hazardous materials and tools shall be supervised.

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f. Outdoor garbage and rubbish containers shall not be accessible to the children.

g. Outdoor play space shall be enclosed as necessary to provide protection.

h. The FDC provider shall maintain personal cleanliness and conform to hygienic practices while preparing food.

i. All food and cooking utensils shall be stored to protect from dust, vermin, leakage from pipes, or other contamination.

j. Food needing refrigeration shall be stored at a temperature that will prevent spoilage and bacterial growth. (40^{o} recommended)

k. Appliances regularly used in the storage and preparation of food shall be safe and in good working order.

l. Except for home-canned meat, fish, and poultry, the use of home-canned foods is acceptable.

m. Effective measures shall be taken to protect against the entrance into the home or breeding of vermin and insects.

6. FDC provider shall have knowledge of where each child in care is at all times.

7. Children in care shall be adequately supervised by the FDC provider or helper.

8. The FDC home shall be safe from fire and structural hazards.

Satisfactory Compliance:

a. An inspection for fire safety shall be made before licensure and whenever a fire hazard appears to be present in the estimation of the agency.

b. Every room below ground level shall have one exit leading directly outside. This exit may be a window large enough for a child to crawl through.

c. Unvented room heaters shall not be permitted.

d. No stove or heater shall be located where it would block escape in case of a stove or heater fire.

e. A portable fire extinguisher shall be provided for the kitchen and cooking areas. This extinguisher shall be in working order and checked annually.

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f. Combustible items shall not be located or stored near the furnace area.

g. Fireplaces, space heaters, steam radiators and hot surfaces such as steam pipes shall be protected by guards.

h. Every closet door latch shall be one that can be opened from the inside.

i. Every bathroom door lock shall be designed to permit the opening of the locked door from the outside in an emergency.

9. The FDC provider shall be prepared to cope with emergencies.

Satisfactory Compliance:

a. The FDC provider shall have information on file that will permit contact with the parents of each child in care.

b. The FDC provider shall make arrangements for a substitute care giver to provide care during emergencies. The substitute care giver shall be eligible for the same training as the licensed FDC provider.

c. A list of emergency telephone numbers shall be prominently posted by the telephone, including police, fire, doctor, and hospital.

d. The FDC provider shall make arrangements in advance for emergency transportation.

e. Emergency procedures shall be planned, written, and posted. They shall include a plan for evacuation.

f. A review of these emergency procedures shall be held not less often than annually.

g. At least one operable flashlight shall be available for use in the event of a power failure.

G. Nutrition:

1. Well-balanced meals and snacks shall be served daily.

Reason: Balanced nutrition is basic to the attainment of good health. A child grows and develops rapidly during early life and this growth and development is related to nutrition.

Satisfactory Compliance:

Each meal served shall include servings from each of the basic four food groups as indicated in the Daily Food Guide.

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DAILY FOOD GUIDE

FOODS	SERVINGS PER DAY	AVERAGE SIZE SERVING BY AGE*		
		1-3 YEARS	3-6 YEARS	6-9 YEARS
MILK GROUP:				
Milk	2-3	½-1 cup	½-1 cup	½-1 cup
Cheese and ice cream occasionally				
MEAT GROUP:				
Meat, poultry, and fish	1-2	1-3 tblsp.	2-4 tblsp.	4-6 tblsp.
As alternatives dried beans or peas or			(1-2 oz. cooked)	(2-3 oz. cooked)
peanut butter		1-3 tblsp.	2-4 tblsp.	4-6 tblsp.
Egg	1*	1	1	1
VEGETABLE AND FRUIT GROUP:				
Dark green vegetables and deep yellow vegetables and fruits for Vitamin A	1	2-3 tblsp.	2-4 tblsp.	¼ cup
Fruit for Vitamin C—citrus, tomato, cabbage	1	1/3-2/3 c	1/3-2/3 c	½ cup
Other fruits and vegetables	2	¼-1/3 c	¼-½ c	½ cup
BREAD AND CEREAL GROUP:				
Bread and cereal, whole grain or enriched	4	½ to 1 slice ¼ c cereal	½ to 1½ slices ½ c cereal	2-3 slices ½ c cereal
OTHER				
Butter or margarine	As spread or seasoning			

*Size of serving will differ with individual children, some may want smaller amounts and some larger.

2. The FDC provider shall obtain from the parent at the time of enrollment, written instructions on each child's special diet or food needs.

Satisfactory Compliance:

a. Any special diet or food needs shall be recorded on the child's admissions and arrangements form.

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b. Parent's wishes on the serving and timing of snacks shall be observed as far as possible.

3. Parents shall be consulted about special food preferences.

4. Flexible feeding schedules shall be provided for infants and toddlers.

Satisfactory Compliance:

a. The infant's or toddler's usual feeding schedule, as given by the child's parent, shall be recorded on the child's enrollment form.

b. The infant's or toddler's usual feeding schedule shall be followed by the FDC provider in so far as is possible.

c. Food and bottles brought from home shall be labeled with the child's name and refrigerated when necessary. Bottles shall be rinsed when empty.

5. Drinking water shall be available to children and offered at frequent intervals.

Satisfactory Compliance:

a. Water bottles for infants shall be identified for each individual infant. The water shall be stored and handled to protect against contamination.

b. Drinking water for toddlers and older children shall be provided in individual or single-service cups.

H. Daily activities: Daily activities shall be defined as the program of the FDC for meeting the needs of children receiving service. Daily activities shall foster normal physical, social, mental, and emotional development of children.

1. Infants.

a. Each infant must be held during bottle feedings until he is safely able to hold his own bottle. Bottles shall not be propped.

Reason: An infant's first sense of security is closely related to his food. Being held during feeding helps him to develop a trust relationship with others. It is possible for a young infant to choke on milk or water from a propped bottle.

b. Each infant must be held, rocked, cuddled, and played with during each day of care.

Reason: Physical closeness to others is indispensable as a first step in social relationships.

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c. Each infant's attempts to communicate must be responded to.

Reason: Baby sounds are the beginning of speech and language development. Socialization is encouraged when the infant receives a response to his babbling.

Satisfactory Compliance:

The FDC provider shall talk and listen to each infant.

d. The infant must be allowed freedom of movement during a large part of his waking day.

Reason: The infant needs large muscle activity in order to develop properly, physically and mentally. The infant learns by exploring his environment.

Satisfactory Compliance:

(1) The non-creeping infant shall spend part of each day on a clean carpeted floor or large blanket.

(2) The creeping infant shall have freedom to explore outside of crib or playpen. A crib or playpen shall be used only for sleeping or for short periods of time when needed for safety or when the provider is attending to other children. During the infant's waking hours, a playpen shall be placed where the infant can watch others. Several hours each day of care shall be spent outside the crib or playpen.

e. The infant must be provided with an environment that stimulates all of his senses.

Reason: The infant develops in response to stimuli; retarded development can occur when there is a lack of stimulation.

Satisfactory Compliance:

Infants should be provided with: (commercial, homemade, or natural)

(1) Things to look at (e.g., crib mobile).

(2) Things to listen to (e.g., rattle, FDC provider's voice).

(3) Things to feel (e.g., a soft ball).

(4) Things to smell (e.g., new baked cookies).

(5) Things to taste (e.g., objects that are nontoxic and too large to swallow or choke him).

f. Weather permitting, each infant must spend some part of each day out-of-doors.

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Reason: Time spent in the outdoor environment helps to foster optimum physical well-being.

Satisfactory Compliance:

Except in inclement weather each healthy infant shall spend some time each day out-of-doors.

2. Toddlers, preschoolers, and school-age children.

a. Each child shall be allowed as much independence as he can safely handle.

Reason: The child needs to establish his own identity; children learn through exploring and manipulating their environment.

Satisfactory Compliance:

Each child shall be allowed and encouraged to move about and handle safe objects in the FDC.

b. Each child shall be provided with limits consistent with his age and understanding.

Reason: The child needs to internalize some rules for his own and others safety.

Satisfactory Compliance:

Each child shall be taught to avoid behavior that would be dangerous to him or to others.

c. Each child shall be encouraged to communicate verbally.

Reason: Speech and language development occurs through practice and encouragement. Socialization is encouraged when the child receives a response to his talking.

Satisfactory Compliance:

The FDC provider shall talk to and listen to each child.

d. Each child shall be given physical signs of affection.

Reason: The child needs physical closeness, although he may reject it at times because of his growing need for independence. This independence must be respected, but rocking, hugging, and other physical signs of affection must be offered.

Satisfactory Compliance:

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Each child shall be given outward signs of affection by the FDC provider, as appropriate for his age and needs.

e. Each child shall be provided with materials and equipment that will foster his development physically, mentally, and emotionally.

Reason: Appropriate materials and equipment encourage activities among children.

Satisfactory Compliance:

(1) The FDC home shall provide commercial, homemade or natural materials and equipment that encourage and stimulate:

Large muscle activities (e.g., large blocks, cardboard cartons).

Small muscle activities (e.g., small blocks).

Creative activities (e.g., dress-up clothes).

Cognitive activities (e.g., puzzles, books).

Social activities (e.g., games).

(2) All equipment shall be of sound construction and in operative condition.

f. Weather permitting, each child shall spend time out-of-doors.

Reason: Time spent in the outdoor environment helps to foster optimum physical well-being.

Satisfactory Compliance:

Except in inclement weather, each healthy child shall spend some time each day out-of-doors.

g. Toilet training shall be undertaken when appropriate to each child's age and stage of development and in cooperation with the parents' wishes.

Satisfactory Compliance:

(1) The FDC provider shall obtain instructions from the parent about timing and methods of toilet training. Any toilet training given by the FDC provider shall be in cooperation with the parent's plan and within the limits of the licensing standards.

(2) No child shall be punished for accidents occurring during toilet training.

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h. Each child shall be napped or rested as appropriate to his age and stage of development and in cooperation with the parent's wishes.

Reason: Children's needs for naps differ even at similar ages.

Satisfactory Compliance:

The FDC provider shall obtain instructions from the parent about the child's need for naps or rests and the parent's wishes about naps. In so far as possible, each child shall take a nap in accordance with the parent's wishes.

3. When transportation is given to FDC children by persons other than their parents, adequate precautions for their safety must be made.

Satisfactory Compliance:

a. No child shall be permitted to remain unattended in any vehicle.

b. Each child being transported shall use an approved safety seat, seat belt, or harness.

c. No more than three persons, including the driver, shall be permitted to occupy the front seat of the vehicle.

d. Any vehicle operated for the transportation of children shall be licensed in accordance with the laws of the State of Minnesota, and the driver shall hold a current and valid driver's license.

e. Insurance coverage shall be provided.

I. Records.

1. The FDC provider shall complete an admissions and arrangements form for each child in care at the time of first enrollment.

Satisfactory Compliance:

a. Admissions and Arrangement Form shall contain the following information:

(1) Name and birth date of the child.

(2) Full name of parent or guardian.

(3) Home address, work address, and telephone numbers where parent or guardian can be reached.

(4) Name, address and telephone number of physician caring for the child who should be consulted for emergencies when parent or guardian cannot be reached.

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(5) Name, address and telephone number of person to be notified in case of emergency, when parent or guardian cannot be reached.

(6) Names of all persons authorized to remove child from FDC home.

(7) Specific instructions from parent or guardian about toilet training, eating, sleeping or napping habits, allergies, and other special health problems.

(8) Enrollment and termination dates.

(9) Financial arrangements.

b. For every infant and toddler, the FDC provider shall get a written statement from the parent or guardian about the specific habits of eating, sleeping, toileting, communication, and comforting.

c. Written consent shall be obtained from the parent or guardian for emergency medical care or treatment, to be used only if the parent or guardian cannot be reached immediately. Medical-care consent may be waived when in conflict with the parent's religious beliefs.

2. The FDC provider shall inform the agency of each admission or termination.

J. Group-family-day-care: In addition to meeting family-day-care standards, group-family-day-care facilities and providers must meet the following standards:

1. Limitations of license: The GFDC shall be licensed for no more than ten children under school-age, including the provider's and helper's children under school-age.

Satisfactory Compliance:

a. No more than three infants and toddlers (under two and one-half years of age) for each provider.

b. No more than two infants (under 15 months of age) for each provider.

c. No more than four infants or six toddlers for each provider-and-helper combination.

d. No more than six infants and toddlers for each provider-and-helper combination.

e. No more than ten preschoolers for each provider, or each provider-and-helper combination.

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f. Part-time children may be counted as one full-time child if they are not in care at the same time.

g. In addition to the licensed capacity, two school-age children per staff person may be in care if:

(1) Care is generally limited to no more than three hours per day, and

(2) exceptions to this limit amount to no more than 30 days per school year.

h. Other child care arrangements shall have the prior approval of the agency.

2. Staff qualifications: Group family day care providers shall have experience and/or training in providing day care to children.

Satisfactory Compliance:

a. A minimum of one year's experience as a licensed family day care provider.

or

b. A minimum of one year's experience as a paid or volunteer staff member of a licensed group day care facility.

or

c. A minimum of one approved child-development course, as defined below:

Child Development Training Course—may include but is not limited to:

	Examples:
Child growth and development	Child psychology
Family relations	Parent effectiveness training
Preschool methods and curriculum development	Music, art
Human relations	Sensitivity training, study of ethnic backgrounds
Food and nutrition	Menu planning
Administration of programs	Budget, management

Training may be offered by county welfare departments, family-day-care associations, day-care centers, groups of centers, related organizations (including professional organization activities such as conventions and seminars), businesses, agencies, vocational schools, colleges or universities.

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One approved child-development training course equals approximately three university or college credits or 30 clock hours in a vocational-technical institute. These child-development courses qualify staff for group-day-care homes and group-day-care centers, but do not imply certification through the Department of Education.

3. Physical environment: Group-family-day-care facilities shall be large enough to provide space for a variety of activities.

Satisfactory Compliance:

a. There shall be a minimum of 35 square feet of useable indoor play area per child, excluding bathrooms. This may include basements, if warm and dry, for large-muscle activities.

b. A crib or padded play pen shall be provided for each infant in attendance.

c. A cot or bed shall be provided for each toddler and preschool child in attendance.

d. There shall be a safe outdoor play area adjacent to the FDC home or park facilities nearby for regular use.

4. *Daily activities:*

a. Each child shall be provided with activities that develop both large and small muscles.

Satisfactory Compliance:

(1) Daily activities shall include large muscle activities, such as running, jumping, skipping, climbing, sliding, rolling, pulling, and pushing.

(2) Daily activities shall include small muscle activities, such as cutting, pasting, and manipulating clay, crayons, and other small objects.

b. Each child shall be provided with activities that develop creativity and imagination.

Satisfactory Compliance:

(1) Daily activities shall include art and music that encourage individual creativity such as making collages, painting, developing rhythm, and dancing.

(2) Daily activity shall include dramatic play, such as "house" and "store".

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c. Each child shall be provided with activities that encourage cognitive development.

Satisfactory Compliance:

Daily activities shall include the development of skills in recognizing colors, shapes, sizes, animals, and so forth.

d. Permission shall be obtained from the parents before allowing school-age children in care to participate in activities outside the Group-Family-Day-Care Facility, such as special interest groups, clubs, bike riding with friends, recreational programs, and the like.

3. Group-Family-Day-Care Minimum Equipment List

PRESCHOOL–
2½ THROUGH 5

Furniture and Supplies:	1. Small tables and chairs 2. Availability of cots or beds 3. First-aid supplies 4. Fire blanket (100% wool)
Large-Muscle Play:	1. Large building blocks (may be of non-durable materials such as milk cartons) 2. One or more durable pieces of large-muscle equipment such as: swing tunnel balance beam climber wheel toys 3. Other large-muscle toys, such as balls and jump ropes
Small-Muscle and Ponder Play:	1. Books–one per child or use of public library 2. Games and toys to learn: number, letter shape, size and color concepts 3. Transportation toys (trucks, cars) 4. Construction toys (small blocks, lincoln log, legos)
Music Activities:	1. Phonograph, piano or musical instruments (homemade or commercial)
Dramatic Play:	1. Dress-up clothes (boys and girls) 2. Homemade play house (such as large cardboard box, blanket tent, etc.) dolls
Art Activities:	1. clay or play dough 4. blunt scissors 2. paper 5. scraps 3. paste 6. paint (non-toxic)
Water Play:	1. Dishpan 2. Basters 3. Measuring cups

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INFANTS AND TODDLERS–0-2½	
Equipment	Cribs Mobiles (homemade or commercial) Safe seat (such as infant seat, high chair, jumper-walker) Pull toys Training chair

Effective date–January 17, 1974

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§ 2.003 Standards for Group-Day-Care of Preschool and School-Age Children.

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Explanation of Report

The general format of the standards drafted by the Day Care Standards Advisory Committee is as follows:

RULE: Designated by all capital letters

REASON: An explanation of the reason behind the rule

SATISFACTORY COMPLIANCE: Method or methods which a center must follow in order to be in full compliance with the rule. Depending on the nature of the rule, SATISFACTORY COMPLIANCE may include a single requirement, several requirements, or alternative methods of satisfying the rule.

When the rule is self-explanatory, REASON and/or SATISFACTORY COMPLIANCE are not included.

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§ 2.003 Standards for Group-Day-Care of Preschool and School-Age Children.

A. Definitions:

Health and safety license. A group-day-care center program that has received an exemption from licensure from the commissioner of education must, in addition, possess a health and safety license from the Department of Public Welfare under DPW Rule 3. The following regulations shall be met:

	Requirements	Exemptions
A. Definitions	All	None
B. Licensing laws and procedures	1 through 16	17
C. Facility	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14	13, 15
D. Program	4, 5, 6	1, 2, 3, 7
E. Health	1, 2, 3	None
F. Admissions	2	1, 3
G. Staff	3, 4 (Staff: Child Ratio)	1, 2, 4, 5 (Staff distribution and group size)
H. Organization	3, 4	1, 2, 4, 6
I. Handicapped	1, 2, b, c, e, 3	2, a, d, 4
Appendices	1 (Minimum Equipment - Infants & Toddlers)	1 (Minimum Equipment - Preschoolers). (Minimum Equipment - School-Age)
	2 (Health Care Summary)	
	3 (Daily Food Guide)	

Accredited course - A course that is offered by or through an institution with an accreditation. Courses need not be taken for credit, but must have an assigned credit value by the institution. An accredited course is considered to be three university or college quarter credits or 30 vocational-technical clock hours of training.

Aide - See staff—Child care assistant.

Affirmative action plan - Statement explaining how a center intends to recruit persons without discrimination.

Age groupings:

Infant - Child aged six weeks through 15 months.
Toddler - Child aged 16 months through 30 months.
Preschool child - Child aged 31 months through five years.
Primary school child - Child aged six through eight years.
Intermediate school child - Child aged nine through 12 years.

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Child development training - Child development training shall include courses that are relevant to the programs. All training should not be in one area. The following are examples of areas of training and courses which may be taken:

Areas of Training	Examples of Courses
Child growth and development	Child psychology
Family relationships	Parent effectiveness training
Preschool methods and curriculum development	Music, art
Human relations	Sensitivity training, study of ethnic backgrounds
Food and nutrition	Menu planning
Administration of programs	Budget, management

To be considered in entry level staff qualification, training must be offered through an accredited body. These child development training courses qualify staff for group-day-care centers but do not imply certification by the State Department of Education.

Child development assistant training program - Program offered by vocational-technical institutes, junior colleges, and the University Technical Institute, involving a minimum of 1,080 hours of activities and courses oriented to and focused on the practical application of child development.

Child development associate - Person meeting the skill and competency requirements by the Office of Child Development.

Commissioner - Commissioner of Public Welfare.

Day care - The care of children outside of their home for part of a 24-hour day by persons unrelated to them by blood or marriage. Day care includes group day care, family day care, and group-family day care (see also DPW Rule 2).

Drop-in care - There are two types of drop-in care:

1. Combined program. The acceptance of additional children into a licensed child care program on an irregular basis (not more than one-fifth of the center's week) but not to exceed the facility's licensed capacity during any part of the day. The percentage of drop-in children shall not exceed ten percent of the total attendance.

2. Total drop-in program. Center whose total licensed capacity is based primarily on children who attend on an irregular basis.

Facility - Physical environment in which a group-day-care program takes place.

Group-day-care center - Any program that, for compensation or otherwise,

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provides day or night care for six or more children at one time. The term includes, but is not limited to, programs for children known as nursery schools, day nurseries, child care centers, play groups, day care centers for school-age children, after-school programs, infant day care centers, cooperative day care centers, and Head Start programs.

Licensed capacity - Maximum number of children who can be in attendance at a center at a given time.

Person (operating a group-day-care facility) - Includes an individual, association, corporation, partnership, any political subdivision of the state, and any agency, board, or department of such a political subdivision.

Program - Combination of activities that, taken together, constitute the non-physical environment of a center. Materials and staff necessary to carry out the center are part of the program.

Department - Department of Public Welfare.

Staff:

Director - Person responsible for all aspects of the operation of the group-day-care center (e.g., administrative duties, staff supervision and training, record keeping, program planning, budgeting, liaison with state and local agencies, etc.).

Teacher - Person responsible for planning and implementing the program of the group-day-care center (e.g., plans and conducts daily program activities, prepares program materials, supervises and trains other staff, etc.). Other titles used to designate persons with these responsibilities include teacher-director, head teacher, and lead teacher.

Assistant teacher - works with the guidance of the teacher and director to carry out the program of the center.

Child care assistant - Assists the teacher or assistant teacher with all aspects of the planned program (Other titles: aide, child-care aide).

Volunteers - Persons offering their services to a group-day-care facility without reimbursement other than for expenses.

Staff development - Programs of practical education, e.g., workshops, courses, seminars, which focus on a specific topic with a designated leader or facilitator for the purpose of job orientation, attitude development, learning or improving work techniques, curriculum development and upgrading standards. Training may be on-site at the center or away from the center. It may be offered by a variety of sources such as individual centers, community sources, local school systems, professional groups, vocational schools, colleges or universities.

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Waiver - Temporary permission to disregard a particular licensing requirement or rule.

Parent cooperative - A nonprofit group-child-care program that is governed by a board of at least 70 percent parent-users of the group-child-care program. The board must meet at least every six weeks, and minutes of these board meetings shall be available for inspection by a representative of the Department. This board shall make all continuing operational decisions about staff, program, budget, and organization structure.

Parent cooperative shall be specifically exempt from regulations in the following sections:

A. Definitions	no exemptions
B. Licensing laws and procedures	no exemptions
C. Facility	no exemptions
D. Program	1 (c and e), 2, 4-6, 7
E. Health, nutrition, and safety	no exemptions
F. Admissions	no exemptions
G. Staff	1, 2, 3 (a, b, d), 4 (staff distribution and group size), 5, 6
H. Organization and administration	2 (b-(2)), 4-b

If a parent cooperative employs staff in the position of director, teacher, and/or assistant teacher who are not parent members, hired staff shall not be exempt from:

G. Staff	1, 2, 3, 5

Other regulations for group-day-care programs may be waived for a parent cooperative as long as the health and safety of children is not endangered (see Section B, 14).

Within the first year of licensure and annually thereafter, information on the exempted sections shall be submitted to the Department.

B. Licensing laws and procedures.

1. Application for license shall be made on the form issued by the State Department of Public Welfare. Application may be obtained from the Department. Application for license is not complete until all supporting documents have been received by the Department.

2. Applicants for licensure shall make contact with the Department to schedule pre-licensing consultation.

3. After application for a license has been approved by the Commissioner, a license shall be issued giving permission for operation. The license shall be issued within 90 days after receipt of the application and all support-

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ing documents. Failure to issue a license within 90 days shall constitute denial of application. The license shall state the dates of validity, the maximum number of children to be present in the program at any one time, their ages, and the hours of operation. The license must be posted in a conspicuous place on the premises.

4. A provisional license shall be issued to all new group-day-care centers for a designated period. A provisional license may be granted for up to one year to a new group-day-care center that meets necessary health and safety requirements but does not meet all requirements for licensure.

Reason: To begin a new program, some discretion is desirable.

Satisfactory compliance:

a. The health, nutrition, and safety requirements of Section V must be met, except as noted (see Section V).

b. The license is issued for a period up to one year and shall not be renewed after one year.

c. A plan for full compliance with standards must accompany the application for licensure.

d. Written notification of the granting of a provisional license by the Department must be made to the child care operator specifying the reason, duration, and conditions for continuing and/or terminating the provisional license. This will include the plan that is required for full compliance.

5. The terms of the regular license are:

a. The license is issued for up to two years and is not transferable to another operator or site.

b. The license is issued after the center has operated under a provisional license for a designated period (see B, 4).

6. Any changes in the terms of the license must receive prior approval from the Department.

7. The license shall prescribe the number and ages of children to be cared for and the hours and days of operation.

8. Any applicant or licensee whose license is denied, revoked, or not renewed may appeal to the Commissioner in accordance with Minn. Stat. 1969, ch. 15. The Department shall notify by certified mail any facility whose license is denied, revoked, or not renewed. The grounds for the Department's action and procedures for perfecting such appeal shall be stated. The license must be returned to the Department, and all advertising for the center must cease.

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9. When the group-day-care center decides to terminate its service, notice of the closing must be sent to the Department and the license must be returned.

10. The licensee must reapply for a renewal license. The Department shall mail proper notice of license expiration and license renewal forms no less than 60 days prior to expiration of the license. The Department shall make arrangements for the relicensing visit to determine whether the Department standards continue to be met.

11. State law provides that every person who operates a facility required to be licensed pursuant to Minn. Stat. §§ 257.081 through 257.111, without a license, or who violates any provision of those sections, shall be guilty of a misdemeanor. Any person who offers or advertises a facility required to be licensed pursuant to Minn. Stat. §§ 257.081 through 257.111, prior to obtaining such a license, except for the purpose of pre-enrolling staff and/or children, or who offers or advertises any facility in violation of any provision of Minn. Stat. §§ 257.081 through 257.111, shall be guilty of a misdemeanor.

12. Pursuant to Minn. Stat. § 257.102, the Department is given the right of entrance and privilege to inspect centers during hours of operation to determine whether standards are being met. The center director or representative shall be present when the Department makes a regular licensing visit.

13. No program may discriminate in admissions or demissions on the basis of race, sex, religion, creed, color, national origin, or source or payment. In employment of staff, no program may discriminate on the basis of race, creed, color, national origin, religion, or sex. No program may discriminate on the basis of physical and/or mental handicap when the handicap does not prevent fulfillment of normal job responsibilities.

Satisfactory compliance:

a. When applying for licensure, every center shall submit:

(1) A signed statement about non-discriminatory admissions hiring policy.

(2) An implementable affirmative action plan designed to recruit minority children and staff where such minority groups are a part of the community.

b. No otherwise eligible child can be excluded on the basis of the specified characteristics, except:

(1) A program established to serve low-income children may give first priority to children of this group only but shall not discriminate within this group.

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(2) A program established to serve children of a particular religious faith may serve these children only but may not discriminate within the group. The program may not discriminate against children from other religious groups when a portion of their fund is derived from public sources.

c. Employment practices shall be based on bona fide occupational qualifications. Employers shall not discriminate on the basis of the specified characteristics by:

(1) Refusing to hire a qualified applicant,

(2) Discharging a qualified employee,

(3) Maintaining a system of employment that unreasonably excludes an applicant, or

(4) Establishing differences in tenure, compensation, terms of employment, upgrading, conditions of work, facilities, or privileges of employment.

14. Regulations may be waived, with the approval of the Department, according to the procedure established for such waiver. Waiver may be granted only if the health and safety of the children are ensured.

Satisfactory compliance:

a. A complete explanation of the reasons and purposes of the waiver must be submitted to the State Agency at the time of application for licensure.

b. Waivers can be granted only in writing and only by the Department and must be signed prior to the beginning of program operation.

c. The granting of a waiver shall not constitute a precedent.

15. Every applicant for a license shall be furnished with a copy of these rules and regulations.

16. Separate licenses shall be required for programs maintained on separate premises even when operated under the same auspices. A separate license shall not be required for separate programs operated on the same premises under the same auspices.

17. The name "school" may be used only by programs having a minimum of one teacher certified by the Minnesota State Department of Education. One certified nursery school teacher must be present during the major part of the program for every 20 children.

C. Facility:

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1. The building must meet legal requirements for zoning, housing, sanitation, fire protection, water supply, and sewage disposal.

Reason: To protect the health and safety of all persons who occupy the building.

Satisfactory compliance:

a. The program must obtain written verification from the various local legal bodies stating that requirements have been met.

b. In the absence of local regulations, compliance shall be satisfied if the requirements of the State Health Department and the State Fire Marshal are met and it is so stated in writing.

c. Newly constructed facilities and altered buildings shall meet the requirements of the State Building Code.

2. There shall be a minimum of 35 square feet of useable floor space (primary space) per child in attendance, exclusive of hallways, bathrooms, lockers, kitchens and floor space occupied by sanitary equipment, but including equipment and furnishings regularly used by the children.

Reason: Program flexibility and child movement needs require that adequate space be available.

Satisfactory compliance:

a. The applicant shall submit a floor plan of the proposed facility to scale.

b. No more than 25 per cent of the proposed primary space shall be occupied by equipment to be left stationary.

c. Where there is question about the useable space, the licensing agent shall measure the available primary space.

d. The licensing agent shall designate the licensed capacity of the program.

3. Primary space designated for the program shall be available only for the children when the program is in operation. This space shall include furnishings and equipment primarily for the program's use. Supplementary space may be shared.

4. All stairways and corridors leading to exits shall be kept clear and free from obstructions at all times.

5. Adequate toilet and washbowls must be provided in a well-ventilated place.

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Satisfactory compliance:

a. There must be at least one toilet and one washbowl provided for each 15 children and one additional toilet and washbowl for each additional 15 children or fraction thereof. Toilets and washbowls must be reachable.

b. Training chairs, instead of the required number of toilets, must be provided for toddlers.

c. Water accessible to children shall not exceed 120°F.

6. Centers must provide care for a child who becomes ill. Supervision must be provided until the child is picked up.

Reason: Children who are not well should not be required to be with a group or involved in its activities. Neither should an ill child be placed in solitary confinement.

Satisfactory compliance: Space designated for use by an ill child need not be permanently arranged but shall be:

a. Used only for other compatible purposes; e.g., private office, library, staff's room, or

b. Effectively protected from the main activity area and the kitchen by screening, and

c. Equipped with a child's cot, and

d. Within sight and hearing of an adult.

7. Floors must be kept clean at all times: must not have splinters, cracks, or broken linoleum, and must not be slippery. Carpeting or rugs may be used but rugs must not be hazardous. Concrete floors shall be tiled, carpeted, or cushioned.

8. A minimum room temperature of 68° shall be maintained in space designated for the program.

9. Ventilation and lighting in every facility must meet the requirements of the State Building Code.

10. Premises shall be kept clean and sanitary.

11. A cot or a crib must be provided for each child taking a nap in a program that includes a rest. Adequate space and accessibility of exit must be maintained.

Reason: Children in a day care program need rest and quiet as part of the daily activity.

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Satisfactory compliance:

a. Infants must be provided with cribs or padded playpens, regardless of type or duration of program.

b. Toddlers and preschoolers under the age of five years who are in programs lasting more than five hours shall be provided with cots.

c. Children older than infants who are in programs lasting less than five hours shall be provided with washable mats or rugs for taking rests.

d. A child sleeping more than four to five hours must be provided with a bed, cot, or crib (depending on ability). The bed, crib, or cot shall have a mattress, safe mattress protector and coverings. Pillows may be provided for children one year old or older, according to individual need.

e. Cribs, cots, or playpens must be so arranged that there is easy access to each child and accessibility of exit is maintained.

f. A crib must be of adequate size for the child's height. Crib mattresses shall be covered.

g. Sheets, pillows, and blankets must not be interchanged and must be kept clean at all times. Bed linens must be laundered at least once a week or when soiled or wet. Blankets, mattress protectors, and pillow protectors shall be laundered when a new child uses the bed.

h. Beds used by members of the household must not be used by the children in the center.

i. Cribs shall not be stacked.

12. All equipment and furniture must be designed for the age group and be substantial, easy to clean, and free from sharp points or corners, splinters, or paints that contain lead. The facility and equipment must also be kept in good repair, with no peeling paint and free from debris and litter.

Reason: Children have certain developmental requirements that can be facilitated by use of equipment and furniture designed for their age group. The health and safety of the children must be protected by an environment and equipment that allows exploration without undue danger.

13. Outdoor play area of at least 75 square feet per child and no less than 1,000 square feet per program must be provided.

Reason: Good child education requires adequate room to engage in large-muscle activity under safe conditions. Outdoor space is also appropriate for other learning activities.

Satisfactory compliance: This requirement will be considered fulfilled by any one of the following:

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a. An adjacent play area where children are rotated in appropriate numbers to maintain 75 square feet per child for outdoor play.

b. Adjacent park facilities within 1000 feet, or

c. Park space that is more than 1000 feet from the group-day-care center, where daily transportation is provided.

14. Play space must be adequately enclosed where necessary to prevent children from leaving the premises unattended and outdoor play time must be directly supervised with the required staff-to-child ratio.

15. Outdoor play space shall be equipped for active large muscle play (see Appendix A).

D. Program:

1. A group-day-care program must show evidence, in writing, of provision for the physical, intellectual, emotional, and social development of the child. Every program shall have internal consistency of goals, objectives, and activities. Every program shall provide a minimum of equipment and materials.

Reason: To fit the developmental requirements, cultural background, and characteristics of each child, day care programs should consider:

a. Health and nutrition needs

b. Need for security

c. Need for freedom

d. Need for structure

e. Need for compassion

f. Need for challenge

Every child needs individualization and freedom of choice, as well as whole-group activities. Needs change as the child grows and develops.

Satisfactory compliance:

a. A written program plan that can be implemented and is observable shall be available for review by the Department. The program plan shall show how the program intends to meet the physical, intellectual, emotional, and social needs of every child. The program plan shall include appropriate ethnic, linguistic, and cultural variations.

b. The program shall submit a schedule of routine daily activities.

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c. The group-day-care center shall organize an environment indoors and outdoors that provides a wide range of materials to meet the varied developmental levels and cultural backgrounds of children, such as:

Construction: blocks, sand table, workbench, water play, trucks, construction sets

Dramatic play: playhouse, puppets, phones

Art: easel, paints, chalk, crayons, clay

Ponder play: flannel boards, chalkboard, pegboard, puzzles, beads, matching games

Science learning: plants, animals, magnets, gears

Library: books, audio-visual materials

Music: rhythm instruments, tapes, records

Place to be alone: a corner or chair where a child can be by himself

Physical development: climbing bars, balance bars, tumbling mats, tunnels for crawling

d. The program plan shall include both indoor and outdoor activities.

e. An inventory of minimum equipment shall be submitted as specified in Appendix A (Minimum Equipment and Supplies).

2. There shall be open shelves for play materials and books, and individual space must be provided for each child's clothing and other personal belongings.

3. The center shall establish and maintain continual communication and exchange of ideas and information between the staff and parents.

Reason: Primary responsibility for a child's health, well-being, and development rests with his parent. Day care staff must work cooperatively with parents.

Satisfactory compliance: The center must provide evidence of compliance with the following:

a. The child's record shall show that planned conferences have been offered to parents in the center or at home. Conferences must be offered twice each year for children two years of age or older, and at least once every two months for children under two.

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b. Every center shall have a written plan on file for activities that will keep parents informed and encourage parent input.

4. Centers serving children under two and one/half must provide for flexibility in programming. Each child must have individual personal contact each day.

Reason: A young child needs prompt attention to his needs to encourage communication and build trust. Personal contact is needed to build perceptual skills, encourage consistency of handling, foster a warm relationship, and provide a series of observations on the child's progress.

Satisfactory compliance:

a. Each infant shall be held during bottle feedings until he is able to safely hold his own bottle. Bottles shall not be propped.

b. Each child shall be held, cuddled, and played with each day.

c. Each child's attempts to communicate shall be responded to. Staff shall talk to and listen to each child.

d. Infants and toddlers shall be allowed freedom of movement during a large part of their waking day.

(1) The non-creeping infant shall spend part of each day on a clean carpeted floor or large blanket.

(2) The creeping infant shall have freedom to explore outside of crib or playpen. A crib or playpen shall be used only for sleeping or for short periods of time. During the infant's waking hours, a playpen shall be placed where the infant can watch others. Several hours each day shall be spent outside the crib or playpen.

(3) The toddler shall be allowed and encouraged to move about, explore, and handle safe objects.

e. Each child shall be provided with materials and equipment that will foster his development physically, mentally, socially, and emotionally. (See Appendix A - Minimum Equipment and Supplies for Infants and Toddlers.)

f. Feeding time shall meet individualized needs of children.

g. There must be a flexible plan for diapering and toileting. Children shall be kept dry and comfortable at all times. A complete change of clothing shall be brought from home to be used as needed. The child shall be changed in his crib or on a table with a change of covering between each diaper change. Staff members shall wash their hands after changing each child. Before being diapered, the child shall be washed with a separate cloth or towel.

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h. An adequate supply of clean diapers shall be available. Diapers may be provided by the parent. When diapers are provided by the center, they shall be single service and disposable. Diapers shall be stored in a sanitary manner.

i. Toilet training shall be undertaken when appropriate according to a child's age and stage of development. Training must be in cooperation with the parent's plan. Children shall be offered frequent opportunities for toileting.

j. Children unable to wash their own hands and faces shall have their hands and faces washed before meals and after toileting.

k. Training chairs shall be washed before meals and after each use.

l. Children under two and one/half years of age shall have a separate area and program from older children.

m. Before admission, the director shall obtain information about the child's eating, sleeping, toileting, communication, and comforting habits and needs.

n. Space used by children sleeping in cribs shall be separate from playrooms or classrooms.

5. Naps and rest in a group-day-care program must meet the needs of the child and the wishes of the parents.

Satisfactory compliance:

a. Each child shall be provided opportunity for enough sleep for his age at regular hours under conditions conducive to rest.

b. Sleeping arrangements shall be so made that no child is deprived of needed sleep or has it unnecessarily interrupted.

c. Quiet activities shall be provided before bedtime to aid relaxation for sleep.

6. No child shall be subjected to corporal or psychological abuse by staff.

Reason: Although families differ in their approach to discipline, harsh or threatening methods are not appropriate for non-family members. Compliance through fear is not the goal of discipline.

Satisfactory compliance:

a. Methods of discipline used by the center shall be discussed with each child's parent at the time of enrollment.

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b. No child shall be handled roughly, such as shoving, hairpulling, ear-pulling, or shaking by staff.

c. No child shall be hit in any way, such as slapping, spanking, or kicking by staff.

d. Isolation and exclusion time shall be geared to age of child, not to exceed ten to 15 minutes. If a child is isolated, the room must be well-ventilated and well-lighted and within sight and hearing of an adult. A child shall not be isolated in a locked room or closet.

e. No child shall be humiliated, shamed, or labeled.

f. A child shall not be punished for lapses in toilet training.

g. Meals and snacks shall not be used as a form of punishment.

h. No discipline shall be delegated to another child.

7. Adult care givers shall be seated with children at snack and meal times.

E. Health, nutrition, and safety:

1. Health:

a. The director of each program shall be responsible for observation of health and development of children, handling illness at the center, accident prevention and emergency procedures, keeping health records complete, and informing parents about community resources.

Reason: Health promotion in young children requires regular observation, accurate record keeping, and systematic follow-up.

Satisfactory compliance:

(1) The director may perform the specified activities, or he may delegate these duties to another paid staff member.

(2) The person responsible for health shall demonstrate skill in record-keeping, communication of health policies, and referral to community resources within one year after licensure.

b. Continuing health consultation shall be sought from appropriate private or public community resources to assist in developing health policies and keeping them current: to assist in screening, referral, and follow-up procedures: and to provide advice about children with special needs.

Satisfactory compliance:

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(1) All programs shall seek regular consultation with a physician or public health nurse. A physician shall at least be available as an emergency resource during the hours of operation.

(2) If infants under one year of age are cared for, the program must have monthly consultation with a public health nurse or a registered nurse with training or experience in infant care. The program must operate under health policies approved by a physician.

c. The center must require a health statement signed by each child's source of medical care. The center may request that a child have a new physical examination.

Satisfactory compliance:

(1) The center shall have on file the name and address of each child's source of regular health supervision and a Health Care Summary (See Appendix B) for each child.

(2) If a child's Health Care Summary is not complete at the time of enrollment or within 30 days after enrollment, the child shall be excluded from the program.

(3) If a child's immunizations are not up-to-date at the time of enrollment, evidence of a plan to get them up-to-date must be on file at the center within 30 days after receipt of the child's Health Care Summary, or the child shall be excluded from the program.

(4) If a tuberculin skin test or X-ray is positive, evidence of satisfactory treatment or follow-up must be recorded.

(5) If parents of a child object to medical examination or treatment on grounds of their religious beliefs, the child's record shall contain a Health Care Summary completed by the parent and a statement signed by the parent indicating their objections to medical examinations and treatments on grounds of religious beliefs.

d. The center shall have a complete, written policy on illness and emergency care, accidents, first-aid, and exclusion of sick children. All staff must have training in the administration of first-aid.

Satisfactory compliance:

(1) At the time of registration, the parent must be given a copy of the policy on emergency and illness care and exclusion of sick children.

(2) A plan must be made with each parent about emergency and illness care that shall include the information specified in Admission Section (VI, B.).

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(3) Any important infections or communicable disease must be reported to all parents.

e. When a child is to be given oral or surface medication, written instructions by a physician or dentist must be provided, and written authorization to administer medication must be given by a parent. Medication must be labeled, stored under lock, or out of the reach of children.

Satisfactory compliance:

(1) The center shall obtain written permission from the child's parents prior to the administration of any medication - prescription or non-prescription.

(2) Medications shall be kept in their original containers bearing the original label with legible information stating:

(a) Prescription number

(b) Name of drug

(c) Strength and quantity of drug

(d) Expiration date of any time-dated drug

(e) Directions for use

(f) Child's name

(g) Physician's name

(h) Date of original issue or, with a refill, the most recent date of issue

(i) Name and address of the licensed pharmacy issuing the medication.

(3) Any drug container having a detached, excessively soiled, or damaged label shall be returned to the parent for relabeling at the issuing pharmacy.

(4) The contents of any drug container without a label or with an illegible label shall be destroyed immediately. Any unused portions of prescription drugs remaining in the facility shall be returned to the parent or destroyed by the licensee by flushing them into the sewer system and removing and destroying the labels from the drug containers.

(5) Medications having a specific expiration date shall not be used after the date of expiration.

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(6) Medication must be stored out of the reach of children or under lock.

(7) The parent must be informed when any medication is given.

f. A ten-unit first-aid kit and directions for its use must be available.

Satisfactory compliance: The following minimum first-aid supplies must be available and accompanied by directions: band-aids, sterile bandages, sterile compresses, adhesive tape, magnifying glass with needles and tweezers for removing splinters, soap (with water) for cleaning cuts, abrasions, etc.

g. Paper towels, roller towels, or air dryers must be provided for the children's use.

h. In programs providing sleep care of four to five hours or more, each child shall have his own clearly identified toothbrush, comb, towel, and face cloth. At least twice a week towels and face cloths must be laundered. Soap and toothpaste shall be provided.

i. Soiled diapers shall be kept in a closed container. This container shall be cleaned daily and shall not be accessible to the children.

j. Preschool children must be monitored in washing their hands and toileting. Children shall be encouraged and helped to keep themselves clean. They shall receive specific training in personal hygiene.

2. Nutrition:

a. A group-day-center must provide or insure the availability of adequate and nutritious meals and snacks appropriate for the ages and needs of the children served. Each regular meal must provide one/third of the child's daily food needs. One meal and two snacks or two meals and one snack shall be provided daily for each child in care five through eight hours. A minimum of two meals must be offered to children in care nine or more hours unless four or more of these hours are spent in sleep.

Reason: Balanced nutrition is basic to health. Eating habits and attitudes about food are formed in the early years. Eating should be a pleasant social experience, and staff should eat with the children. Children should be encouraged but not forced to eat.

Satisfactory compliance:

(1) The current USDA Daily Food Guide shall be utilized in planning adequate quantities of the Basic Four foods appropriate for the age of the child (see Appendix C). Ethnic food shall be included where appropriate.

(2) The Daily Food Guide shall be used as a pattern not only for

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hot lunches served at the center but also for cold lunches and lunches brought from home. These are acceptable when parents are informed about nutritionally adequate lunches. The center shall provide supplements to bag lunches as needed and proper refrigeration.

(3) Snacks shall include a beverage plus one or more of the following: raw vegetables; cheese; cereal product; or fruit. Snacks must be provided at suitable intervals and served at least one and one-half hours before meals.

(4) The admission interview shall include information about food habits and practices, food likes and dislikes, and cultural patterns of food selection and preparation that may be used by the staff in serving foods.

b. Menus must be planned in advance for a cycle of at least one month, posted for parents' information, and reviewed for nutritional adequacy at least once a year.

Reason: Cycle menu planning saves time and results in more carefully planned menus, better cost control through improved purchasing, better nutritionally balanced and more varied menus, easier advance planning of work schedules, and more uniform and better food preparation. When menus are posted, parents know what foods are served, eliminating duplication of menus at home.

c. Group-day-care center personnel shall understand personal sanitation and methods of handling, preparing, and serving food in a safe and sanitary manner. The preparation of food by children must be carefully supervised. The program shall comply with the provisions of applicable state and local food ordinances.

d. Consideration must be given to the modified or therapeutic diet needs of children as prescribed by source of health care.

Satisfactory compliance:

(1) The diet orders must be filed and the entire staff informed of the diet restrictions.

(2) The director must check with the parents about the length of time the child is to be on the diet.

(3) The diet plan is to be carefully followed by obtaining the consultative services of a qualified nutritionist or dietitian to interpret the diet orders as needed.

(4) For the child requiring a rigid diet because of severe diabetes, sodium restriction, ketogenic, or phenylketonuria, food must be brought from home.

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e. The diet of an infant shall be determined by the child's parents in consultation with their source of health care.

Reason: Nutritional adequacy and sanitation are the two "musts" of infant feeding.

Satisfactory compliance:

(1) Formula or milk and solid foods, including vitamin and iron supplements, must be fed in prescribed quantities and at specified time intervals. Written diet instructions shall be obtained from the parent.

(2) The sources, preparation, handling, and storage of formula, milk, solid foods, and supplements for children under one year of age shall be approved by a physician. These policies and procedures, signed by the physician, shall be kept on file at the center.

(3) The parent shall be informed daily of the amount and kind of food intake of the infant.

(4) Each infant's feeding schedule shall be available to staff.

f. Drinking water shall be available to children and offered at frequent intervals.

Satisfactory compliance:

(1) Water bottles for infants shall be prepared, packaged, and identified for each individual infant. Each bottle shall be stored and handled to protect against contamination. Each infant's usual need for water shall be recorded, as given by the infant's parent, on the individual enrollment form.

(2) Drinking water for toddlers and older children shall be provided in individual drinking cups or approved drinking fountains.

3. Safety:

a. Every child care center shall have written accident prevention procedures based on common causes of accidents in the age group served.

Satisfactory compliance:

(1) At least twice a year a staff member shall inspect the center for hazards. All hazards shall be discussed with staff and corrected, where possible. Procedures shall be devised to prevent accidents and eliminate hazards.

(2) Fire prevention precautions shall be consistent with the State Fire Marshal's Code.

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(3) Written procedures for accident prevention shall include at least poisoning, aspiration and choking, injury, burns, and pedestrian accidents.

(4) Accident reports or an accident log must be kept on all accidents, except minor scratches and abrasions. Reports should be analyzed at least annually and procedures adjusted to prevent recurring accidents.

(5) Staff shall have a practical understanding of at least the center's safety procedures, special hazards, and common accidents occurring at the center, detailed instruction in evacuation procedures, use of the fire extinguisher, and how to report accidents.

(6) The person in charge shall know where the fuse box is located, and how to pull the main electrical switch.

b. Centers shall establish procedures to be followed in case of emergencies or accidents.

Reason: Advance planning is necessary to insure safe, efficient actions in a period of emergency.

Satisfactory compliance:

(1) Procedures for fires, tornadoes, blizzards, illness of staff, accidents, breakdown of transportation, power failure, and missing persons shall be determined. Where appropriate, plans for emergency shelter of children and staff must be designated.

(2) All staff and children shall participate in monthly fire drills based on fire evacuation procedures.

(3) Written plans for fire emergencies shall show primary and secondary exits. Plans shall include details of rescue of children, contact of fire department, and closing-off of fire area, in that order of priority.

c. Centers must be equipped with the number of fire extinguishers determined by the State Fire Marshal. Extinguishers must be in working order and checked annually.

d. All electrical outlets must be covered or protected when not in use.

e. Every facility must have a non-coin operated phone that is readily accessible.

f. A list of emergency numbers shall be prominently posted by the telephone: police, fire, doctor, ambulance, hospital.

g. The center shall make arrangements in advance for emergency transportation.

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h. Radiators, fireplaces, hot pipes, steam radiators, and other hot surfaces shall be protected by guards.

i. Sharp scissors, knives, matches, and other potential hazards to children shall be stored out of their reach. The use of potentially hazardous materials and tools by children shall be supervised.

j. Stairways used by the children shall have reachable hand railings.

F. Admissions:

1. Each program shall have an admission policy that specifies the age range of children being served:

a. Infants: six weeks through 15 months.

b. Toddlers: 16 months through 30 months.

c. Preschool: 31 months through five years.

d. Primary: six years through eight years.

e. Intermediate: nine years through twelve years.

2. Admission procedures developed must provide the care-giver with sufficient information and instruction from the parent to enable the care-giver to make decisions or act in behalf of the child's welfare in the absence of the parent.

Satisfactory compliance: Prior to admission of the child, the care-giver shall obtain written information from the person or persons legally responsible for the child covering the following items:

a. The child's full name, birth date, and current address

b. The name and address of the parent or parents, or of the person(s) legally responsible for the child

c. Telephone number or instructions as to how the person(s) responsible for the child may be reached when the child is in the day care program.

d. Names of persons authorized to take the child from the day care facility and their address, and persons not so authorized

e. Name, address, and telephone number of the health care source to be called in case of emergency

f. Names, addresses, and telephone numbers of person(s) who can assume responsibility for the child if the parent cannot be reached in an emergency

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g. Health statement and immunization data as specified in the Health Section (E, 1-b)

h. Signed authorization to the effect that the parent gives permission to the center to act in an emergency situation when the parent cannot be reached or is delayed in arriving

i. Written permission for participation in specific research, experimentation, or publicity activities

j. Written permission for the child to participate in activities not sponsored by the center. Permission must include type of activity, location, dates, and times of the activity

k. Special diet needs

3. Admission policies and procedures must ensure initial and continuing communication between the family and the facility to assure compatibility in their mutual responsibility for the child's welfare.

Satisfactory compliance:

a. A plan for admission of the child that includes a pre-admission conference with parent and child

b. A plan for continuing contact between the parents and the center, D, 2

G. Staff:

1. Each staff person must be appropriately qualified through training, experience, and personal qualities for the age group and cultural background with which he works. (Note: For an explanation of the term Child Development Training Course, used in this section, see "Definitions". The qualifications indicated for staff positions relate strictly to group-day-care positions and do not imply certicication by the State Department of Education.)

Reason: The relationships that a child develops with important adults are considered as vital for his emotional security, intellectual development, and health psychological growth.

Satisfactory compliance:

a. Director: (of all programs) Person or persons responsible for administration of a program must have administrative and supervisory experience or capability as well as knowledge of program, staff relationships, and day care operations. Administrators with teaching duties must also possess the qualifications of a teacher. The director shall be at least 18 years of age and shall be a mature responsible person.

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Satisfactory compliance:

b. Teacher - alternatives for qualification

	Training		Experience		Number of Accredited Child Development Training Courses or Hours
(1)	Post-secondary certificate in Child Development Assistant Training Program (minimum of 1080 hours)	PLUS	One year (1560 hours) Assistant Teacher**	PLUS	1 course or 30 hours
OR (2)	(no requirement)	PLUS	Two years (3120 hours) as Assistant Teacher**	PLUS	3 courses or 90 hours
OR (3)	BA or BS in any field from an accredited college or university	PLUS	** *	PLUS	6 courses or 180 hours (May be included as part of BA or BS degree)
OR (4)	A degree in Child Development or Nursery Kindergarten Education from an accredited college or university	PLUS	**		(no requirement)
OR (5)	Certification by the State Department of Education for Nursery School	PLUS	**		(no requirement)
OR (6)	Compliance with the competency level requirements of Child Development Associate		(no requirement)		(no requirement)
OR (7)	INFANT-TODDLER ONLY (no requirement)		Three years (4680) hours) as a licensed Family Day Care Provider or Group Family Day Care Provider	PLUS	3 courses or 90 hours

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OR	SCHOOL-AGE ONLY			
(8)	Certification by the State Department of Education for Elementary or Secondary Education	(no requirement)		(no requirement)

**INFANT-TODDLER ONLY - Three months (480 hours) of required experience must be in an infant and/or toddler program.
*SCHOOL-AGE ONLY - Six months (600 hours) experience in a related field (e.g., playground leader, tutor, student teaching, teacher's aide).

Satisfactory compliance:

c. Assistant teacher - alternatives for qualification

	Training		Experience		Number of Accredited Child Development Training Courses or Hours
(1)	Post-secondary certificate in Child Development Assistant Training Program (minimum of 1080 hours)	PLUS	**		(no requirement)
OR (2)	(no requirement)		Six months (780 hours as Child Care Assistant (Child Care Aide) or Student Teacher	PLUS	3 courses or 90 hours
OR (3)	Two years of post-secondary education	PLUS	**	PLUS	3 courses or 90 hours
OR (4)	INFANT-TODDLER ONLY		Six months (780 hours) with infants and/or toddlers as a licensed Family Day Care Provider or a Group-Family Day Care Provider	PLUS	3 courses or 90 hours

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OR SCHOOL-AGE ONLY (5)	One year (1200 hours) in a related field (e.g., playground leader, tutor, student teaching, teacher's aide).	(no requirement)

**INFANT-TODDLER ONLY - 150 hours of experience in an infant and/or toddler program.

d. Teachers and assistant teachers employed on the date of promulgation of these standards must comply with one of the alternatives for qualification within three years after that date.

e. Child Care Assistant (Child Care Aide) for all age groupings:

(1) The following alternatives are available for qualification: High school vocational child care training course, or Orientation training course in the center.

(2) The Child Care Assistant must be at least 15 years of age.

f. Volunteers for all age groupings: To be counted in the staff-to-child ratio, volunteers must:

(1) Be at least 15 years of age

(2) Participate in an orientation to the program

(3) Participate in any in-service training given to paid staff by the center.

2. Staff development training for all regular administrative, teaching, and support services staff members, including volunteers, must be a part of every center's educational program.

Reason: Proper preparation and continuous training of the total staff will better ensure development and maintenance of high-quality day care services.

Satisfactory compliance:

a. Each center shall be responsible for working out a plan with each staff person with direct teaching responsibilities or direct responsibility for supervision of that staff, e.g., director, for a minimum of the equivalent of 2% of his/her work hours to be spent in staff development.

b. This training can be provided by individual centers, a sponsoring agency, community sources, local school systems, professional groups, colleges, universities, or area vocational schools.

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c. All other administrative staff, volunteers not counted in staff ratios, and support staff, e.g., cook, bus drivers, must receive an orientation to the program including appropriate licensing standards within the two weeks of employment.

3. All personnel in regular contact with children, including volunteers and drivers, shall be physically, mentally, and emotionally competent to care for children and free from serious communicable disease.

Satisfactory compliance:

a. References must be required by the director from all child care staff relating to their ability to care for young children.

b. Prior to employment, the paid employee must submit a statement signed by his source of medical care and based on a thorough examination within three months. Statements must be submitted every two years thereafter.

c. All staff must submit evidence of freedom from tuberculosis before employment and annually.

d. A probation period must be set for new employees, during which physical, mental and emotional competence to care for children is evaluated and discussed with the employee by the employer.

e. Employees with communicable disease presenting an important health hazard to the group shall be excluded.

f. No person shall be hired or retained as a staff member, paid or volunteer, who has:

(1) Been convicted of or admitted to or been the subject of substantial evidence of an act of child battering, child abuse, or child molesting.

(2) Used alcohol or drugs such that its effects are apparent during working hours that children are in care, or

(3) Been convicted for or admitted to any felony or any offense involving moral turpitude.

4. Staff ratio must be met and maintained by operators of all programs: appropriate distribution of staff shall include a team that has individuals with competences of a teacher, assistant teacher and child care assistant. Volunteers under supervision may be counted in the staff ratio. The staff member must be with the children to be included in the staff-to-child ratio. When there are children of different ages in the same group, the ratio for the youngest age group shall prevail. Janitors and bus drivers shall not be counted in the staff ratio when performing these duties.

Reason: The administering agency must ensure that capable staff in the recommended ratio is always present and is capable of providing for health and safety of each child and that each member of the staff has a clear under-

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standing of his responsibility as explained in orientation sessions and provided in a written form.

Satisfactory compliance:

a. Infants: six weeks through 15 months.
Staff Ratio: one to four
Group Size: no more than eight in an activity group.
Staff Distribution: one teacher for every 16 children
+
one teacher or assistant teacher for every group,
+
child care assistants and volunteers as needed to meet staff ratio.

b. Toddlers: 16 months through 30 months.
Staff Ratio: one to seven.
Group Size: No more than 14 children in an activity group.
Staff Distribution: one teacher for every 28 children,
+
one teacher or assistant teacher for every group,
+
child care assistants and volunteers as needed to meet staff ratio.

c. Pre-School: 31 months through five years.
Staff Ratio: one to ten
Group Size: No more than 20 children in an activity group.
Staff Distribution: one teacher for every 40 children,
+
one teacher or assistant teacher for every group.
+
child care assistants and volunteers as needed to meet staff ratio.
Note: There shall be no more than ten two-and-one-half year olds in any activity group of 20 children.

d. School-Age: six years through twelve years.
Staff Ratio: one to 15
Group Size: No more than 30 children in an activity group.
Staff Distribution: one teacher for every 60 children,
+
one teacher or assistant teacher for every group,
+
child care assistants and volunteers as needed to meet staff ratio.

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5. Each center with more than one staff member must set personnel policies relating to health, working conditions, in-service training, probation period, evaluation, sick leave, vacation, benefits, and salary increments. Policies shall comply with appropriate state and federal laws.

Reason: It is important that there be a clear understanding between administration and staff about the work situation and the responsibilities of both the administration and the staff member.

Satisfactory compliance: Each center with more than one staff member must have a written statement of personnel policies. This statement shall include:

a. Policies in accordance with Fair-Employment laws and regulations

b. Job description for all staff

c. Description of probation period and method of staff evaluation

d. A clearly defined in-service training program

e. Policies on hiring, firing, promotions, and salary increments

6. In centers providing sleep care of four to five hours or more, staff ratios specified in VII.D. shall be maintained until the children are settled for sleep. While children are sleeping, a minimum number of adults must remain awake and available to the children throughout the sleep period.

Satisfactory compliance:

a. One adult for every four sleeping infants but no fewer than two adults for the center

b. One adult for every ten sleeping toddlers but no fewer than two adults for the center

c. One adult for every 20 sleeping preschoolers but no fewer than two adults for the center

d. One adult for every 25 sleeping school-age children but no fewer than two adults for the center

7. The director shall make arrangements in advance for substitute staff.

H. Organization and administration:

1. A group-day-care program shall have written policies available for inspection by the department. These policies shall be made available to parents and staff members.

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Reason: Established policies and procedures facilitate consistency and promote understanding.

Satisfactory compliance: There shall be written policies covering the following areas:

a. The type of program offered to children and their parents

b. The ages and numbers of children in each age group to be served

c. Hours of operation

d. Days of operation

e. Meals and snacks to be served

f. Provisions that can be made for special needs of individual children

g. Admission requirements and enrollment procedures

h. Affirmative action plan

i. Plan for parent information

j. Plan for substitute staff

k. Insurance coverage

l. Procedures for the handling of sick children

m. Provisions for illness and emergency care

n. Accident prevention procedures

o. Requirements about personal belongings brought to the center

p. Transportation arrangements

q. Permission for trips

r. Personnel policies

s. Fees and the plan for payment

2. Legal responsibility and administrative authority must be clearly defined for every group-day-care facility.

Satisfactory compliance:

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a. The name, address, and telephone number of the individual or governing body legally responsible for the center shall be supplied to the licensing agent.

b. The legally responsible individual or group shall be held accountable for:

(1) Determining and implementing policies

(2) The performance of the director of the program

(3) Adequate financing to carry out the planned program

(4) The adherence to all rules and regulations that affect the program and the facility

(5) Reporting any suspected instances of child abuse or neglect

3. Within 48 hours after the occurrence of an unusual accident, such as the death or serious injury of a child, a report shall be submitted to the department. A serious injury shall be defined as one that requires the hospitalization of the child. A report shall also be submitted following the occurrence of a fire that requires the services of the fire department.

4. A group-day-care program must establish and maintain required records. All personal records must be kept confidential.

Satisfactory compliance: The following shall be made available to the licensing agent:

a. Daily attendance records for children

b. Current staff records containing, as a minimum, identifying and emergency information, health clearances, education, experience, and current training, and terms of employment

c. Current record for each child containing information specified in Section F, 2 and 3

d. List of all current staff members

e. List of available substitute staff

f. Staffing pattern showing staff-to-child ratios during hours of operation

5. When transportation is provided by a group-day-care center, children must be protected by properly operated and maintained vehicles, adequate staff supervision, licensed drivers, safety precautions, and provision for liability insurance and for adequate medical care.

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Reason: A group of young children, particularly when infants and toddlers are included, traveling together in cars or buses, presents a special hazard that is different from that of school children or of the normal passenger traffic that was considered in the development of protective laws on transportation in most states. For the children's safety, it is therefore important to require additional provisions appropriate to the age and development of the children.

Satisfactory compliance:

a. Vehicles must have standard equipment and be in satisfactory operating condition. Each vehicle must have a fire extinguisher and a first-aid kit.

b. All drivers must meet requirements for a Minnesota Department of Public Safety Class C driver's license, permitting transportation of nine or fewer children. (Information is available from the Drivers License Division, Department of Public Safety, St. Paul, Minnesota.)

c. If infants or toddlers are transported, there must be a minimum of one adult for every five infants and toddlers, in addition to the driver.

d. There must be at least one adult in addition to the driver in every vehicle if five or more children are being transported.

e. Each child transported shall have and use a seat and a seat belt while the vehicle is in motion. Infants shall be transported in special approved infant safety seats; toddlers in toddler seats.

f. Children and sponsoring groups must be protected by liability insurance, and provisions for adequate medical care must be made.

g. A preschool child or a toddler may not be left unattended at the time of pick-up or delivery.

h. Except in unusual circumstances, children are not to be transported more than one hour per trip.

i. No more than three persons, including the driver, shall occupy the front seat of any vehicle.

Satisfactory compliance for vans or buses:

a. Vehicles must have standard equipment and be in satisfactory operating condition. Each vehicle must have a fire extinguisher and a first-aid kit.

b. All drivers must meet requirements for a Minnesota Department of Public Safety Class B driver's license, permitting operation of a vehicle designed and equipped to transport more than ten passengers (Information available from Drivers License Division, Department of Public Safety, St. Paul, Minnesota).

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c. Anyone driving a van or school bus labeled "School Bus" or with school bus sign uncovered, must have a Minnesota Department of Public Safety Class B driver's license with School Bus Endorsement. (Information available from Drivers License Division, Department of Public Safety, St. Paul, Minnesota.)

d. If infants or toddlers are transported, there must be a minimum of one adult for every five infants and toddlers in addition to the driver.

e. There must be at least one adult in addition to the driver in every vehicle if five or more children are being transported.

f. Drivers and passengers must wear seat belts when the vehicle is equipped with them. Infants shall be transported in special approved infant safety seats, toddlers in toddler seats.

g. A preschool child or toddler may not be left unattended at time of pick-up or delivery.

h. Except in unusual circumstances, children are not to be transported more than one hour per trip.

i. No more than three persons, including the driver, shall occupy the front seat of any vehicle.

j. Children and sponsoring groups must be protected by liability insurance and provisions for adequate medical care must be made.

6. Group-day-care centers shall provide insurance coverage.

Satisfactory compliance: A certificate of insurance shall be obtained showing the following:

a. General liability coverage for bodily injury ($100,000 per person; $300,000 per suit)

b. Automobile insurance, where transportation is provided by the center, including secondary coverage on automobile owned by staff member and used to transport children ($100,000 per person; $300,000 per suit)

c. Workmen's Compensation and Unemployment Insurance

I. Group-day-care centers serving the educationally or developmentally "handicapped" child.

1. Written permission must be obtained from the licensing agent prior to enrolling handicapped children.

Reason: Centers are encouraged to integrate handicapped children into a group of normal children whenever feasible for the center and for the child.

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The special needs of the handicapped child must be met. "Handicapped" is defined as involving a sensory defect, physical or mental deficiency, or emotional disturbance.

2. The group-day-care center shall obtain the assistance of a qualified consultant prior to the enrollment of any handicapped child.

Satisfactory compliance:

a. The center shall have written program modifications based on the determination of the qualified consultant and the needs of the individual handicapped child. These program modifications shall be understood by program staff.

b. Additional staff as recommended by the consultant shall be available.

c. Modified equipment and supplies as recommended by the consultant shall be available.

d. Training of staff as recommended by the consultant shall be arranged.

e. Modifications of the physical facilities shall be made as recommended by the consultant and in conformance with the State Building Code.

3. Prior to the admission of any handicapped child, the group-day-care center shall obtain information from the parent, the physician, and the state or local education agency about any special problems or needs that may affect the child's use of the program. Where indicated, a psychological evaluation shall be made and be available to the center.

4. The progress of the handicapped child shall be evaluated no less than annually by a qualified consultant.

Rule Effective: December 24, 1977.

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MINIMUM EQUIPMENT AND SUPPLIES–LATCH KEY PROGRAMS–FOR EVERY 20 CHILDREN
(Quantity of equipment is to increase in proportion to licensed capacity of center)

	PROVISIONAL LICENSE	REGULAR LICENSE (additional equipment and supplies)
Furniture:	1. Sufficient tables and chairs with backs (children's) (one chair per child; no folding chairs). 2. First-aid kit. 3. Cot with blanket (ill child). 4. Chairs with backs (for staff). 5. Low open shelves and bookcases (one foot per child). 6. Space/equipment for maintenance of children's records. 7. Individual space for outer clothing. 8. Area rug or carpet. 9. Equipment for a child's private hide-away corner; e.g., pillow, covered mattress, bedspread.	
Active, large-muscle play: (for indoors)	1. Four pieces of a variety of recreation sports equipment, for example: equipment for volley ball, ping pong, basketball, obstacle course, rope climbing, tumbling. climber balls trampoline	Six Pieces

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LATCH KEY PROGRAM (continued)

	PROVISIONAL LICENSE	REGULAR LICENSE (additional equipment and supplies)
Active, large-muscle play: (for outdoors)	1. Four pieces of a variety of recreation and sports equipment, for example: standard heavy duty playground equipment balls and bats skates - roller and ice sleds, toboggans	Six Pieces
Art and music activities:	1. Phonograph 2. Records - at least 10 3. Materials for crafts - at least six types - e.g., tile, wood, clay, paper mache, paint, leather, foam, beads, shells, paper	Records - at least 15 Materials - at least 8 types
Dramatic play:	Area for dramatic play opportunities equipped with: 1. Materials for cooking and woodworking. 2. Materials for theater arts, costuming, puppets, and durable mirror.	
Ponder Play:	1. Materials and equipment for opportunities to: read, play games, cook, sew, experiment. 2. Books - one per child. 3. Games - one per two children. 4. Puzzles - one per child. 5. Science items - one per every four children, for example: magnet, magnifying glass, science set, plants.	Books - two per child Games - one per child

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LATCH KEY PROGRAM (continued)

	PROVISIONAL LICENSE	REGULAR LICENSE (additional equipment and supplies)
Expendable supplies:	1. Clay and playdough 2. Tempera and finger paints (non-toxic) 3. Paper (colored and white) 4. Paste (non-toxic) 5. Scraps - collage materials 6. Paint brushes 7. Crayons 8. Blunt scissors 9. Aprons or smocks	
Fine-motor development:	1. Manipulative toys—one per every two children; e.g., Erector set, Lincoln logs, TinkerToys, pegs and peg boards, interlocking plastic forms, building bricks	
Language development:	1. Pictures 2. Bulletin board 3. Flannel board and flannel set	
Food service supplies:	1. Dishes, silverware and cups for snacks and/or meals.	

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APPENDIX A
MINIMUM EQUIPMENT AND SUPPLIES - PRESCHOOL PROGRAMS - FOR EVERY 20 CHILDREN
(Quantity of equipment is to increase in proportion to licensed capacity of facility)

	PROVISIONAL LICENSE	REGULAR LICENSE (additional equipment and supplies)	PROGRAMS OPERATING LESS THAN FOUR HOURS (exceptions permitted)
Furniture:	1. Sufficient tables and chairs with backs for children (one chair per child - no folding chairs). 2. One cot per licensed capacity. 3. First-aid kit. 4. Cot with blanket (for ill child). 5. Chairs with backs (for staff). 6. Low open shelves and book-cases (one foot per child) 7. Space/equipment for maintenance of children's records. 8. Individual spaces for outer clothing 9. Area rug or carpeting.		2. Mats instead of cots
Active, large-muscle play: (for indoors)	1. Large building blocks (may be of non-durable material) at least 24. 2. Two pieces of durable large-muscle equipment per every 20 children such as: climber	1. Durable large building blocks - at least 48 per every 20 children. 2. Three pieces of durable large-muscle equipment per every 20 children.	

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PRESCHOOL PROGRAMS (continued)

	PROVISIONAL LICENSE	REGULAR LICENSE (additional equipment and supplies)	PROGRAMS OPERATING LESS THAN FOUR HOURS (exceptions permitted)
Active, large-muscle play: (for indoors) (cont.)	rocking boat triangle set tunnel walking plank		
Active, large-muscle play: (for outdoors)	1. Two pieces of durable large-muscle equipment such as: climber swing slide sand-box large wheel toys	1. Three pieces of durable large-muscle equipment.	
Art and music activities:	1. Phonograph 2. Records - at least six 3. One double easel	3. Double easels - one for each 15 children. 4. Rhythm band 2. Records - at least 10	
Dramatic Play:	1. Small blocks (at least 200 pieces) 2. Three small durable transportation toys per every 20 children for block area 3. One spontaneous dramatic play	2. Six small durable transportation toys per every 20 children for block area 3. At least two areas for spontaneous dramatic play each having at least three	

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PRESCHOOL PROGRAMS (continued)

	PROVISIONAL LICENSE	REGULAR LICENSE (additional equipment and supplies)	PROGRAMS OPERATING LESS THAN FOUR HOURS (exceptions permitted)
Dramatic Play: (cont.)	area with at least two pieces of permanent equipment; pretend area work bench (wood-work and tools) housekeeping area; e.g., doll bed, stove, sink, refrigerator, cupboard, etc. 4. Accessories: dolls, dishes, pots and pans	pieces of equipment 4. At least one full-length mirror 5. Dress-up clothes	
Ponder Play:	1. Books - one per every child 2. Puzzles - one per every four children 3. Cognitive games - one per every four children; e.g., number concepts letter concepts shape concepts size concepts color concepts	1. Two per every child 2. One per every two children 2a. Puzzle rack 3. One per every two children 4. Science items; e.g., magnet, magnifying glass, pets, plants	
Expendable supplies:	1. Clay or playdough 2. Tempera or finger paints (non-toxic)		

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PRESCHOOL PROGRAMS (continued)

	PROVISIONAL LICENSE	REGULAR LICENSE (additional equipment and supplies)	PROGRAMS OPERATING LESS THAN FOUR HOURS (exceptions permitted)
Expendable supplies: (cont.)	3. Paper (colored and white) 4. Paste (non-toxic) 5. Scraps - collage materials 6. Paint brushes 7. Crayons 8. Blunt scissors 9. Aprons - smocks		
Fine-motor development:	1. Manipulative toys - one per every four children; e.g., pegs and peg-boards, beads and strings, interlocking plastic forms 2. Sand or water play equipment	1. One per every three children	
Language development:	1. Pictures 2. Bulletin boards 3. Flannel board and flannel sets		
Food service supplies:	1. Dishes, silverware, and cups, if meals are to be served		

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MINIMUM EQUIPMENT AND SUPPLIES - INFANT AND TODDLER PROGRAMS - FOR EVERY 20 INFANTS AND TODDLERS
(Quantity of equipment is to increase in proportion to licensed capacity of facility.)

	INFANT PROGRAMS	TODDLER PROGRAMS
Furniture:	1. Sufficient infant-sized tables and chairs with backs for infants able to sit alone One chair per infant; no folding chairs	1. Same as furniture for preschool program plus:
	2. One crib with mattress and blanket per infant in attendance	2. Training chairs
	3. Ten-unit first-aid kit	
	4. Crib with mattress and blanket for ill infant	
	5. Chairs with backs (for staff)	
	6. Low open shelves and bookcases (one foot per child)	
	7. Space and equipment for maintenance of children's records	
	8. Adult rocker	
	9. Individual space for outer clothing	
	10. High chairs	
	11. Infant seats	
	12. Baby walkers	
	13. Bathing tub	
	14. Changing table with changeable covering	13. Bathing tub
	15. Diaper pail with liners	14. Changing table with changeable covering
	16. Area rug or carpeting	15. Diaper pail with liners
	17. Play pens	
	18. Gates as needed for safety	18. Gates as needed for safety

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	INFANT PROGRAMS (continued)	TODDLER PROGRAMS (continued)
Active large-muscle play:	1. Large building blocks (may be of non-durable material) - at least 20 2. Five pieces of durable large-muscle equipment for every 20 infants such as: Baby bouncers Large turning balls Body wheels Riding stools 3. Large open plastic ball 4. Water-play equipment	SAME AS PRESCHOOL PROGRAMS 2. Five pieces of durable, large-muscle equipment for every 20 toddlers, such as: Two-step slide Rocking boat Indoor gym house
Art and music activities:	1. Phonograph 2. Records - at least six 3. Musical pull-toys 4. Rattles 5. Drum (without sticks)	Same as preschool programs
Fine motor development:	1. Matching and feeling toys - one per every two children, such as: plastic clutch toys form toys rattles pull toys feeling balls 2. Manipulative toys - one per every two children such as: teething toys wooden rattles shape toys clutch balls	Same as preschool programs

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	INFANT PROGRAMS (continued)	TODDLER PROGRAMS (continued)
Language development:	1. Pictures 2. Bulletin boards	Same as preschool programs
Linens and supplies:	1. For each crib: bumpers, sheets (cotton, plus rubber and/or plastic), blankets 2. Bath towels 3. Wash cloths 4. Diapers 5. Cover(s) for changing table 6. Sterile cotton balls 7. Facial tissues 8. Soap 9. Petroleum jelly or bland diaper-rash ointment 10. Rubber-bulb ear syringe with blunt plastic or rubber tip	Same as preschool programs 3. Wash cloths 4. Diapers 5. Cover(s) for changing table 7. Facial tissues 8. Soap 9. Petroleum jelly or bland diaper-rash ointment

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APPENDIX B

HEALTH CARE SUMMARY
(To be completed by health care source)

NAME OF CHILD Birth Date

ADDRESS Telephone

PARENT(S) OR GUARDIAN

Date of last physical examination:

How long have you been seeing this child?

How frequently do you see this child when he is not ill?

Does this child have any allergies (including allergies to medications)?

Is a modified diet necessary?

Is any condition present that might result in an emergency?

What is the status of the child's Vision

Hearing

Speech

Please list below the important health problems. Indicate if you or someone else is following the child for the problem and check which problems require special attention at the center:

Important Health Problems	Followed By You	Followed by Other Medical Source (name)	Requires Special Attention at Center

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Immunizations and Tuberculin Test Records:

*D(P)T	1st date	*Poliomyelitis	1st date
*	2nd date	*	2nd date
*	3rd date	*	3rd date
*Booster date		*Booster date	
*Rubella date		Mumps date	
*Rubella date			

*Required

Tuberculin Test

date results

If positive, what are the plans for treatment and/or follow-up?

Are the immunizations up-to-date?

If not, what is the plan to bring them up to date?

Other information helpful to the group-day-care center:

Source of health care

Associates or clinic

Address

Date

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APPENDIX C

DAILY FOOD GUIDE

FOODS	SERVINGS PER DAY	AVERAGE SIZE SERVING BY AGE*		
MILK GROUP		1 - 3 yrs.	3 - 6 yrs.	6 - 9 yrs.
Milk (pasteurized, homogenized, and fortified Vitamin D)	2-3 servings	½ to 1 cup	½ to 1 cup	1 cup
Cheese and ice cream occasionally				
MEAT GROUPS				
Meat, poultry, fish	1 - 2 servings	1 to 3 tbs.	2 to 4 tbs. (1 to 2 oz. cooked)	4 to 6 tbs. (2 to 3 oz. cooked)
As alternates dried beans or peas or peanut butter		1 to 3 tbs.	2 to 4 tbs.	4 to 6 tbs.
Egg	1	1	1	1
VEGETABLE AND FRUIT GROUP	4 or more servings			
Dark green vegetables and deep yellow vegetables and fruits for Vitamin A	1 serving	2 tbs.	2 to 4 tbs.	¼ cup
Fruit for Vitamin C citrus, tomato, cabbage	1 serving	1/3 - 2/3 cup	1/3 - 2/3 cup	½ cup
Other fruits and vegetables	2 servings	¼ - 1/3 cup	¼ - 1/3 cup	½ cup
BREAD AND CEREAL GROUP				
Bread and cereal, whole grain or enriched	4 servings	½ to 1 slice ¼ cup cereal	½ to 1½ slices ½ cup cereal	2 to 3 slices ½ cup cereal
OTHER				
Butter or margarine	As spread or seasoning			

*Size of serving will differ with individual children; some may want smaller amounts and some larger.

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§ 2.004 Standards for the licensing of private child-caring or placing agencies.

A. This rule governs the operation of agencies engaged in, or seeking to engage in, child placement or other child-welfare services in Minnesota and sets forth the requirements necessary for such agencies to be licensed.

B. "Agency" means any individual, organization, association, or corporation planning for, giving direction to, or providing needed service or assistance to children and parents in their own homes and placing them in foster care.

It includes any social service department of a child-caring institution that carries these responsibilities or gives the services herein described.

C. Procedures.

1. Persons desiring a license or a renewal of license of this type shall apply to the Commissioner of Public Welfare. The Commissioner or his designee shall determine the competence of such persons to be licensed for the purposes described in the application; and he has the authority to issue such license. In making his determination, the Commissioner shall be guided by the rules in this and subsequent sections. All licenses shall expire one year after date of issuance unless sooner revoked.

2. An individual or organization planning to operate a child-welfare agency shall file an application for a license with the Commissioner at least 90 days before it begins to operate as an agency, on forms provided by the Department of Public Welfare.

3. In addition to the application, an applicant seeking license shall submit such information as the Commissioner may require to make proper determination of the competence of the agency to be licensed.

4. An agency desiring to renew its license shall submit an application for relicensing at least 30 days before the license is due to expire. In applying for such renewal, the agency shall file with its application such information as the Commissioner may require to make a proper determination.

5. The Commissioner or his designated agent shall have ready access to records of all services given by a licensed agency, and records related to administration and financing of such services. He may from time to time require agencies to supply information or make reports to him about agency services and their administration.

D. Organization and administration.

1. The purposes or function of the agency shall be clearly defined. Such definition shall include the geographical areas to be served, which children and parents will be accepted for care and service, and the specific services to be provided for in behalf of these children.

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2. The agency shall meet a need in the geographical area it serves or plans to serve.

3. The agency shall be organized according to a legal form of association or corporation recognized by the laws of the State of Minnesota.

4. The agency shall have a sound plan of financing that gives assurance of sufficient funds to enable it to carry out its defined purposes and provide proper care for children. A new agency shall have sufficient funds assured to carry it through the first year of operation.

5. All financial accounts shall be audited at least once a year and the report made a part of agency records.

6. Qualifications of personnel:

a. The executive or director shall have had training and responsible experience in work with children and their families and demonstrated executive ability.

b. The case-work supervisor shall be a graduate of an accredited school of social work or have successfully completed two years in such a school. In addition, the case-work supervisor must have had a minimum of two years experience in a family and children's agency, or in a children's agency, as a case worker or case-worker supervisor. In agencies not having a case-work supervisor, the executive or case worker shall meet these qualifications.

c. Case workers shall be at least college graduates.

d. Where an agency currently licensed does not meet these requirements, future changes in personnel shall conform to these requirements.

E. Social services.

1. The agency shall make provision for a social-service program including social case work with parents, foster parents, and children.

2. The agency shall be responsible for making social-service studies to determine that in the best interests of the child and his family, it is necessary and desirable that the child be accepted by the agency.

3. The agency shall make provision for continuing social services to parents, foster parents, and child while the child is in placement.

4. The agency shall be responsible for keeping case records of all children and parents accepted for care and service.

5. The placement agency shall make a thorough social study of each foster boarding home. The rules set by the Commissioner for the study and

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approval of such homes shall be the basis on which an agency recommends that a home be licensed in the case of a foster boarding home or approved for placement of a child in adoption.

6. The agency shall keep a record of each home studied and of subsequent supervision or services given by the agency to approved homes. The content of such records shall be in conformity to the Commissioner's rules relating to such records.

7. An agency shall place children, in so far as practicable, in facilities having the same religious beliefs as the child's parents.

8. Agencies providing social services for children in institutions are subject to rules and regulations governing such services (see 12 MCAR § 2.005).

F. Health services.

1. The agency shall require each child to have a complete physical examination within two weeks prior to placement, and such examination shall include proper tests for communicable diseases.

2. The agency shall make provisions for subsequent periodic health examinations of each child.

3. The agency, in cooperation with parents, shall make provision for immunization, treatment of illness, and carrying out corrective measures and treatment of remediable defects or deformities in consultation and cooperation with proper licensed medical persons or organizations.

4. The agency, in cooperation with parents, shall make provision for adequate periodic dental examination and treatment including necessary prophylaxis, repair, and extractions.

5. The agency shall make provision and establish procedures for hospitalization of children under its care.

6. The agency shall keep adequate health records for each child.

7. The agency shall furnish adequate clothing for each child under care.

G. Education.

1. The agency shall be responsible for providing children with opportunity for religious education and experience. The agency shall have a defined policy on its religious practices for the information of those wishing to place children with it. In the religious education and experience provided, the agency shall take into consideration the religious affiliations or expressed wishes of the parents and the child.

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2. The agency shall be responsible for providing opportunity for academic and vocational training in accordance with the abilities and needs of the children.

H. Expense reimbursement from families who receive children for adoption.

1. Any agency that has been continuously under licensure for a period of at least five years and the terms of such licensure include authority to place children for adoption, may apply to the Commissioner of Public Welfare for authority to receive expense reimbursement as provided by Minn. Stat., § 317.65, subd. 7, as amended by Laws of 1971, ch. 42.

2. Application shall be made in the following manner:

a. The agency shall file with the Commissioner a description of its plan in such form and including such information as shall be prescribed by the Commissioner on an application form provided by him.

b. Within 30 days after receipt of an agency's application, the Commissioner shall notify the agency, in writing, that the plan is approved as submitted, that additional information is needed before a decision can be made, or that modification of the plan will be required before the plan can be approved.

3. No agency shall ask for or receive adoption expense reimbursement until it has received the Commissioner's written approval of its plan.

4. Application for any major amendment to a plan shall be made in such form as the Commissioner shall prescribe, and the amended plan shall not be put into effect until the agency has received the Commissioner's written approval.

5. The Commissioner shall review the operation of the plan at least annually. Renewal of license shall, unless the agency is otherwise informed, constitute authorization for continuance of a previously approved expense reimbursement plan.

6. The Commissioner may revoke his approval of an agency's plan or require modification of its plan or practices when in his judgment such action is necessary to insure effective adoption services and full conformity to his rules and to the provisions of the statutes.

7. No agency's plan shall be approved unless it meets the following requirements:

a. The case record for each family applying to the agency to adopt a child shall include:

(1) Evidence of the fact that the agency's reimbursement plan

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was explained to the family, and a statement of the arrangements made between the family and agency for payment.

(2) The considerations that entered into the agency's decision to place or not place a child with a family.

(3) A description of services given for which reimbursement is sought.

b. The agency shall maintain fiscal records, by individual family, of payments made to the agency and shall report information annually in the form requested by the Commissioner.

c. The agency shall maintain a register of all children placed for adoption whether or not reimbursement was received. This shall include name and record number of each child and family and the date of placement.

8. The amount of expense reimbursement requested shall not exceed the average cost of the home study, provision of service to the child prior to adoptive placement, and supervision of the child in the home and shall be related to the extent of the family's ability to pay such cost, provided that the maximum reimbursement requested shall in no case exceed $600.

I. Refusal of license.

1. Failure or inability to comply with the above standards shall be cause for refusal or revocation of license.

Effective Date—November 15, 1971.

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§ 2.005 Standards for child-caring institutions.

Introduction.

The purpose of child-care licensing is the protection of children in care away from their own families. Rules for licensing identify risks and define appropriate safeguards.

The licensing of child-welfare agencies has been a legally designated function of the Minnesota Department of Public Welfare and is described in Minn. Stat., §§ 257.01 through 257.15.

These rules, as revised October 20, 1971, establish the minimum level of care for children in the care of licensees. They reflect the quality of care developed by the Minnesota child welfare institutions over many years of service. The rules emphasize the responsibility of licensed agencies to give foremost consideration to each child's spiritual, mental, physical, social, and emotional development and growth. To accomplish this purpose and maintain eligibility for a license, each agency must establish a philosophy of care that will provide the child with variety, stimulation, and gradual transition from dependence to more independence, as well as experience in coping with realities of the physical and social environment through contacts with it and through effective ties with adults. In addition to applying to private child-caring institutions, these same standards are also to be applicable to all the institutions operated by the State of Minnesota in caring for mentally ill and/or emotionally handicapped children.

In developing these rules, the Department was assisted by an advisory committee representing staff of various types of public and voluntary institutions, the legal and medical professions, referral agencies, and the interested public. A draft of the proposed rules was then presented at several informal open meetings within the state, and a later draft was presented at a formal public hearing in St. Paul, on August 30, 1971. The final draft of the proposed rules was reviewed and approved by the Department of Public Welfare October 20, 1971.

A. Definitions.

1. This rule governs the operation of institutions engaged in or seeking to engage in the care of children who are emotionally and/or socially handicapped and sets forth the requirements necessary for such institutions to be licensed.

2. "Institution" is defined for licensing purposes as a facility for care and treatment of children that has an administrative organization and structure approved under state law for providing shelter, food, training, treatment, and other aspects of care of more than ten children on a 24-hours basis.

3. This rule does not apply to institutions exempt from license as provided by law and to foster-care facilities, group homes, and institutions for

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mentally retarded, which fall under other licensing standards, and residential settings under the jurisdiction of the Department of Corrections.

4. A child is defined as meaning a person under the age of 18 years.

5. For the purposes of admission, an "emotionally handicapped child" is defined in this rule as a child who in the judgment of a professional social worker, psychologist, or psychiatrist is exhibiting those symptoms and behavior patterns that are determined to be of such nature that the child needs the care and treatment given in an institution governed by this rule.

6. For the purposes of admission, "treatment" is defined in this rule as giving to an emotionally handicapped child those professional services that are deemed necessary and appropriate to assist the child in returning to the community in a manner that will enable the child to function to the child's fullest possible extent.

7. "Applicant for license" is defined in this rule as the individual or corporation applying for license to operate an institution governed by these standards.

B. Procedures for licensing.

1. An applicant desiring a license or a renewal of license shall make application—in the case of a new application, prior to caring for children—to the Commissioner of Public Welfare, who shall make a determination according to 12 MCAR § 2.005 of the suitability of such applicant to be licensed for the purpose of giving care to children. In making this determination, the Commissioner shall be guided by the rules in this and subsequent sections. When an initial license is being issued to any facility, it shall remain in force for one year. When a license is being renewed, it may be issued for a period of up to two years, in the discretion of the Commissioner of Public Welfare. Every license shall prescribe the number and age groupings of children who may receive care at any one time.

Effective date—January 17, 1974.

2. Any applicant planning to enter into child care shall submit materials that the Commissioner may require to make a proper determination of competence of the applicant to be licensed. These materials are to include at least the following:

a. An architectural plan that shows feasible relationship to the program. (See section entitled "Plant, Grounds, and Equipment".) Experience has shown that Fire Marshal and Department of Health consultation is needed early in a building plan to avoid later problems. In so far as possible, it is, therefore, recommended that applicants for new institutions, and/or remodeling of existing institutions, arrange either with the assistance of the Department of Public Welfare or independently, to meet directly with the State Health and Fire Departments for the purpose of reviewing said architectural plans as soon as they are developed.

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b. A comprehensive description of the proposed program plan that also relates to the material contained in this rule under the sections entitled "Program for Care and Treatment" and Organization and Administration".

c. Funding base for building and operation of the institution.

d. A plan for what the institution will do to cover professional liability, as, for example, insurance against malpractice.

e. A statement describing the competence of the applicant(s) as it relates to providing care and treatment of children.

It is the responsibility of the applicant(s) to complete all of the above material before final consideration can be given to the initial request and/or updating material in the case of relicensure. Upon receipt of the above material by the Commissioner of Public Welfare, the application will be completely processed within 90 days after the day of receipt of same. In the event that the applicant is dissatisfied with a decision made on the license request, please refer to the section entitled "Rights and Obligations".

3. An institution desiring to renew its license shall submit an application for relicensing within a period of 45 days before the license is due to expire. In applying for such renewal, the director of each institution shall file with its application a statement that describes any and all changes that have modified the institution's physical plant, program plan, funding base, or professional competence since the granting or previous renewal of license to operate under this standard.

4. The Commissioner and/or his delegated representative staff shall have the responsibility to provide continuing monitoring of each institution in a manner that offers appropriate consultation to each institution and also assures that the standards are being maintained.

C. Organization and administration.

1. The purposes or function of the institution shall be clearly defined. Such definition shall include the geographical area to be served and how this area was determined, ages and types of children to be accepted for care, and the specific extent, limitation, and scope of services for which licensing authority is being sought.

2. It is recommended that the institution be located within reasonable traveling distance of the population the institution plans to serve. It is also recommended that public transportation facilities be within reasonable walking distance of the institution.

3. The institution shall be incorporated in accordance with the laws of the State of Minnesota as outlined and prescribed in § 317.65, Minn. Stat., particularly as it relates to governing boards and annual audits if the institution is to be operated as a nonprofit corporation. If the applicant is to oper-

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ate as a private business, a copy of any and all agreements related to operational policy shall be filed with the Commissioner of Public Welfare. The Commissioner of Public Welfare requires such a private business concern to file a copy of any and all policies related to the planned operation of an institution under these standards to permit a review of the organizational goals in a manner similar to review of a nonprofit corporation. The Commissioner does not intend to require a private business to incorporate solely for the purpose of providing service to children under this rule.

4. The institution shall have a sound plan of financing that gives assurance of sufficient funds to enable it to carry out its defined purposes and provide proper care for children. A new institution shall have sufficient funds assured to carry it through the first year of operation. It is highly recommended that the institution develop clear, concise billing procedures and give some consideration to development of written placement contracts between the institution and the parent or legal guardian of the child. (See "Records and Reports", Section C.9., for details.)

5. The institution is encouraged to have an advisory board that is broadly representative of the community it serves.

6. All financial accounts shall be audited by a certified public accountant from outside the institution staff or board at least once a year, and the report shall be made a part of institution records. An opinion prepared by said auditors about the institution's present and predicted financial solvency shall be filed with the Commissioner of Public Welfare at the time of each relicensure.

7. Discriminatory practices are prohibited (see Administrative Manual, III-3000 through -3700, for further details). All public welfare programs and activities in Minnesota administered by the Commissioner of Public Welfare and by his agents—the county welfare departments and the state institutions—by county nursing homes licensed by him, and by any other agencies or organizations administered by or through the State Agency are to be administered in such a manner that no person will, on the ground of race, color, religion, or national origin, be excluded from participation in; be denied any aid, care, services, or other benefits of; or be otherwise subjected to discrimination in any program administered or supervised by the Minnesota Department of Public Welfare. § 363.03, Minn. Stat., shall also apply as it relates to discrimination of staff and/or clientele.

8. It shall be required that the licensee or corporation, in cooperation with the Department of Public Welfare, or on its own accord, produce evidence to the Commissioner of Public Welfare that an annual review of its purpose and goals, and the extent to which the purpose and goals are being accomplished, was done.

9. Every institution shall maintain a confidential case record for each child. Each record shall contain:

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a. Application for service.

b. A social study of the family or investigation of application, including an explanation of custody and legal responsibility for the child.

c. A verification of age.

d. Medical consent signed by parents or legal guardian.

e. Reports on medical examinations, including immunizations, any drugs received at the institution, dental examinations, and psychological and psychiatric examinations when given.

f. A record of the child's development, reason(s) for continuation of institutional treatment, case work with him and with his family, and plan for discharge. The case record material shall be reviewed at least every six months and will be brought up to date at that time.

g. A statistical report on each child receiving service as required by the Commissioner of Public Welfare on forms furnished by the Department for that purpose.

h. It is recommended that when a child is committed for care, a written agreement between parents and/or legal guardian and the institution be prepared and signed by the intake case worker as the agency representative and by the parents and/or legal guardian. The parents and/or legal guardian should receive a copy, and the original should be filed in the child's record. The statement should cover at least:

(1) A clear statement as to who has financial responsibility.

(2) How payments are to be made to cover the cost of care.

(3) Exactly what items are and are not covered by the normal or regular institution cost, like holding a bed open when the child is not at the institution.

(4) Medical arrangements.

(5) Visiting arrangements and expectations.

(6) Arrangements for clothing and allowances.

(7) Arrangements for vacations.

(8) Regulations about gifts permitted.

(9) Arrangements for parents and/or legal guardian participation through regularly scheduled interviews with the institution.

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(10) The requirement that the child may be removed from the institution only after prior agreement with the institution and with sufficient advance notice so that the child and institution can be suitably prepared.

(11) The institution's policy and/or personal allowance to be provided the child at the institution.

(12) In a placement made on a court order, at least a written memorandum of the rights and responsibilities of the parents.

D. Program for care and treatment.

1. Admissions.

a. Only those children shall be admitted who are found eligible according to the institution's formally prescribed admission policies. Such admission policies must be pre-authorized by the Commissioner of Public Welfare and will include how the intake services will be extended, as well as the financing of any service plan developed between parents, agencies, and the institution's intake department.

b. Every institution shall have specific intake policies that are a part of the institution's written policy statements describing exactly what professional staff shall have the authority to admit a child. As a part of any admission committee for an institution, there shall be at least one professional social worker. Intake policies shall be carefully reviewed at least annually and changed as needs and conditions in the community change or as the staff and program of the institution change to meet these changing needs.

c. Admissions, in addition to keeping within the stated policies of the institution, shall be limited to those children for whom the institution is qualified by staff, equipment, and needs of children already in residence to give the care deemed necessary.

d. Admission decisions shall be based upon a complete social study of the total situation of the child and his needs as well as the total situation at the institution at a given time in order that the ultimate welfare of the individual child shall be the major consideration.

e. Such social study shall be made before a child is admitted, except when emergency care must be given, and then the study shall be made immediately thereafter.

f. The social study shall include all that information that will permit a careful analysis of each case to make sure that each child admitted is in need of the type of care and service the institution can provide. The social study shall also include information from agencies involved with the child and his family.

g. Prior to final placement, unless there are highly unusual circum-

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stances, the child, his parent, and/or his legal guardian shall have a pre-placement visit to the institution at least 24 hours before final placement.

2. Diagnosis and treatment while in the institution.

a. The institution, through its social services, shall have the responsibility for keeping the child in contact, where appropriate and possible, with his family and relatives and for assuring that services are provided to the family in behalf of the child by the institution staff, another professional public or private social service agency, or both. The institution and the placing agency shall also specifically determine for each child appropriate conferences involving the institution, the parent(s), the placing agency, and the child, to review the over-all situation. These formal reviews are to be planned for each child at least every six months. For a child placed in an institution for a period of less than six months, the formal reviews are to be planned at appropriate shorter intervals. Written summaries of the review shall be sent to the referring agencies and shall be prepared by the institution. A written progress report should also be sent to the parent and/or legal guardian of the child at least every six months.

b. The professional staff shall assist the child and family in understanding their problems and shall help the child and family in attempting to solve them.

c. The professional staff shall work closely with the child-care staff and with staff of other agencies giving service in order that all persons working with the child and his family may understand the effect of past and present behavior and environment on the child's actions and feelings.

d. In the gaining of an understanding of the child and his relationship to his family and others, the services of specialists in the field of medicine, psychiatry, and psychology shall be used as need for such services is indicated.

e. The institution shall develop and implement a treatment program based on meeting the particular needs of each child as a part of the institution program design as far as practical and possible.

f. Where possible and practical, some opportunities for self-governing councils should be considered for the clientele.

g. In the matter of work experience, each institution shall differentiate between work and daily living chores; and where an institution has a work program, it shall:

(1) Provide work experience for children that is appropriate to the age and abilities of the child. Where appropriate, work shall be assigned and supervision provided with a view toward training and contributing to his/her growth. Work shall not interfere with the child's time for school study periods, play, sleep, normal community contacts, or visits with his/her family.

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(2) Not use the children as substitutes for staff.

(3) Comply with the rules of the Department of Labor and Human Relations on child labor, especially the use of dangerous machinery and hazardous equipment. Operation of such machinery shall be conducted only in the immediate presence of an adult.

(4) Differentiate between the chores that the children are expected to perform as their share in the business of living together, specific work assignments available to children as a means of earning money, and jobs performed in or out of the institution to gain vocational training.

(5) Give children some choice in their chores and change from routine duties often to provide a variety of experiences.

h. No child shall be used for soliciting funds for an agency in any way that would be harmful or cause embarrassment to the child or his family; and the written consent of the parent or legal guardian shall be obtained prior to the agency's using a child's picture, person, or name in any form or a written, visual, or verbal communication system.

i. Each child shall have a recreational-activities plan developed to assist the child meet his/her own unique recreational needs.

3. Isolation.

This term is defined in this rule as separating the child for a temporary period of time from the rest of the institution population. Whenever an institution does utilize isolation, seclusion, or quiet rooms, adequate safeguards must be taken to prevent any detrimental effects upon the physical or emotional development of the child. Caution must be exercised in determining the frequency and duration of such periods, and the final decision to place a child in isolation must be made by the director of the institution or previously authorized staff.

If children are locked in rooms for security or isolation reasons, the following conditions must prevail:

a. The proximity of the staff will allow for visual and auditory contact with the child at all times.

b. All dangerous objects must be removed from the child prior to his placement in isolation.

c. Rooms must have doors that open out and with keyless locks that have immediate release mechanisms.

d. All fixtures within the room shall be tamper-proof, with security mattresses of fire-resistant material. Switches must be located immediately outside the room.

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e. Smoke or fire-monitoring devices must be an inherent part of the room, as well as proper ventilation.

f. Appropriate entries must be made in the child's file.

g. A child in isolation must be provided the same diet that other children in the institution are receiving.

4. Child-care and -development program.

a. Medical care:

(1) Except in the case of emergencies, no child shall be accepted in an institution without a physical examination and a statement signed by a licensed medical doctor specifying any physical defects the child may have. In an emergency admission, examination shall follow within 72 hours.

(2) Either prior to admission or as soon thereafter as practical, the child shall be immunized against smallpox, diphtheria, and such other diseases as the physician may recommend.

(3) Definite arrangements shall be made with at least one licensed medical doctor for the medical care of children. This shall include arrangements for necessary visits to the institution as well as office visits.

(4) Every child shall have a complete physical examination at least annually. A child having a physical defect shall not be allowed to participate in activities injurious to his health. Efforts shall be made by the institution to have physical defects of the children corrected through proper medical care.

(5) The staff members shall have a clear understanding as to what medical care, including first aid, may be given by them without specific orders from a licensed medical doctor. They shall be instructed as to how to obtain further medical care and how to handle emergency cases. To accomplish this objective, at least one member of the staff in attendance or on duty during the children's waking hours must have satisfactorily completed current first-aid training and have on file at the institution a certificate from the American Red Cross so noting this fact.

(6) Arrangements shall be made with a hospital for the admission of children from the institution in the event of serious illness or an emergency.

(7) Each member of the child-caring staff shall be able to recognize the common symptoms of illnesses of children and to note any marked physical defects of children. A sterile clinical thermometer shall be kept available. Child-caring staff shall be able to provide practical-nursing care.

(8) Each child shall have a separate medical record that shall include the statement of the medical doctor who examined him at the time of

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admission to the institution; a record of his immunizations; consent of parents or guardian for medical care; a record of his annual measuring and weighing; a statement from the medical doctor who gave him his annual physical examination; and a record of the medical care given at the institution. The latter shall include a record of his hospitalization; an up-to-date recording of any and all drugs, including prescriptions, quantity directions, physician's name, date of issue, and the name of the pharmacy; significant illnesses or accidents; and attempts at correcting physical defects.

(9) Prescribed drugs and medicines shall be obtained on an individual prescription basis with the following labeling:

Name of pharmacy.
Patient's name.
Prescription number.
Prescribing practitioner.
Directions for use.
Date of original issue or renewal.

In addition, we recommend:

Name of drug.
Potency of drug.
Quantity of drug.
Expiration date (when applicable).

Drugs and medications shall be administered to the patient by a responsible staff person in accordance with medical instructions. All drugs shall be stored in a locked (double lock for narcotics) cabinet, and keys for the cabinet shall be kept under the supervision of a designated responsible staff person assigned to administer the drugs. The medication cabinet shall be equipped with separate cubicles, plainly labeled with the patient's name.

Medications belonging to the patient shall be returned to the patient's guardian or parents upon discharge or shall be destroyed by the person designated responsible for drug storage and administration by flushing the drugs into the sewer system and removing and destroying the labels from the container. It is illegal to accumulate a store of drugs (see Minn. Stat. § 151.37).

Refills of medications shall be obtained by contact with the pharmacy, which is required to obtain refill authorization from the prescribing physician.

The institution may possess a limited quantity of non-prescription drugs and administer them under the supervision of the staff.

b. Dental care:

(1) The institution shall have a definite agreement for one or more licensed dentists for the dental care of children.

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(2) Each child shall receive a dental examination at least once a year.

(3) Included in the child's medical record shall be a dental record showing dates of examinations and by whom given.

c. General health:

(1) Each child shall have enough sleep for his age at regular and reasonable hours and under conditions conducive to rest. While children are asleep, at least one staff member shall be near enough to hear calls.

(2) Children shall be encouraged and helped to keep themselves clean. They shall receive specific training in personal hygiene.

(3) Bathing and toilet facilities shall be properly maintained and kept clean.

(4) Each child shall have his own clearly identified toothbrush, comb, an adequate supply of towels and washcloths, and his own separate place for keeping these personal articles.

(5) Menus shall provide for varied, balanced, and adequate diet for all children in the institution. This daily diet shall also meet the child's daily nutritional requirements and recognize the variations in appetite and encourage but not force children to eat.

(6) Each child shall be provided with clothing for his own exclusive use that is comfortable, appropriate for current weather conditions, and of such type as not to make him conspicuous in the community. Upon intake and discharge from the institution, the child's clothing status will be discussed and agreed upon between the referring and receiving parties.

(7) Electric lighting in combination with natural lighting shall be of sufficient quantity and diffusion as to provide reasonable comfort to eyesight.

(8) The institution shall provide equipment for indoor and outdoor play and shall make provision for active daily play and exercise.

d. Education and training:

(1) All children shall attend school in the local school district until the age of 16 years unless they are excluded for reasons that meet the guidelines of a properly designated school authority. The institution shall promptly notify the school district in the locality of the institution about any transfers in or out of the local school by the institution's clientele. A school operated within the institution shall meet the standards of the State Department of Education and the local school district. A special plan for education of a child shall be worked out when he is unable to attend the neighborhood

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school. The local school district is responsible for providing education to the child or children in the institution as described in Minn. Stat., § 120.17, especially subd. 6 and 8.

(2) Children shall be provided an opportunity to receive instruction in their religion. No child shall be required to attend religious services or to receive religious instruction if the child chooses not to attend services or receive religious instruction.

(3) Discipline shall be maintained by an attitude of the staff that shall be diagnostic and remedial, rather than punitive. Corporal punishment shall not be administered.

e. Children shall not be required to be solely responsible for any major phase of institutional operation or maintenance, such as cooking, laundering, housekeeping, farming, and repairing. Children shall not be considered as substitutes for employed staff.

5. Discharge.

The decision that a child no longer needs or can benefit by what the particular institution can offer him shall be reached in a joint conference in which child-care worker, case worker, group worker, teacher, other staff as needed, and the referring agency participate, with the executive carrying out final responsibility consistent with the following concepts:

a. The length of time a child spends in an institution shall be as brief as possible in accordance with his specific needs.

b. It is a part of the institution's responsibility to help the child and his parents or legal guardian prepare for termination of placement in the institution, whether the move is to return the child home or to a foster family, adoptive family, another institution, or the home of relatives.

c. If the parents, the legal guardian, or the child needs or wants further help after discharge from the institution, the institution and referring agency shall be responsible for either meeting the request for service directly or referring the parents, the legal guardian, or the child to another appropriate source.

6. Responsibility for notification of runaway children.

The institution shall be required to notify the child's parent(s) and/or legal guardian or referring agency within twelve hours after the child's whereabouts are unknown. The institution shall also notify the police within a reasonable period of time after it is confirmed that the child has attempted to run from the institution. When the child is found, the institution shall promptly report the child's return to the child's parents and/or legal guardian. Cooperative working relationships between the local police and the institution shall be established and at least annually reviewed in a joint meeting between the local police chief and the institution director.

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E. All personnel–staff and volunteers.

1. Every employee shall be mentally and physically capable of performing the duties assigned to him or her. There shall also be sufficient staff to carry out the institution's program and to assure the programming provisions of this rule. Every staff member shall have a physical examination before he/she begins work and annually thereafter. Initial examination shall include a Mantoux test, and a chest x-ray when the Mantoux is positive.

2. The ratio of child-care staff to children in care shall be dependent on the need of the children, but the ratio of such staff to children shall not be less than the following schedule:

Age of the Child	Minimum Ratio of Staff to Children During Waking Hours
Four to five	One staff member to three children
Six to eight	One staff member to four children
Nine to eleven	One staff member to six children
Twelve to sixteen	One staff member to eight children

There must be a staff person available at night in each individual unit, or hall, and a provision made whereby another staff person may be summoned in an emergency.

In an institution, the superintendent, supervisor, and teachers shall not be included in computing the waking hours schedule and could only be included in staff ratio if they have a regularly scheduled assignment within the immediate vicinity and call of the children during the night.

The ratio of professional staff to children shall be dependent on the needs of the children, but there shall be at least one professionally trained worker for every twelve children in the institution. "Professionally trained" shall be defined as possession, at the minimum, of a B.A. degree. Based on a 40-hours week, this ratio is intended to mean, as a minimum, that each child should be able to receive at least three and one-third hours of professional service each and every week.

3. The institution staff shall include:

a. Administrator:

The administrator shall have had training and experience and furnish references to the institution executive or board to verify his proficiency in working with children that will help equip him for his duties and make him temperamentally adapted to work with children, committees, and other community groups. The education and experience qualifications of the administrator shall not be less that the following:

A B.A. degree in one of the behavioral sciences (special education, vocational

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counseling, psychology, social work) plus a minimum of five years od experience in residential treatment.

or

A master's or doctor's degree in one of the behavioral sciences (as defined above) plus a minimum of three years of experience in residential treatment.

All directors currently employed with lesser qualifications are "grandfathered" in as of the date of these standards. Where there are over 50 children in an institution, the administrator should have an executive assistant or a program director. The person responsible for program direction shall be equipped by training and/or experience.

b. Clerical staff:

Each institution shall have sufficient clerical services to keep correspondence, records, and bookkeeping in good order.

c. Child-care staff:

Resident-care staff shall have training and experience sufficient to equip them for their duties. Staff members shall be at least 21 years of age unless their maturity and the staff supervision and support justify having younger persons on duty.

d. Service personnel:

Domestic and maintenance staff shall be employed to carry on the everyday housekeeping and maintenance functions in sufficient number so that those employed to give direct care to children are not prevented from giving supervision to the children because of other duties.

e. Social-work services:

Social-work services through qualified social workers shall be provided by the institution. In an institution with more than 24 children, the master's degree worker should be in addition to the professionally trained director. All other social workers shall have at least a B.A. degree, and it is desired that this degree be in the behavioral sciences. The social workers should be supervised by a person professionally trained in the behavioral sciences. An institution providing social-work services through its own social-services department must also meet requirements relating to licensing of social-services agencies.

f. Adjunctive clinical services:

The services of a psychologist, psychiatrist, and physician must be made available for the children requiring these services. Professional staff who are employed, or whose services are used, by the institution shall have the special qualifications obtained through training and experience in their respective

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fields to render satisfactorily the services expected of them. Such staff include, but are not limited to, medical, dental, and health specialists; nutritionists; psychologists; music and vocational therapists; and teachers or educators. Each institution shall contract for psychiatric services to provide a specified number of hours of consultation each month to the staff.

g. Volunteers:

Volunteers can be utilized by an institution to provide specialized skills and interest not otherwise available to the children through staff and to offer opportunities for relationships and individualized attention if used in accordance with the treatment program of the institution and for the child.

h. Relief staff:

Relief personnel should be a part of the regular staff and able to understand and work toward the habilitative and rehabilitative goals of the institution.

i. Recreational staff:

A recreational staff is an important aspect of the treatment program, and staff members holding such responsibilities shall have training and experience in recreational activities.

4. Personnal policies.

Policies related to employment shall be in writing and include at least the following:

a. Description of the specific duties each employee is expected to perform, when they are to be performed, and other persons involved in their performance.

b. Recruitment and selection of new employees, the qualifications required/desired for each position, and, in general, how these qualifications are verified when an individual is hired.

c. Salary pay plan, mileage, expenses, and a list of all fringe benefits, such as hospitalization and retirement.

d. A description of the probation period and a list of conditions whereby termination will be considered.

e. Work schedules that describe what the vacation, holidays, sick leave and daily periods of relief of the institution are.

f. Confidentiality—All employees shall receive both oral and written instructions as they relate to their individual responsibility for preserving confidentiality of the clientele.

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g. Training—Each agency shall describe the type and duration of its in-service training program related to each position in the institution.

h. Notification of all employees as to whom to consult and how to do so in the event of an emergency.

i. Opportunities for attendance at workshops, institutes, and/or continuing education.

j. General promotional requirements and/or opportunities shown in writing.

k. Performance evaluations—It is recommended that each employee receive an evaluation at least annually and that the employee share in the evaluation process.

l. Provision of a copy of the institution's organization chart for each employee.

F. Plant, grounds, and equipment.

In addition to the broad statements contained in this section and this rule, the specific standards of the State Fire Marshal and the State Health Department, as well as local building codes where they exist, shall also be applicable.

1. Grounds.

There shall be sufficient outdoor recreational space available.

2. Buildings.

a. Plans for a new building, additions, or structural alterations, when such plans affect services to children, shall comply with local building codes and shall be submitted for approval and consultation to the Department of Public Welfare before contracts are let or work is begun.

b. In any new construction, each child shall have at least 100 square feet in a single room, 80 square feet in a double room, and 70 square feet in a triple room for a sleeping room. In any institution licensed prior to this standard revision, no child shall have less than 70 square feet for a sleeping room. Each child shall have his own bed provided with springs, mattress, and bed covering in good condition. Each child shall also have an area to store his personal belongings in a manner that assures privacy. There should not be more than four children in each sleeping room, with two being more desirable. Children shall not sleep in basements or attics.

c. Dining rooms shall be cheerful and attractive, and furnishings shall be well constructed and designed for use of children within the institution's age range.

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d. The living rooms shall be large enough to provide comfortable and cheerful living quarters for the children.

e. There shall be sufficient space provided for indoor quiet play and active group play.

f. Heating facilities shall be provided that will keep the temperature in living quarters of the institution within the range of 70-74 degrees Fahrenheit.

g. It is recommended that natural light, where possible, be available in every sleeping area used by children and staff.

h. In combination with natural light, electric lighting shall be installed of sufficient quantity and diffusion to provide reasonable illumination.

i. Ventilation shall be available in every room in the institution that is used by the children and staff.

j. Staff quarters shall be separate from those of children although near enough to assure proper supervision of children.

3. Fire.

a. Care shall be exercised by the staff to prevent children from using matches, from playing around unprotected and unsupervised fires, or from handling flammable or combustible materials. Children shall be instructed on fire prevention.

b. Blankets, bedspreads, drapes, clothing, and bedding materials should be made of non-combustible or fire-retardative material, as certified by manufacturer.

c. All electrical and heating equipment shall be approved by Underwriters Laboratory or other nationally recognized testing laboratories. All electrical equipment and installations shall comply with the State Board of Electricity and the National Electric Code.

d. Flammable liquids, such as gasoline, kerosene, fuel oil, etc., shall be stored as provided by regulations of local and state fire authorities.

e. The staff and children residing in an institution shall be trained in properly reporting a fire, in extinguishing a small fire, and in evacuation from the building in case of fire. Fire drills shall be held periodically. Fire extinguishers shall be provided and maintained throughout each building in accordance with standards of the State Fire Marshal. The institution shall comply with all regulations of the State Fire Marshal that relate to operation of such buildings.

f. All buildings of institutions licensed for the first time and/or new

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construction in existing institutions shall be of non-combustible construction and shall be at least one-hour fire-resistant for all one-story buildings and at least two-hour fire-resistant for all buildings more than one story.

g. Within existing buildings of frame construction, children shall not be housed above the second-floor level. At least one-half of the required exits from the second-floor level shall discharge directly to the exterior of the building at grade. All vertical openings between the first- and second-floor levels shall be enclosed at the first-floor level with at least one-hour fire-resistive construction, and any door openings into this enclosure shall be solid core wood or its equivalent. A complete automatic and manual fire alarm system shall also be provided within the building, and plans and specifications for such system shall be submitted to the State Fire Marshal's office for review prior to installation.

4. Sanitation.

a. Kitchens and kitchen equipment shall meet standards of the State Department of Health.

b. There shall be an adequate available supply of hot and cold water to serve the institution. Toilet facilities shall be maintained in a sanitary condition equal to standards prescribed by the State Department of Health. There shall be separate toilet and bath facilities for boys and girls and separate facilities for employees. There shall not be less than one lavatory with hot and cold water for every six children, one toilet for every eight children, and one tub or shower for every ten children. In addition, there shall be a minimum of one tub or shower in each building in which children live.

c. Sewage shall be disposed of through sewage systems that comply with state ordinances.

d. The milk supply shall meet state ordinances.

e. Drinking water shall be supplied from an approved system that complies with State Health Department regulations.

f. Proper facilities for staff and program sanitation shall be provided throughout the institution buildings and premises for the purpose of insuring cleanliness and protection against disease.

G. Rights and obligations of the applicant.

1. An applicant has the right to make an application to receive a license to operate an institution under this standard.

2. If an applicant is dissatisfied with a decision made on his application, he has the right to appeal in accordance with the procedures outlined in Minn. Stat., § 257.11. In order to assure prompt attention, a person or persons intending to initiate such an appeal should file a notice of such intent

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with the Commissioner of Public Welfare within 30 days after denial of their initial request for license was received. This same appeal process shall apply to applicants whose relicensing was denied.

3. An institution has the right to set the cost of care for treatment at the institution. It is recommended that this cost be based on a dollar amount that will adequately reflect the institution's intent to meet the standards of this rule and the program intent of the institution. It should be recognized by prospective clientele that in order to provide continuing, competent care for children in placement, the cost of care will have to reflect a dollar amount that will enable the institution to maintain a facility that has a plant, program, and personnel to meet its responsibilities.

4. An applicant has the right to request consultation from the Department of Public Welfare to assist the applicant in understanding this rule and its requirements.

5. The applicant has the obligation to provide services to emotionally handicapped children as outlined in this standard and Minn. Stat., §§ 257.01 through 257.15, § 317.65, and § 151.31, in order to retain a license to operate in the State of Minnesota. Therefore, failure or inability to comply with the above standards and laws shall be cause for refusal or revocation of license.

Effective Date—November 15, 1971.

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§ 2.006 Standards for maternity shelters.

Minn. Stat., § 624, establishes the authority of the Commissioner of Public Welfare to set rules governing the operation of maternity shelters. The Commissioner of Public Welfare hereby promulgates the following rule and regulation to establish standards for maternity shelters.

A. Definition.

"Maternity shelter", as used in these standards, means any home or institution that provides residential care for three or more pregnant women.

B. Organization and administration.

1. Purpose and function.

Each maternity shelter shall clearly define its purpose and function. The function and services of the shelter shall be related to the need of the unmarried mother and her child, to needs of the community as a whole, and to the other health and social-service resources.

2. Organization.

a. The maternity shelter shall be incorporated in accordance with the laws of the State of Minnesota.

b. There shall be a board of directors responsible for policies and for the financing of the shelter. The board should be composed of persons representative of the community served.

c. There shall be written policies and procedures relating to board structure and organization. The policies and procedures shall be subject to constant re-evaluation in the light of changing needs.

3. Financing and accounting.

a. The maternity shelter shall have a plan of financing that gives assurance of sufficient funds to enable it to carry out its defined purposes and provide proper care of the unmarried mothers. A new maternity shelter shall have sufficient funds assured to carry it through the first year of operation.

b. All financial accounts shall be audited by a certified public accountant from outside the maternity shelter staff or board at least once a year; and the report shall be made part of the shelter's records subject to review by the Commissioner of Public Welfare.

4. Personnel.

a. All employees shall be persons of good character, good health, and emotional stability, with appropriate education and experience to carry out the duties assigned to them.

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b. There shall be a sufficient number of staff members to provide adequately for social services, education, physical and mental health, group activities and discussion, and religious needs of the girls and women in care. These people may be permanent staff members or may serve in an auxiliary capacity.

c. There shall be written personnel policies and job descriptions approved by the board of directors.

d. A salary range for each type of position shall be established in writing and shall be adequate to attract and hold efficient personnel, equivalent to prevailing rates of pay in similar positions in the community, and commensurate with the duties and responsibilities of the position.

e. Personnel policy shall provide specifically for vacations, sick leave, holidays, and maximum work week. The work week should not exceed 40 hours. There should be a minimum of two weeks vacation, twelve days sick leave, and seven holidays per year.

f. Each staff member shall have a physical examination, including chest x-ray, before he begins work and annually thereafter. Report on such examination for each employee shall be kept on file.

g. Individual personnel records should be kept for each employee, to include evaluations of job performance.

5. Staff.

a. Executive director. The executive director shall be a person of appropriate training and experience, proven executive ability, knowledge of the work to be administered, and an understanding of the unwed mother and her needs. She should have a college degree with professional training and experience in social work or its equivalent and experience in working with people, to be able to carry out her duties and work with committees and other community groups.

b. Social services. The maternity shelter shall make provision for social services either by employing qualified social workers on the maternity shelter staff or by arrangement with an authorized social-work agency. Psychiatric and psychological services should be available as needed.

c. Group-living staff. Group-living staff shall be persons of unquestionable moral and emotional fitness, with adequate education and experience to equip them for their duties. Each person in the shelter should have an understanding of unmarried mothers and their needs.

d. Clerical staff. Each maternity shelter shall have adequate clerical services to keep correspondence, records, bookkeeping, and files current and in good order.

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e. Other staff. Domestic and maintenance staff shall be employed to carry on the everyday housekeeping and maintenance functions in sufficient numbers to care for the upkeep of the maternity shelter.

C. Buildings and grounds.

1. Location.

The maternity shelter shall be so located as to provide easy access to hospitals, fire protection services, and other community facilities.

2. Health and safety.

a. All buildings shall conform to local or state building codes and shall be approved by the State Fire Marshal or local fire bureau.

b. The maternity shelter shall comply with local or state sanitary and safety requirements relating to water supply, plumbing, cleanliness, heating and ventilation, laundry, and garbage and waste disposal.

3. Living arrangement.

a. The maternity shelter shall be planned and furnished to create an atmosphere of cheerfulness and contentment.

b. There shall be provision for a reasonable degree of privacy as well as for appropriate group-living experiences.

c. The area of sleeping rooms shall be not less than an average of 500 cubic feet per person. Four occupants per room should be considered a maximum.

d. The living room, dining room, and other group activity areas shall be large enough to provide for comfortable and cheerful group living.

4. Grounds.

There should be sufficient well-kept grounds for recreation and outdoor activities.

D. Social services.

1. Admission policies.

a. The basis for eligibility for admission is the ability to use the services available.

b. Shelters under religious auspices, or those set up to serve a particular group, should define their admission policies clearly. In general, policy should state that no application will be rejected because of age, race, color, religion, legal residence, marital status, prior pregnancy, or economic status.

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c. Policy about time of admission should be flexible to allow for individual needs. Eligibility should not depend on the plan for the child or on willingness to remain in the maternity shelter for any specified period of time.

d. If the maternity shelter cannot provide appropriate living arrangements for care of an unmarried mother at the time when such care is needed, policy should provide for referral to other community resources that can better meet the woman's needs.

e. If possible, at time of admission, provision should be made—by the shelter—for payment of expenses of living arrangements and medical care for the unmarried mother and for boarding care and other expenses for the child. Nevertheless, services should not be withheld solely because of inability to pay.

2. Case-work services.

Case-work services shall be available to each unmarried mother admitted to a maternity shelter program, either through its own professional staff or through an approved social agency in the community.

a. Case-work service shall be offered to each unwed mother, and she should be referred for such service as soon as possible.

b. The initial case-work interview shall be held within ten days after referral.

c. Case-work interviews shall be regularly scheduled, with reasonable frequency based on individual needs. Intervals between case-work interviews shall not exceed two weeks.

d. Case-work service shall include help in adjustment to pregnancy, to separation from natural environment, and to group living. Case-work service should include psychological and psychiatric help as needed to facilitate diagnosis and treatment.

e. The case worker shall be responsible for providing help in formulating a long-term plan for the mother and baby.

f. Every unwed mother shall be given the choice of keeping or relinquishing her child and of deciding whether or not she sees her child. Help with this decision is part of the case-work process.

g. The case-work agency, at the request of the mother, shall arrange for referral to a licensed child-placing agency for any baby needing adoptive placement or other foster care. The maternity shelter staff shall not place children for adoption or foster care.

3. Group-work services.

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Individual case-work service should be supplemented by group discussions to help girls and women to understand themselves and to make sound plans for the future. They should be led by a qualified social worker who has familiarity with modern social-work concepts about the problems and treatment of unwed mothers.

4. Staffing.

Provision should be made for regularly scheduled conferences involving the case worker, the group worker, and resident personnel in discussions on the total planning for each girl and woman in care. Other persons of therapeutic importance in a given case may also be included in these discussions, such as psychiatric consultant, clergyman, teacher, parent, relative, etc.

5. Case recording.

A confidential record shall be maintained for each resident, including identifying information, a brief social history, and a record of case-work planning and services needed. The record may also include psychological reports and medical recommendations.

E. Medical and health services.

1. Initial examination at the time of intake shall include:

a. A complete medical history, including a history of previous pregnancies, general health, and significant health history of the family.

b. A complete physical examination, including:

(1) Estimation of the progress of this pregnancy, with determination of pelvic measurements and significant abdominal findings.

(2) Weight, temperature, pulse, respiration, and blood pressure.

(3) Urinalysis, hemoglobin determination, and blood RH.

(4) Serological test for syphilis and cervical and urethral smears for gonorrhea (to be sent to State Health Department).

(5) Mantoux test or chest x-ray.

2. The maternity shelter shall enter into a written agreement with a licensed hospital in the community to provide facilities for obstetrical deliveries and post-partum care.

3. The maternity shelter shall make provisions for adequate prenatal and postnatal care for both the unmarried mother and her child.

a. During the first seven months of pregnancy, the unmarried mother should be seen by the physician not less than every four weeks, every

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two weeks from then until the last month, and then every week until delivery.

b. At each visit a urinalysis should be done, blood pressure recorded, and the patient weighed.

c. A hemoglobin determination should be done, preferably each month, or at least once each trimester.

d. A final and complete postnatal examination shall be made by the physician before discharge.

4. If possible, the care of the unwed mother must be supervised by a specialist in obstetrics, and the care of the child must be supervised by a specialist in pediatrics. Adequate consultation by other specialists should be readily available.

5. Medications shall be dispensed only on orders of the attending physician.

F. Education.

1. Formal education.

Opportunities shall be provided for continuing education for girls whose education has been interrupted by pregnancy. Arrangements shall be made with the local department of education to provide qualified teachers and to insure continuance of school and proper credit for work completed in the maternity shelter. The school program should offer a wide variety of subjects, in order that each girl can study courses for which her home school can give credit. Every effort should be made to insure confidentiality both in requesting transcripts and in transferring credit.

2. Informal education.

a. Instruction in health, prenatal care, delivery, and post-partum care shall be given to all residents.

b. A wide variety of activities should be provided to meet varying interests, abilities, needs, and new experiences and to provide an opportunity to find new ways of adjusting to life situations.

(1) Informal discussions, in small groups having mutual interests and problems, should be led by a person trained in social group work when possible.

(2) A varied recreation program should be developed to teach acceptable means of using leisure time as an outlet for emotions, self-expression, and the give and take of social relations.

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G. Religion.

1. The religious program shall give consideration to:

a. The place of religion in one's total life experience, with its traditional role in crisis situations.

b. The importance of religion in building and maintaining moral standards.

c. The value of religion in acquiring a positive self-image.

d. The likelihood of resentment and hostility toward religion on the part of some individuals, particularly when it is identified with authority.

2. The maternity shelter shall provide opportunities for each resident to follow, as she may wish, the practices of her religion. In an instance in which the shelter is maintained by a particular church group, this may be accomplished by having a resident chaplain responsible for religious activities. In other instances, arrangements may be made for carefully selected clergymen in the area to provide these services.

3. Pastoral counseling should become a part of the total helping process, and the clergyman should be considered a part of the helping team.

H. Residential program.

1. The residential program shall have the following objectives:

a. To provide a setting that will facilitate use of professional services designed:

(1) To meet emotional, medical, spiritual, educational, and recreational needs during a pregnancy.

(2) To prepare the residents for a more mature, emotionally satisfying and socially acceptable way of living.

b. To provide a positive experience of living with other girls that can alleviate guilt, decrease hostility, increase self-esteem and self-understanding, and provide an opportunity for companionship and for participation and self-expression in group activities.

c. To provide healthful and supportive relationships:

(1) Through a process of daily association with staff processing qualities worthy of emulation.

(2) Through association with adults who are well-adjusted in their own lives.

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(3) Through daily living experiences that can foster the personality growth of individuals.

d. To provide an environment that will insure comfortable shelter, appropriate food, privacy, security, relaxation, and freedom from pressures, with simultaneous opportunity for optimum self-direction, self-responsibility, and self-determination.

(1) A daily schedule and policies of conduct that make group living pleasant for all should be in writing and available to the resident on admission. Both should be flexible and adaptable to individual needs.

(2) Residents should have a part in planning activities of the group and some choice in participating. There should also be opportunities for group discussion and group decisions on problems of group living.

(3) Work should be considered a part of the therapeutic program, and work assignments should be a part of the plan for the girl's physical, mental, and emotional health and happiness.

(a) Proper supervision should be provided to make the work a learning experience in the skill and in carrying responsibility.

(b) The wishes and ability of each resident shall be taken into account in assignments, as well as her need for leisure and privacy.

(c) Disagreeable tasks shall not be used as punishment.

(d) Work assignments shall be so planned that they will not interfere with other aspects of the treatment program.

(4) Any practice not in conformity with the spirit of these objectives (censorship of mail, prohibition against a girl's use of her own room during free time, undue restriction of freedom to leave the grounds or to receive visitors, etc.) violates the requirements of this section.

(5) Each maternity shelter shall define the methods and procedures to be used by staff in implementing these objectives.

I. Revocation of license.

Failure or inability to comply with above standards shall be cause for refusal or revocation of license.

Effective date—February 1, 1965.

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§ 2.008 Standards for group homes and licensing procedures.

The authority of the Department of Public Welfare, Licensing Division, to prescribe and publish minimum standards for the approval and licensing of group homes is contained under Minn. Stat., §§ 257.081 through 257.15. Standards prescribed, and contained herein, shall be in force until revoked or revised by authority of the Department.

The Commissioner of Public Welfare is delegated responsibility by the State Legislature to see that the minimum requirements as herein prescribed are met and maintained by county welfare departments, licensed child-placing agencies, licensed children's institutions, foster-family group homes, and independent operators of group homes.

A. Introduction.

In our day, we are greatly concerned about every child in society and his need for proper care. We have the responsibility to see that proper resources are established and maintained. With our growing child and youth population and expansion of needs, we find that there are gaps between the service needed and the variety of resources available to provide the service.

In recent years, in an attempt to meet diverse needs, new resources for care have been established. One of these new resources is the group home. Group homes provide a type of care that is not available through traditional foster families or institutions. Group homes are not meant to replace either of these types of care but present a unique opportunity to combine different aspects of treatment from both resources. Group homes can provide adult guidance and professional services to the child placed out of his own home and yet keep the child in community living. The facility is community based, and the program is community oriented.

The group home represents a resource that has tremendous flexibility in giving care to children of all ages with varying needs. Group-home care should be used on a selective basis as a treatment of choice. The group home should not be considered a panacea of care for children. It is a distinct resource in its own right that is part of the whole broad spectrum of resources available to children.

B. Definition.

1. Group home—A specialized facility that provides care on a 24-hours-a-day basis for a selected group of not more than ten children. The facility can be owned, rented, or leased by a county welfare department, licensed child-placing agency, licensed children's institution, or independent operator, or subsidized by any of the above. The specialized care will be a planned treatment program under the direction and control of an agency, institution, or independent operator. Natural children of the group-home parents under 21 years of age, if present in the home, are included in the total number of children living in the home.

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2. Children—Persons under the age of 18 years of age or persons over 16 years of age if for reasons of mental retardation they still require the protection needed by persons under 16 years of age (Minn. Stat., § 257.081, subd. 6).

3. Group-home parent—A person who carries out the continuing daily living program and provides care to the children. This may be a member of the agency staff or a person subsidized for the care he or she provides. It may be a married couple, a single person, or single persons working on a shift basis.

4. Agency—The party responsible for providing social service, administration, and the direction and control of the program. This party can be a county welfare department, licensed child-placing agency, licensed children's institution, or independent operator.

C. Organization and administration.

1. The philosophy, purpose, and function of the group home shall be clearly defined in writing and maintained as part of the group-home file in the agency.

2. The agency shall similarly define, in writing, and file a statement of the geographic area to be served, ages and kind of children to be accepted for care, and the specific extent, limitations, and scope of service for which the group home is established.

3. The agency shall have on file a written agreement between itself and the group-home parents. The agreement shall contain the following items:

a. Admissions and discharge policy for the residents.

b. Program plans for residents.

c. Terms of the agreement as they affect length of time to be in effect and what conditions necessitate the formulation of a new agreement.

d. The roles, responsibility, and authority of the agency and its personnel and group-home parents.

e. The per diem or monthly care rate paid to the group-home parents.

f. The maximum number of children to be cared for in the group home.

4. The agency shall have a sound plan of financing that will give assurance of sufficient funds to enable it to carry out its defined purposes and to provide proper care for children.

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5. There shall be a system of business management and staffing to assure maintenance of complete and accurate accounts, books, and records. All records are subject to review by the Commissioner of Public Welfare.

6. The agency shall coordinate its services and program with appropriate persons, agencies, and organizations in the community. This shall include schools, vocational training centers, mental health centers, job placements, day-activity centers, parent organizations, and churches.

7. Clothing, personal allowance, spending money, and medical expenses for the children in the group home shall be worked out by the agencies involved.

8. All licensed individuals, agencies, or organizations shall operate on a nondiscriminatory basis, according equal treatment and access to their services to all persons.

9. It is recommended that the agency invest time in public relations before and after the group home is established to help establish community understanding and acceptance. Interpretation to key community leaders as well as the immediate neighborhood could minimize public relations problems as the group home operates.*

D. Personnel.

1. The director of the agency will be the chief administrator of the group home. The chief administrator may direct the total operation of the group home or may delegate this duty.

2. All employees shall be persons of good character, good physical and emotional health, and appropriate age and maturity and shall possess sufficient ability and education to carry out adequately the duties assigned to them.

3. There shall be sufficient staff to carry out the group-home program.

4. The agency shall provide qualified social-service staff for the group home either from within its own structure or through contractual arrangements.

It is recommended that not more than two persons provide continuing social service to any group home.*

5. Each group home shall have full-time group-home parents. If a married couple is employed in this position, at least one of them shall be on a full-time basis. A group-home parent shall be on duty at all times.

6. Adequate arrangements shall be made for substitute group parents

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to serve in emergency situations, vacation, illness, and when the regular group parents have their time off.

It is recommended that the full-time group-home parents receive two weeks vacation per year and that they be allowed one full day off per week.*

7. The agency shall provide medical and dental staff for the care of the group-home residents either from within its own structure or through contractual arrangements.

8. Additional staff to carry out the group-home program:

a. Psychiatric consultation—to provide consultation on a case basis as well as over-all treatment goals for the group.

b. Psychological consultation—to provide testing for assessment purposes at the time of admission as well as to measure gains throughout the stay or at the time of dismissal. The psychologist may also be used to set up and carry out a research project to evaluate the program and its impact on the children.

c. Service personnel—a cook, a housekeeper, or maintenance personnel may be hired to perform specific duties. This could relieve the group-home parents of these functions and allow them more time with the children in carrying out the program.

d. Volunteer services—to augment and assist other personnel in carrying out the program. Volunteers shall be aware of, and interested in, the needs of children. They shall be oriented to the program, staff, and children of the group home.

e. Trained group worker—to carry out direct group treatment services, consult about over-all group programs, and provide training in group process to the group-home parents.*

9. Adequate arrangements shall be made for clerical services to keep correspondence, records, bookkeeping, and files current and in good order.

10. Adequate arrangements shall be made for auxiliary staff as required by the program being offered. Such staff may be recreational personnel, remedial teaching personnel, or nursing personnel.

11. It is recommended that the staff ratio in a group home be one staff member for every five children.*

E. Program.

1. The program shall be a composite of the services offered in the

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group home, community, and agency supervising and directing the operation of the group home.

2. The program shall be based on the purpose of the group home, with plans for the individual children as well as the total group.

3. A program plan for each child shall be formulated by the agency in conjunction with the group-home staff, community resources, and auxiliary services at the time of intake. This plan shall be re-evaluated at least every six months, with changes implemented according to the needs of the child.

4. All school-age children shall be referred to the local school district for educational planning and placement.**

It is recommended that this referral to the local school take place prior to placement in the group home to insure that the child is eligible for service and that the local school has an appropriate program.*

5. Group living shall be used in planful and purposeful ways to help the children develop constructive relationships to adults and to other children and constructive patterns of handling time, money, and care of belongings and property.

6. Community-living experiences shall be used in conjunction with plans for education and training, recreational and social pursuits, job placements, and attendance at religious services.

7. Social service shall be a clearly defined and identifiable phase of the total care, treatment, and training program. Social service shall be provided on both an individual and a group basis.

It is recommended that social service be extended to the families of the residents whenever feasible and in accordance with the planning of the child.*

8. Leisure-time activities shall be planned to allow for constructive activities that enhance social and physical skills. Time shall also be available for completion of academic assignments and to allow for individual pursuits.

9. All children shall have medical and dental examinations yearly, or more often if necessary.

It is recommended that each child be given a medical and dental examination prior to admittance into the group home.*

10. Each child shall have the opportunity to practice his religious preference.

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**"Local school district" means the district in which the group home is located.

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F. Records.

1. The supervising agency shall maintain a record on each group home. The record shall contain a copy of each of the following items:

a. The philosophy, purpose, and function of the group home.

b. A statement of the geographic area to be served, ages and kind of children to be accepted for care, and the specific extent, limitations, and scope of service for which the group home is established.

c. The agreement between the agency and the group-home parents.

d. The intake policy and procedure.

e. The arrangements for the provision of social services.

f. The arrangements for the provision of medical and dental services.

g. Personnel policies.

h. Criteria for selection of group-home parents.

The criteria outlined in the Standards for Foster Boarding Homes for Children, DPW Rule 1, (c), for foster parents may be used in the development of the criteria for the selection of group-home parents.*

i. Names of group-home parents and substitute group-home parents.

j. The State Fire Marshal report.

k. A floor plan of the group home, with designated room dimensions.

2. The financial record of the group home shall be maintained in the agency.

3. The agency shall maintain a record on each individual resident in the group home. The record shall contain a copy of each of the following items:

a. Admission information.

b. Objectives of individual planning.

c. Reports on progress toward the accomplishment of these objectives.

d. Dismissal summary.

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4. The group-home parents shall maintain medical records on each child.

5. The agency shall send the referring agency a record of the child's progress at least every six months.

6. Board minutes, articles of incorporation, and transactions of the group home shall be a matter of record.

7. Information on record pertaining to an individual or his family shall be held confidential and released only to authorized persons or agencies.

G. Physical facility.

1. The location of the group home shall be related to the program it offers. It shall be accessible to religious, school, training, and recreation facilities and other appropriate community resources.

It is recommended that the home be located in a residential area and be undifferentiated from other residences. It is helpful to locate in a neighborhood where there are other children and the neighborhood accepts children and their behavior.*

2. The grounds shall provide adequate outdoor spece for recreational pursuits.

3. The group home shall meet the regulations of the local health authorities as well as local zoning and building codes. Consultation with the State Health Department is available if desired.

4. The group home shall meet the requirements set forth by the State Fire Marshal. The State Fire Marshal shall inspect all facilities.

5. Building.

a. There shall be living and recreation space of 35 square feet of floor space per child. This may include living room, dining room, and recreation room but excludes bathrooms, halls, laundry room, bedrooms, furnace room, and kitchen.

b. The dining area shall be large enough to comfortably accommodate all the children, the group-home parents, and guests at a meal. The room shall be cheerful, well ventilated, and convenient to the kitchen.

c. Every sleeping room for the accommodation of one child shall contain 80 square feet of floor space, with a minimum horizontal dimension of eight feet.

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d. Every sleeping room for the accommodation of more than one child shall contain 60 square feet of floor space per child, with a minimum horizontal dimension of eight feet. Each child shall have an individual bed. Individual beds shall be at least three feet apart.

e. No bedroom shall accommodate more than four children.

It is recommended that there be no more than two children per bedroom. It may also be helpful to have single occupancy rooms.*

f. Each resident shall have a set of dresser drawers to accommodate personal articles and clothing.

g. Each resident shall have an individual storage closet or locker for day-to-day clothing, and other storage space for clothing not currently used.

h. There shall be one toilet for every five children, one lavatory with hot and cold water for every five children, and one tub or shower for every five children. The toilet facilities shall be maintained in a sanitary condition equal to the local health regulations. All group homes that house children of both sexes shall have separate toilet and bath facilities for each sex.

i. The heating plant shall be of a size and capacity to maintain a temperature of 70 degrees Fahrenheit in all rooms.

j. Provisions shall be made for laundry facilities adequate in space and equipment to meet the needs of the children, the group-home parents, and the home.

k. The group-home parents' quarters shall be separate from those of the children but near enough to provide proper supervision.

It is recommended that the group-home parents have a separate bathroom, bedroom, and living room.*

l. A flash light and a first-aid kit shall be available in every group home for emergency use.

m. All medications for the children in the group home, as well as household poisons, shall be kept in a safe and secure place.

H. Procedure for licensing.

1. A family that owns, rents, or leases a facility and desires to use this as a group home, while receiving direction and supervision from an agency, shall apply to the county welfare department of the county in which it resides or to a licensed child-placing agency serving the area for a study of its facility, staff, and program. The study shall be based on the rules established

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in these standards. Upon completion of the study, the county welfare department or licensed child-placing agency shall send an application for license along with a recommendation for licensure to the Commissioner of Public Welfare. A license will be issued by the Commissioner in accordance with the rules in these standards.

2. An independent operator who owns, rents, or leases a facility and desires to use this as a group home, while providing administration, direction, and supervision from within the structure, shall apply to either the county welfare department of the county in which the facility is located, or to a licensed child-placing agency serving the area, or to the State Department of Public Welfare for a study of the organization, facility, staff, and program. The study shall be conducted by the organization to which the application is made and based on the rules established in these standards. Upon completion of the study, the organization conducting the study shall send an application for license along with a recommendation for licensure to the Commissioner of Public Welfare. Prior to the issuance of a license, a record shall be on file in the Department of Public Welfare containing all of the information and items listed in Section F.1. of these standards. A license will be issued by the Commissioner in accordance with the rules of these standards.

3. A licensed children's institution or licensed child-placing agency that owns, rents, or leases a facility and desires to use this as a group home, while providing administration, direction, and supervision from within its own structure, shall apply to either the county welfare department of the county in which the group home is located or to the child-placing agency serving the area for a study of its organization, facility, staff, and program. In the case of a licensed child-placing agency, that agency can complete the study on its own group home. The study shall be conducted by the organization to which the application is made and based on the rules established in these standards. Upon completion of the study, the organization completing the study shall send an application for license along with a recommendation for licensure to the Commissioner of Public Welfare. Prior to the issuance of a license, a record shall be on file in the Department of Public Welfare containing all of the information and items listed in Section F.1. of these standards. A license will be issued by the Commissioner in accordance with the rules in these standards.

4. A county welfare department that owns, rents, or leases a facility that it plans to operate as a group home is exempt from licensure, by law, since the home is considered a part of the total agency. Ninety days prior to the actual operation of the group home, the county welfare department shall submit a study based on the rules established in these standards indicating the fact that the home meets the standards set forth by the Commissioner of Public Welfare. In addition, prior to operation, a record shall be on file in the Department of Public Welfare containing all of the information and items listed in Section F.2. of these standards. Upon the receipt of this information the Department of Public Welfare will verify the statement and ascertain the fact that the home meets the standards set forth by the Commissioner. If the Department of Public Welfare questions the statement in any manner or

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form, it must notify the county welfare department, in writing, of its concern, within 30 days after the receipt of this report.

5. No children shall be placed in any group home prior to its being licensed.

6. When an initial license is being issued to any facility, it shall remain in force for one year. When a license is being renewed, it may be issued for a period of up to two years, in the discretion of the Commissioner of Public Welfare. Every license shall prescribe the number and age groupings of children who may receive care at any one time.

7. Application for relicensure shall be sent in by the agency to the Department of Public Welfare 30 days prior to expiration of the license. Application shall be accompanied by a statement indicating the fact that the home still meets the requirements of the standards set forth by the Commissioner. Any changes in the facility, organization, administration, or program shall be noted in this statement.

I. Provisional license.

1. A provisional license may be issued by the Department of Public Welfare for a period not to exceed one year to allow an agency reasonable time to become eligible for a regular license. A written statement describing the need for a provisional license and the length of the provisional license shall be on file in the agency record and with the Department of Public Welfare.

J. Licensing exceptions.

1. If, in the licensing procedure or enforcement of these standards, the Department of Public Welfare finds that to require a particular group home to comply strictly with one or more of the provisions of these standards will result in undue hardship and if the group home is in substantial compliance with said standards and the general purpose and intent and, in addition, it complies with such specific condition or conditions as the Department of Public Welfare may deem necessary for the protection of the health, safety, and welfare of children, an exception may be granted by the Department of Public Welfare.

K. Refusal of license.

1. Failure or inability to comply with the above standards shall be cause for refusal or revocation of license.

2. The right of fair hearing and appeal shall be honored in accordance with Minnesota law.

Effective Date—July 8, 1969.

insert new: 12 MCAR § 2.010,
AR00335T

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W02

12 S MCAR 2.014 Grants for community support services for chronically mentally ill persons.

A. Statutory citation: The authority for this rule is Laws of Minnesota 1979, chapter 324, section 12, codified as Minnesota Statutes, section 256E.12.

B. Purpose: The purposes of this rule are to govern grant applications, approval of applications, allocation of grants, and maintenance of financial statements by grant recipients. In order to carry out these purposes, this rule will set minimum standards for the contents of grant applications, allocation and award of grants, and maintenance of financial statements to carry out the intent of the authorizing legislation.

C. Introduction.

1. The provisions of this rule shall be severable. If any clause, sentence, or provision is declared illegal or of no effect, the validity of the remainder of this rule and its applicability shall not be affected.

2. This rule shall not be construed as requiring expenditures of moneys not available.

3. Any provision of this rule inconsistent with any state or federal law is superseded by that law.

D. Applicability.

1. This rule applies to those county boards of commissioners which apply, either individually or jointly with neighboring counties, to the Commissioner of Public Welfare for grants to carry out the purposes of this rule.

2. The county board of commissioners may request funds under this rule for programs and services for chronically mentally ill people to be carried out by the county or by any public or private organization or any combination of these organizations with which the county contracts.

E. Definitions.

1. Administrative overhead: All project costs other than those included in "allowable direct service costs."

2. Allowable direct service costs:

a. Salaries and related expenses (e.g., payroll, taxes, health insurance, telephone, personal liability insurance, postage, recruitment) of personnel providing services directly to clients in the project (this includes "support" personnel to the extent that such personnel perform client-related duties such as client recordkeeping, individual program planning and on-site program supervision).

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b. Local (in-state) travel costs of above personnel.

c. Consumable supplies used:

(1) By the above personnel in performing client-related duties.

(2) By clients in carrying out program activities.

d. Minor expenditures which are justified by showing that the expenditures meet the criteria in 12 MCAR S 2.014 H.3.

e. Crisis home room and board costs which are justified by showing that it would not be cost-effective to charge the individual or third parties for these costs.

3. Case management: A direct service provided by mental health workers to chronically mentally ill people. Essential components of case management are 1) monitoring and supervising individual clients, 2) assuring coordination and availability of treatment/rehabilitation/support services and 3) providing access for the client to problem-solving resources. These activities which are essentially coordinating and problem-solving functions are provided and periodically reviewed over the period of time that the case is open. It shall include, but not be limited to: (a) assessment of the client's strengths, problems, and needs; (b) development of and carrying out the individual program plan; (c) coordinating the various service components in the continuum of care to carry out the individual program plan; (d) providing linkage between the service system and the client; (e) assuring that clients are involved with appropriate resources and services in accordance with the individual program plan; (f) monitoring and periodically revising of the individual program plan; (g) influencing service providers to respond to client needs; and (h) stimulating the development of needed services and resources; and (i) protecting the rights and dignity of clients being served.

4. Chronic mental illness: A condition characterized by severe and persistent symptoms of mental or emotional disability, and diminished levels of functioning relative to primary aspects of daily living, such as personal relations, living arrangements, work skills, recreation and mobility.

5. Commissioner: Commissioner of Public Welfare or a designated representative.

6. Community support services: A network of services coordinated to meet the needs of chronically mentally ill people and to develop their potential ability to function more independently without being unnecessarily isolated or excluded from the general community. These services are based on identified needs of a specified population at risk of recurring episodes of mental illness and are designed to assist such people to improve their functioning in primary aspects of daily

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living, as identified in the definition of chronic mental illness.

7. County board of commissioners: That body of duly elected officials responsible for the governance of its county under the authority of Minnesota Statutes, sections 375.02 to 375.55.

8. Crisis home: A facility providing room, board, and support and referral services for up to four persons, for up to five days, while individuals are assisted to resolve an acute crisis or emergency situation which requires temporary housing.

9. Crisis management: Short-term services provided, to the extent possible, in the client's usual surroundings including the client's own home or substitute home, aimed at the reduction of acute emotional disabilities and their physical and social manifestations and the restoration of emotional equilibrium. Such services must be available 24 hours a day, seven days a week.

10. Day treatment program: A program of administratively organized and programmatically structured services operating less than 24 hours a day for chronically mentally ill people which devotes a significant share of the scheduled program day to the teaching of independent living skills, psychosocial rehabilitation, psychotherapy, and development of socialization skills so that the participants may function more independently and more effectively in their own communities.

11. Department: State Department of Public Welfare.

12. Designated agency: That agency selected by the county board of commissioners pursuant to Minnesota Statutes, section 253A.02, subdivision 23, as amended.

13. Drop-in center: A facility offering semistructured services and activities for chronically mentally ill people, including support and social skill development.

14. Independent living skills: Those skills necessary for an individual to function successfully independently, such as money management; cooking; grooming; obtaining and holding employment; and personal health maintenance, including medication management.

15. Individual program plan (IPP): A written plan of treatment and rehabilitation containing measurable goals and objectives designed to meet the particular needs of an individual client which has been jointly developed and regularly reviewed by appropriate providers, the assigned case manager, and the client.

16. Program: A formal continuum of care that is a coordinated combination of services, with clear goals and measurable objectives. Programs are directed toward meeting the

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needs of specific disability groups, and individuals within those groups, while allowing for the ready movement of individuals between appropriate services.

17. Project: Specific formally organized services for which application for funds are being made under this rule.

18. Residential facility: Any facility or part of a facility not currently licensed as a hospital, offering administratively organized and programmatically structured 24 hours a day room, board and relevant services to foster the independence of chronically mentally ill people.

19. Service: A specific identifiable, goal-oriented activity which, for purposes of this rule, is provided to reduce major disabilities related to chronic mental illness.

F. Allocation.

1. Priority of allocation:

a. Funds will be awarded for continuation of projects previously funded under DPW Temporary Rule 14 or for new or expanded services which provide direct services to chronically mentally ill people and emphasize crisis management, independent living skill training and case management components. Priority of allocation will be made to applicants previously funded under the authority of DPW Temporary Rule 14 if such applicants otherwise meet the terms of this permanent rule. Day treatment, crisis homes, and drop-in centers are examples of services which may be funded under this rule.

b. Programs and services provided at the site of a long-term residential facility may be funded but will be given a lower priority than those provided away from the residential facility, unless the applicant county documents that the residents of the facility are unable to leave the facility to make use of the services.

c. Applications proposing services not mentioned in this section will be considered if there is a documented local need for them.

2. Regional priorities: To the extent that the applications submitted are equally meritorious, the department will allocate funds in such a way that amounts are awarded, pro rata, according to population size, approximately one-half to applying counties from Region XI and approximately one-half to applying counties from the balance of the state. If there are not sufficient acceptable applications from one group of counties as defined above, the remaining funds will be awarded to qualifying applications from the other group of counties.

3. The commissioner may reallocate funds within each fiscal year, which have been awarded to counties but not used by them.

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G. Content of applications.

1. Applications must contain at least the following information, following the problem, objectives, method, evaluation (POME) format.

a. Problem: A clearly defined statement of the problem to be addressed by the proposed service; the population at risk; and the evidence of the need for this service.

b. Objectives: A statement of the measurable time-limited outcomes of the proposed service.

c. Methods: The modalities of treatment and rehabilitation to be used; a description of how individual program plans will be used in carrying out the service; a description of how case management will be used in carrying out the service; a description of how the proposed service will fit into the local continuum of care and service; and a description of the proposed site(s) and providers to be used. If the providers and sites have not been finally determined at the time of application, the department will consider the application if it contains indications of potential providers and sites.

d. Evaluation: A description of how the county boards of commissioners will determine the effectiveness of projects funded under this rule.

2. A budget shall be included with the application, completed on designated budget forms. Dollar amounts for the various items included in the budget document shall reflect and be based upon the prevailing cost of like components in the local community. It shall indicate the total cost of the project, showing the state and local shares. The specification of the local share shall indicate the amount of actual local funds committed to the project source.

3. If the service is proposed by and for more than one county, the chairpersons of all participating county boards of commissioners shall sign the application.

4. Six complete copies of the application and budget shall be submitted to the department.

H. Use of project funds.

1. The purpose of this experimental, time-limited appropriation is to provide new or expanded programs and services to chronically mentally ill adults in such a way as to maximize the use of the funds in a relatively short period of time to test their effectiveness. The use of the funds available under this appropriation for capital expenditures or nonservice related costs would not serve this purpose and therefore will not be allowed.

2. Treatment of other income received by the project:

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a. For projects funded under the authority of this rule, any income other than county funds received as a reimbursement for project costs (e.g., Title XIX fees) will be applied first to the local share of the project's budget. The income in excess of the local share shall be applied to the state share.

3. If an applicant can show that an expenditure other than for a direct service is 1) relatively minor, 2) essential for the project to operate, and 3) cannot be paid for from local funds, such an expenditure shall be paid for from funds available under this rule, with the approval of the commissioner.

4. State funds available under this rule shall not be used to pay room and board costs, except for such costs in crisis homes, and then only if it can be demonstrated not to be cost-effective to charge the individual or third parties for these costs.

5. Funds available under this rule shall not be used to replace existing fiscal support of programs and services. In the event that existing fiscal support of a mental illness program or service is eliminated or reduced by circumstances beyond the control of the county board of commissioners, application may be made for funds available under this rule to replace the existing funds which have been eliminated or reduced, provided that specific documentation of the elimination or reduction in fiscal support accompanies the application.

6. State funds available under this rule shall not be used for construction, renovation or rent of buildings, nor shall they be used for the purchase or lease of equipment or vehicles. Local matching funds, once identified and committed, may be used for these purposes and will be counted as administrative overhead.

I. Administrative overhead.

1. Up to a maximum of ten percent of the total project budget may be used for administrative overhead in a currently operating project. In situations where services are being developed, the maximum allowed for administrative overhead shall be 25 percent of the total project budget for the duration of the first project grant.

J. Local match. The local match or ten percent of the total budget of the project shall consist of funds committed to the project. The fee income, if any, may be counted as part of the local matching share.

K. Maintenance of financial statements. Grant recipients shall maintain their financial records, using generally accepted accounting procedures, in such a way that expenditures can be easily compared with the approved budgets; that the state and local contributions can be readily and separately identified; and that documentation is available for all expenditures.

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L. Budget revision procedures.

1. After a grant award is made, as long as state funds are used for allowable expenses as defined by this rule, budget revisions (including transfer between approved projects) and/or line item transfers totaling up to ten percent of the project budget may be made with county board approval. Revisions in excess of ten percent require both county board and department approval.

The county board may delegate its approval of budget revisions, if such delegation is specified in county board minutes.

2. All requests for budget revision approval shall include the reason for the revision and a statement as to how the revision will affect program objectives.

Approval for budget revisions and line item transfers shall not be granted unless such revisions or transfers are consistent with the provisions of this rule.

M. Reporting requirements. The commissioner is required by Minnesota Statutes, section 256E.12 to collect data and periodic reports as is deemed necessary to demonstrate the effectiveness of the services. Therefore, the commissioner shall require that those county boards of commissioners receiving funds under this rule report to the department the number and kinds of persons served, the cost of providing the services, results achieved, and other relevant data deemed necessary. This information, along with an evaluation from the county board of commissioners, will be used as the basis for an evaluation by the commissioner of the specific projects in his report to the legislature.

N. Duration of awards.

1. Awards to applicant counties that are not assigned to a specific project within 60 calendar days of the awarding of the funds shall revert to the department for reallocation.

O. Other applicable laws and rules.

1. To the extent that a project funded under this rule is also subject to other Minnesota laws and rules, it must also meet the standards of those laws and rules.

2. If a determination is made that all applicable laws, rules and regulations cannot be met immediately, but that the applicant county has a definite, reasonable timetable to meet all necessary requirements within four months, the application shall be considered for funding.

W02 12 MCAR S 2.016 Procedures governing the administration of specified therapies to state hospital patients.

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A. Introduction. This rule governs the administration of the treatment methods specified in part B. of this rule to committed patients residing at state hospitals.

B. Regulated Treatments. The following treatments must be administered pursuant to the provisions of parts C. through E. of this rule:

1. functional neurosurgery (psychosurgery)

2. electroconvulsive therapy, or any other convulsive therapy;

3. coma therapy (including insulin);

4. injection of any chemical substance as an aversive therapy;

5. medically prescribed maintenance therapy using substances set forth in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 United States Code, section 812. Provided, however, that this rule shall not apply to the prescription of any substance set forth in Schedule II when:

(a) such prescription is made for the treatment of Parkinsonism, epilepsy, hyperperistalsis, narcolepsy, or hyperkinesia, or

(b) such prescription is necessary for the preoperative or postoperative care of the patient.

C. Procedures. None of the treatment methods listed in Part B. shall be administered to a patient committed to a state hospital unless the medical director of the state hospital, on the basis of consultation with the patient's treating physician, has determined in accordance with the provisions of part D. of this rule that the treatment method is medically indicated for the committed patient; and

1. the court order committing the patient to the state hospital authorizes administration of the proposed treatment method; or

2. in the case of committed adult patients, written consent is obtained on a form which specifies the nature, purpose, risks and effects of the proposed treatment and advises the patient of the right to consult with any other persons regarding this decision and to withdraw consent at any time. The signed consent shall be accessible to the patient and must include a certification by the medical director of the state hospital or the patient's treating physician that the patient has read and understands the terms of the document and that the patient is competent to give an informed consent to the proposed treatment; or

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3. in the case of a committed mentally retarded resident, written consent is obtained from the closest responsible relative on a form which specifies the nature, purpose, risks and effects of the proposed treatment and advises the relative of the right to consult with any other persons regarding the decision and to withdraw consent at any time. The signed consent shall be accessible to the resident's responsible relative and must include a certification by the medical director of the state hospital or the resident's treating physician that the relative has read and understands the terms of the document. If the retarded resident also is under guardianship or conservatorship of the commissioner, Department of Public Welfare, Minnesota Statutes, section 252A.11 the commissioner must give the above consent as provided in subdivision 1 (a) or (g) in addition to the relative's consent. A certification shall be made by the medical director of the state hospital or the resident's treating physician that the retarded resident has received an explanation of the proposed treatment to the extent of the retarded resident's understanding; or

4. judicial authorization for the administration of the proposed treatment is granted by a court of competent jurisdiction pursuant to the provisions of part E. of this rule; or

5. in the case of committed minors, including mentally retarded minors, treatments regulated by this rule may not be administered without prior judicial authorization pursuant to part E. of this rule.

D. Factors to be considered in determining medical indications. In assessing whether any of the treatment methods listed in part B. are medically indicated for a committed patient, the medical director and the patient's physician shall consider the following factors in relation to such patient:

1. the predicted extent and duration of changes in mental activity and behavior patterns effected by the treatment;

2. the risks of adverse side effects compared with potential benefits to the patient;

3. the experimental nature of the treatment;

4. its acceptance by the medical community of this state and whether less intrusive methods would secure the same benefits;

5. the extent of intrusion into the patient's body and the pain connected with the treatment; and

6. the patient's ability to competently determine for himself whether the treatment is desirable.

E. Hearings. In cases where the provisions of part C.4. of

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this rule apply, none of the treatment methods specified in part B. of this rule shall be administered absent judicial authorization. The state hospital medical director or his designee shall petition the probate or the county court of the county financially responsible for the patient as specified by Minnesota Statutes, section 256D.18, subdivision 2. Where necessary and appropriate, this court may arrange to have the matter heard in the county of the patient's presence.

1. The petition shall state the nature of the proposed treatment, describe its purpose, recite the risks and effects of the procedure and recite the findings of the medical director and/or treating physician as provided in parts C. and D. of this rule.

2. The petition shall request the appointment of a guardian ad litem to represent the patient and that this person be an attorney if legal counsel is not otherwise available to the patient.

3. A copy of the petition shall be supplied to the welfare department or other designated agency in the county of financial responsibility in advance of the hearing.

4. The medical director shall seek representation from the county attorney of the county in which the hearing is held. In the event the county attorney is unable to provide such representation, the medical director shall seek legal representation through the Department of Public Welfare.

5. The cost of such hearings shall be met by the county financially responsible for the patient as specified by Minnesota Statutes, section 256D.18, subdivision 2.

F. Exception. This rule does not affect the administration of generally recognized treatment methods not specified in part B.

G. Definitions.

1. Functional neurosurgery (psychosurgery) - a general term used to describe brain operations done to relieve the symptoms of mental illness, and includes the ablation or destruction of histologically normal brain cells by any medical or surgical procedure. This term includes, but is not limited to, a lobotomy.

2. Convulsive therapy - a type of psychiatric treatment where central nervous system seizures are induced by electrical, chemical, or other means.

3. Coma therapy - any type of psychiatric treatment where loss of consciousness occurs as a part of the regular treatment process.

4. Aversive therapy - a treatment procedure where noxious

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substances (or other unpleasant stimuli) are used to produce a change in behavior.

5. Schedule II drugs - a general category of drugs controlled by federal law because of increased risk of abuse and/or addiction.

W02

12 MCAR S 2.018 Standards for the provision of semi-independent living service (SILS) to people who are mentally retarded.

A. Statutory authority.

1. Minnesota Statutes, section 252.28 (1978), as amended, Laws of Minnesota, 1980, chapter 612, provide for the determination of need, location, and program of public and private residential and day care facilities and services for mentally retarded children and adults. This statute further provides that the commissioner shall establish uniform rules, regulations, and program standards for each type of residential and day facility or service for more than four retarded persons.

2. Minnesota Statutes, sections 245.781 to 245.812, Public Welfare Licensing Act, provide for the development and promulgation of rules and regulations for the operation and maintenance of day care and residential facilities and agencies, for granting, suspending, and revoking licenses and provisional licenses. It also provides that no individual, corporation, partnership, voluntary association, or other organization may operate a day care or residential facility or agency unless licensed to do so by the commissioner.

B. Introduction.

1. Statement of purpose.

a. To establish standards for the provision of services to mentally retarded persons whose dependency requires services above the level of food and lodging, but who do not need 24-hour per day care or supervision, as provided in residences licensed under 12 MCAR S 2.034.

b. To assist clients in achieving their highest potential in self-sufficiency and independence in the least restrictive environment.

c. To insure that an individual program plan is developed with each client, and each client receives those services he needs to achieve or maintain independence.

d. To prescribe minimum program standards for semi-independent living services.

2. Applicability.

a. This rule applies to any person, organization or

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association engaged in the operation and provision of semi-independent living services (SILS) to adults who are or may be mentally retarded, as provided and defined in 12 MCAR S 2.185 A.4.k. and m. This rule sets forth the requirements for any individual, organization, or association providing SILS to more than four mentally retarded adults to be licensed pursuant to Minnesota Statutes, section 252.28, and Minnesota Statutes, sections 245.781 to 245.812, the Public Welfare Licensing Act.

b. Licensure under this rule does not require concurrent compliance with other Department of Public Welfare licensing rules or with Minnesota Health Department supervised living facility standards promulgated under Minnesota Statutes, section 144.56.

c. This rule does not govern the living arrangement of clients. Semi-independent living services licensed under this rule may be provided to persons living in a variety of ordinary community settings other than state hospitals and community residential facilities licensed under 12 MCAR S 2.034 and supervised living facility standards. Community living arrangements in which SILS are provided may include the following, but not be limited to: client's own home, foster home, apartment or rooming house.

3. Procedures for licensing.

a. Application for determination of need for SILS shall be made to the county board or its designee. Procedures for determination of need shall be as provided for in 12 MCAR S 2.185 D.

b. Upon notification that a need for the service has been found by the commissioner, application for license may be made to the commissioner.

c. Applicants shall submit such materials and information as may be required by the commissioner to make proper determination of the nature and adequacy of the services to be provided. Application for license shall not be considered complete until all required documents have been received by the commissioner in accordance with this rule.

d. Any SILS provider desiring to renew a license shall submit an application at least 30 days prior to expiration of the license. A renewal license may be issued for a period up to two years at the discretion of the commissioner.

e. The license or a formal letter of denial, including reasons for denial, shall be issued within 90 days after receipt of the completed application. The initial license issued to any new SILS provider shall be provisional for a designated period of time not to exceed one (1) year (Minnesota Statutes, section 245.783, subdivision 3).

f. Provisional license shall be granted by the

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commissioner under the terms of Minnesota Statutes, section 245.783, subdivision 3.

g. When a specific requirement cannot be met or an innovative alternative is desirable, a variance must be requested in writing. The variance request shall state (a) the reason the current requirement cannot be met, (b) the proposed alternative, and (c) the date the alternative or requirement shall be met, not to exceed one year. No variance shall be granted that would threaten the health, safety or rights of clients.

4. Technical provisions.

a. Failure to comply with these standards or applicable state law shall be cause for denial, revocation or suspension of license.

b. Denial, revocation or suspension of license may be appealed pursuant to Minnesota Statutes, chapter 15, the Minnesota Administrative Procedures Act.

c. The provisions of this rule shall be severable. If any clause, sentence or provision is declared illegal or of no effect, the validity of the remainder of this rule and its applicability shall not be affected.

d. Any provision of this rule which is inconsistent with any state or federal law is superseded by that law.

C. Definitions.

1. "Applicant." Any adult referred to the SILS provider for services. The term may also refer to an applicant for licensure under this rule.

2. "Client." Adults who need more than food and lodging, but less than 24-hour per day program of service and supervision, receiving services as provided in this rule.

3. "Commissioner." Commissioner of public welfare or designee.

4. "County board." That body of duly elected officials responsible for the governance of its county under the authority of Minnesota Statutes, sections 375.02 to 375.55. When a human service board has been established under Minnesota Statutes, sections 402.02 to 402.10, it shall be considered to be the county board, for purposes of this rule.

5. "Individual program plan (IPP)." A detailed plan for each client which sets forth both short-term and long-term goals with detailed methods of achieving movement toward the individual service plan of the local social service agency.

6. "Individual service plan." An analysis by the local

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social service agency of services needed by the client, including identification of the type of residential placement, if needed, and the general type of program required by the client to meet the assessed needs within a specified period of time.

7. "Interdisciplinary team." A team consisting, at a minimum, of the client, the client's legal guardian (if any), local social service agency representative and the program director, or SILS staff member. Other persons relevant to a particular client's needs may be included. The interdisciplinary team is responsible for the development and evaluation of the client's individual program plan and determination of need for semi-independent living services.

8. "Legal guardian." A person(s) appointed under Minnesota Statutes, chapter 252A or 525 as guardian or conservator of the person (or estate or both) of anyone who has been legally judged to be incompetent to manage his or her person or estate. The commissioner of public welfare may be appointed as guardian or conservator.

9. "Local social service agency (LSSA)." A local agency designated and authorized by the county board or human service board, to be responsible for providing social services. Social services include the case management and referral of applicants for semi-independent living services.

10. "May." Indicates that the provisions or practices stated in this rule are permitted.

11. "Mentally retarded person." A mentally retarded person refers to any person who has been diagnosed as having significantly subaverage intellectual functioning existing concurrently with demonstrated deficits in adaptive behavior and manifested during the developmental period.

12. "Normalization." To provide the client with a normal existence. If this is not possible, to provide the person with the alternative which is least restrictive. This includes making available to the client patterns and conditions of everyday life that are as close as possible to the norms and patterns of the mainstream of society.

13. "Provider". An individual, organization or association which exercises general direction over the policies and provision of SILS, and is responsible for the welfare of individuals being served.

14. "Semi-independent living services (SILS)." A system of services that includes training, counseling, instruction, supervision and assistance provided in accordance with the client's individual program plan. Services may include assistance in budgeting, meal preparation, shopping, personal appearance, counseling and related social support services needed to maintain and improve the client's functioning. Such

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services shall not extend to clients needing 24-hour per day supervision and services. Persons needing a 24-hour per day program of supervision and services shall not be accepted or retained in a semi-independent living service.

15. "Shall." Indicates that the requirement, provision, or practice stated in this rule is mandatory.

D. Program and service standards.

1. Admission. The provider shall maintain written policies and procedures, which shall be available to the local social service agency and to the general public, covering the following:

a. Preadmission and admission procedures.

b. Prerequisite client skills for admission.

c. Admission criteria including age, type and degree of handicap.

d. Nondiscriminatory practices with regard to race, creed, sex or national origin.

e. Description of services.

f. Discharge procedures.

g. Cost rates for services and arrangements available for payment.

h. The requirement that each client must have a current medical and dental examination.

i. Waiting lists and selection priorities.

2. Comprehensive assessments.

a. Behavioral assessments.

(1) A behavioral assessment, conducted by SILS staff at least annually, shall objectively describe the behavioral status of the client. The assessment instrument must be acceptable to the LSSA.

(2) Upon admission, the behavioral assessment shall be completed prior to the development of the individual program plan. This assessment may use data from any appropriate assessment conducted within the previous 12 months.

b. Physical assessment.

(1) Upon admission, there shall be a medical examination of the client conducted by a licensed physician within one year preceding admission, or one month following

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admission which includes reevaluation date or schedule recommended by the physician.

(2) There shall be a record of dental examination in the client's record, and reexamination schedule recommended by the dentist.

c. Additional assessments determined to be needed by the interdisciplinary team shall be conducted or arranged by the provider.

3. Individual program plan (IPP). The provider shall have a letter of referral from the responsible local social service agency, including a copy of the individual service plan, for each client. The interdisciplinary team shall evaluate each client's needs, and identify those needs having priority, within 30 days of admission. An annual individual program plan (IPP) for each client shall thereafter be established and evaluated to meet client needs.

a. The IPP shall be based on needs identified in the behavioral assessment, and on the individual service plan of the local social service agency, which shall include at least the following areas:

(1) Training in meal planning, meal preparation and shopping.

(2) Training in first-aid skills, responding to emergencies and symptoms of illness.

(3) Training in money management.

(4) Training in self-administration of prescription and nonprescription medication.

(5) Training in the use of the telephone and other public utilities.

(6) Development of the client's social, recreational and transportation abilities.

(7) Specific training plan concerning the development of more appropriate behaviors for clients displaying inappropriate behaviors.

(8) Training in matters of personal appearance and hygiene.

(9) Training in apartment or living environment maintenance, when indicated.

(10) Training in use of community resources including but not limited to police, fire, hospital emergency resources.

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(11) Training in rights and responsibilities of community living.

b. The IPP shall establish program goals and behavioral objectives stated in measurable terms which specify the time limit for achieving each behavioral objective. The IPP shall also identify the person(s) responsible for implementation of the IPP.

c. The IPP shall describe the services to be provided, and how they will be obtained.

d. The annual IPP shall be reviewed at least quarterly by staff. The reviews shall include written report of:

(1) Client's progress toward goals and behavioral objectives.

(2) Need for continued services and any recommendation concerning alternative services and/or living arrangements.

(3) Recommended change in guardianship status (if any).

E. Administrative standards.

1. The provider shall have a written statement of the SILS program philosophy, purpose and goals which:

a. Is consistent with the principles of normalization.

b. Includes expected client outcomes.

c. Is available to the public.

d. Is reviewed by the provider at least annually and revised as needed.

2. The SILS provider shall be responsible for program direction for all clients, which shall include the provision, continuation and coordination of services in accordance with the client's IPP.

3. The provider shall employ a program director, and may employ more than one to assist in program direction.

4. The provider may employ other staff to carry out the programs for clients, providing that such staff are under the supervision of a qualified program director.

a. The program director shall have at least a bachelor's degree in a field related to mental retardation services, and at least one year experience in working with mentally retarded persons. Five years' experience in working full-time with clients under professional supervision in a

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developmental program for mentally retarded persons may be substituted for a bachelor's degree if in the judgment of the commissioner such experiences result in ability to perform the duties of the program director.

b. The program director shall insure that all clients have demonstrated the ability to contact a staff person for assistance in an emergency.

c. The program director shall insure that the SILS program is in conformance with applicable civil rights and affirmative action laws.

5. Discharge.

a. Except in an emergency, planning for discharge shall be made only with prior involvement of the client, LSSA representative and guardian (if any).

b. Planning for termination of services by the provider shall include referral to any follow-up services the LSSA considers necessary.

c. The provider shall provide counseling about the advantages and disadvantages of termination of services to the client and/or legal guardian, if requested by the client or the LSSA.

d. The provider shall prepare a discharge summary which includes:

(1) A summary of findings, events, and progress during the period of services to the client.

(2) Written evidence of the reason for discharge.

(3) If discharged to another service, specific recommendations for future programming shall be included in the discharge summary and transmitted to the LSSA of responsibility. A copy may be sent to the receiving service provider.

e. In the event of death of a client:

(1) The provider shall notify the LSSA and guardian or responsible relative.

(2) The date, time and circumstances of the client's death shall be recorded in the client's record.

(3) If the client dies unattended by a physician, the coroner or medical examiner shall be notified.

(4) A copy of the records of the deceased client shall be transmitted to the local social service agency.

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6. Client records.

a. The SILS provider shall maintain a record for each client, which contains the following information:

(1) Client's name, address and telephone number, birth date, and date of admission to and discharge from SILS.

(2) Name, address and phone number of legal guardian (if any) and person to contact in an emergency.

(3) Record of current medication prescription and adverse reactions to drugs (if any).

(4) Special diet needs and food allergies (if any).

(5) Name and address of the client's LSSA case manager.

(6) Name and address of the client's physician or clinic and dentist.

(7) The results of behavioral and physicial assessments conducted within the past 12 months and the LSSA's individual service plan.

(8) The client's IPP and quarterly reviews.

(9) Any physician's and dentist's orders within the past two years, including special instructions for self-medication, care and treatment.

(10) Summary of professional service delivery during the past year, including specialized therapy, and the client's progress in therapy.

(11) Summary of client's progress or lack of progress in previous programs, job skills and employment history.

(12) Client's current place of employment or day program.

(13) A complete record of the client's funds if such funds are managed by the SILS provider.

b. Access to client records.

(1) All information contained in the client's record shall be handled in a manner consistent with the Government Data Practices Act, Minnesota Statutes, sections 15.162 to 15.1699. The client shall have access to his record upon request, with accommodations for interpretation that meets his needs.

(2) The provider shall be responsible for the safekeeping of client records, and for securing them against loss or use by unauthorized persons.

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(3) The client's record shall be removed from the provider's jurisdiction and custody only in accordance with a court order, subpoena, or statute.

(4) The provider shall have written policies governing access, duplication and dissemination of information.

(5) Written consent of the client or guardian (if any) shall be required for the release of information concerning the client to persons not otherwise authorized to receive it. The client's record shall specify the information requested to be released, purpose for which the information is released and expiration date for release of information.

(6) All client records shall be maintained by the provider following discharge of the client for at least two years.

7. Client rights.

a. The provider shall have written policies and procedures concerning the exercise and protection of client human and civil rights, which shall be available to LSSA, clients, guardians.

b. The provider shall have complaint procedures which shall include:

(1) The name and telephone number of persons who may be contacted in order to register a complaint.

(2) The time schedule established for registration of complaints.

(3) The time limits for decisions to be made by the provider.

c. The provider shall inform clients of their right to appeal the suspension, reduction or termination of services to the commissioner pursuant to Minnesota Statutes, section 256.045 as a social service appeal.

d. Upon request of the client, the provider shall instruct and assist clients in how to obtain legal assistance.

e. The provider shall have a written statement of policies and procedures that protect the financial interests of the clients.

f. If the provider manages the client's money, the following shall be recorded:

(1) Written permission from the client or his legal guardian.

(2) Reasons the provider is to manage the client's

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money.

(3) A complete record of the use of the client's money and reconciliation of the account.

g. Clients who work for the SILS provider shall be considered employees of the provider with all the rights and privileges of an employee.

8. The provider shall have a current written description of its organization, which includes the major operating services and person(s) having administrative responsibility, available to the local social service agency.

9. The provider shall have written personnel policies available to staff. The policies shall include:

a. Application and hiring procedures.

b. Provisions for non-discrimination.

c. Description of probationary period, if any, and procedures for annual performance evaluation.

d. Procedures for suspension and dismissal.

e. Employee benefits.

f. Grievances and appeal procedures.

g. Prohibition of mistreatment, neglect, or abuse of clients, and mandatory reporting of any mistreatment, neglect or abuse.

h. Plans for staff orientation, training.

i. Prohibition of the use of any aversive or deprivation procedures.

10. The provider shall have a written plan and procedure in case of fire, severe illness, accident, severe weather and missing persons.

a. Orientation in emergency procedures shall be recorded for each client and employee within one month of admission or employment.

b. This plan shall be reviewed quarterly with clients.

11. The provider shall maintain records of financial transactions and agreements with the referring LSSA.

12. The provider shall have a written plan for establishing service rates, which shall include at least 30-day advanced notice of change in rates.

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13. Living arrangements.

a. When living arrangements are provided by the SILS provider as a part of the SILS program, the living arrangements are not subject to this rule, and therefore need not be licensed. Living arrangements are subject to applicable health, safety, sanitation and zoning codes. When living arrangements are provided as a part of the SILS program plan, the provider shall assure the local social service agency that the living arrangements are in conformance with the client's individual program plan, and applicable health, safety, sanitation and zoning codes. Living arrangements so provided shall include provisions for the preparation of meals, sleeping, bathing, mail, and access to telephone and transportation.

b. When living arrangements are not provided as a part of the SILS program, the provider may assist the local social service agency and client as agreed upon in:

(1) Choosing and arranging for a appropriate living environment.

(2) Developing client skills in choosing and making living arrangements.

(3) Developing client skills in shopping, seeking employment, paying rent and other bills, and in the use of public transportation and other community services.

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§ 2.019 Experimental program for the home care and training of children who are mentally retarded.

A. Introduction.

1. This rule governs the administration of reimbursement to local boards for the cost of home care and training of children who are mentally retarded pursuant to this program of family subsidy, as provided in Minn. Stat. § 252.27, subd. 4.

2. Definitions.

a. Child—Any person under the chronological age of 18 years.

b. Home—The home of the natural, adoptive or stepparent(s), or legal guardian, in which the child is or would be living for purposes of this experimental program.

c. Licensed community residential facility for mentally retarded persons—A facility which is licensed under Minnesota Department of Public Welfare Rule No. 34 Minn. Stat. § 252.28), and the Minnesota Department of Health Rule for supervised living facilities (Minn. Stat. § 144.56).

d. Local board—A county welfare/human service board established under the authority of Minn. Stat., ch. 393 or ch. 402, as amended.

e. Mentally retarded person—A mentally retarded person refers to any person who has been diagnosed as having significantly subaverage intellectual functioning existing concurrently with demonstrated deficits in adaptive behavior and manifested during the developmental period.

(1) Intellectual functioning shall be assessed by one or more of the professionally recognized standardized tests developed for that purpose; significantly subaverage refers to performance which is approximately two or more standard deviations from the mean or average of the tests.

(2) Adaptive behavior shall be determined through the use of published scales, or by a combination of pertinent test data, professional observations, and the utilization of all available sources of information regarding the person's behavior which indicates the degree with which the individual meets the standards of personal independence and social responsibilities expected of his age and peer group.

f. Minnesota Developmental Programming System (MDPS) Behavioral Scales—A tool used in assessing mentally retarded persons to assess their behavioral skills, provide a basis for planning programs to increase their skills and consequently their independence, and determine what new behavioral skills have been acquired over a period of time.

g. Parent—A natural, adoptive or stepfather or mother or a legal guardian.

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h. State Agency—Minnesota Department of Public Welfare.

B. Eligibility for participation in the program.

1. The program shall be for those children who, at the time of application, are residing in Minnesota and (a) who are living at home, or (b) who are residing in a state hospital or in a licensed community residential facility for the mentally retarded who, under this program, would return to their own home. Those children living at home must also be determined by the local board eligible for placement in a state hospital or a licensed community residential facility for the mentally retarded.

2. Each child considered for participation shall have been diagnosed as mentally retarded.

3. Parent(s) of children participating in this program shall be informed by the local board that this program is experimental in nature, and that due to its experimental nature, those parent(s) must consent, in writing, to the following conditions:

a. Participation in the behavioral assessment of the child by means of the Minnesota Developmental Programming System which will be provided by the local board.

b. Furnishing sociodemographic data about the home environment.

c. Participation in evaluating the child's progress toward meeting his goals in the individualized treatment plan on a quarterly schedule.

Parent(s) shall also be informed by the local board that the program is financed through June 30, 1977, and that continuation will be contingent upon success of the program and further appropriations by the Minnesota Legislature.

The state agency and local board shall assure in writing to the parent(s) that his participation and furnishing information for the purposes of evaluation will be solely for the purposes of evaluating the program and that all data collected will be rigorously safeguarded with regard to confidentiality of data. All data accumulated on the child, his program and his environment will be available to the parent(s).

4. Acceptance and approval of applications by the state agency with priority given on the basis of the following factors:

a. Severely handicapped persons.

b. Degree of need in family environment (i.e., single parent families).

c. Potential for greatest benefit—i.e., degree of developmental ad-

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vancement as measured by the Minnesota Developmental Programming System.

C. Procedures.

1. Application is submitted by the local board to the Commissioner, Department of Public Welfare, Mental Retardation Division, Centennial Office Building, St. Paul, Minnesota 55155, Attention: Director.

Application must include:

a. Application for social services, DPW-1400

b. Service plan and agreement, DPW-1950

c. Diagnostic data

d. Evidence of eligibility for institutionalization.

e. Grant amount requested for services specified in Clb

Forms DPW-1400 and 1950 are not to be used to determine financial eligibility for grants but for identifying name and address information and defining needed services.

2. The local board shall provide the state agency with quarterly progress reports concerning progress of the child. Quarterly progress report forms will be furnished by the state agency upon acceptance of the child into the program.

3. Upon approval by the state agency, the local board shall make grants to the parent(s) of the mentally retarded child. The grant shall be an amount equal to the direct costs of the services outlined in the service agreement subject to a maximum of $250 per month. The costs shall include one or more of the services provided in Minn. Stat. § 252.27, subd. 4, or related services stipulated in the individual program plan. Reimbursable costs shall not include resources already available such as special education classes, daytime activity center programs, or medical costs covered by insurance if these resources are available at no cost to the child or parent(s).

D. Payment.

1. Local boards shall receive quarterly reimbursements from the state agency by filing the prescribed claim forms.

Effective Date—March 7, 1977.
(1 S.R. 1206, February 15, 1977)

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Repealed 7SR 1376 3-28-83

§ 2.021 Pilot program of non-residential services for mentally ill persons.

A. Introduction.

1. This rule governs the financing of social and rehabilitative service costs to assist the counties of Dakota, Washington, and Ramsey in providing those nonresidential social and rehabilitative services to mentally ill residents of those counties who would otherwise be hospitalized or who are unable to use currently available after-care services. Services eligible for state financing under this rule shall be those contained in the individualized treatment plans of the mentally ill persons as determined by the above-named counties. The goal of the individualized treatment plans shall be to enable those persons to live independently in the community without further hospitalization.

2. Definitions:

a. County welfare board: A legally established board under the authority of Minn. Stat. 1974, ch. 393.

b. Human service board: Single county or multi-county board established under the authority of Minn. Stat. ch. 402 (1974), amended.

c. Community mental health board: A board organized under the authority of Minn. Stat. §§ 245.61-245.69 to provide local mental health programs and services.

d. Mentally ill person: A person defined by Minn. Stat. § 253A.02, subd. 3.

e. Social and rehabilitative services: Those activities provided to carry out the individualized treatment plan for each eligible mentally ill person.

f. State agency: Minnesota Department of Public Welfare.

B. Standards for the awarding of grants.

1. The state agency will apportion the available funds to the three above-named counties on the basis of their most current population as determined by the Metropolitan Council. The initial apportionment of available funds will be made for a period not to exceed 14 months, from May 1, 1976 to June 30, 1977. Subsequent apportionments will be made on a fiscal year basis.

2. By mutual agreement of the county welfare board and community mental health board, in such a county where there are separate such boards, or by a human service board where such board exists, a county's share of the available funds under this rule may be assigned directly to a designated intermediary which is willing to accept this responsibility to carry out the purposes of this rule. Such fiscal intermediary shall be a legally established

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county welfare board, community mental health board, or human service board in one of the three above-named counties. Such designation and acceptance of the designation of the fiscal intermediary shall be in writing. The fiscal intermediary shall maintain such records as the commissioner of public welfare may require, and shall report to the commissioner on such forms and at such times as the commissioner shall indicate.

3. The funds available under this rule may be used to pay for expenses within the budget approved by the commissioner.

4. All vendors providing services eligible for reimbursement under this rule shall maintain records on each person served that document the existence of a written individualized treatment plan for each such person, the services provided to each such person to carry out the individualized treatment, the duration of such service, the outcomes of such services, and their costs. Such records shall be available for review by the county agency responsible for individual case management designated in accordance with B. 5. infra.

5. Each of the three counties shall determine the county agency responsible for the case management of eligible persons and such agencies shall periodically review the progress of each eligible person with the fiscal intermediary, if one is designated, and with vendors authorized to provide services contained in each eligible person's individualized treatment plan.

6. By mutual agreement between any two or more of the above-named three counties, those funds available under this rule and apportioned to any one of these counties that are not needed by that county may be made available to the other county, or counties, to carry out the purposes of this rule. Funds may cover approved costs incurred after June 1, 1976.

C. Application.

1. Each of the three above-named counties may apply to the commissioner of public welfare for its share of the funds available under this rule, designating the fiscal intermediary if one is selected. The application shall be jointly signed by the county welfare board and the community mental health center board, or their designees where they are separate boards. In the event that a human service board is established in any of these counties, that board or its designee shall sign the application. In lieu of the above procedure and upon agreement of the county welfare boards and community mental health center boards or human service boards, if such are established in all three of the above-named counties, a designated fiscal intermediary may make a single application to the commissioner of public welfare for funds available under this rule. Such application shall specify the amount of funds being proportionately requested by each county and shall be jointly signed by the county welfare board and the community mental health board, or human service board, in each county.

2. Applications are to be sent to the Commissioner, Department of Public Welfare, Attention: Director, Mental Health Program Division.

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3. Applications are to include the following:

a. Narrative description of the proposed services, the number of mentally ill persons expected to use the services, assurance that the individualized treatment programs of these persons will document their need for the proposed services, and a statement of the expected results.

b. A budget which states the cost of the proposed services.

D. Evaluation.

1. In accordance with Laws of 1976, ch. 327, the commissioner of public welfare shall establish the procedures necessary to monitor and evaluate each pilot program funded under this rule and shall make all necessary reports to the legislature. The commissioner may allocate funds for this purpose.

E. Reports to the state agency.

1. The commissioner of public welfare shall require that those local boards and agencies receiving funds under this rule shall report to the state agency the number of persons served, their county of residence, the costs of providing services to them, the results achieved, and other relevant data as requested.

Effective Date—October 24, 1976.
(Cite 1 S.R. 520)

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Repealed 7 SR 1376
3-28-83

§ 2.022 Community-based residential services for mentally ill persons.

A. Introduction.

1. This rule governs state financing for residential and related social and rehabilitative service costs to assist mentally ill persons to use community-based resources rather than state institutional services.

2. Definitions.

a. County welfare board: A board established under the authority of Minn. Stat. ch. 393.

b. Human service board: Single county or multi-county boards established under the authority of Minn. Stat. ch. 402, as amended.

c. Community mental health board: A board organized under the authority of Minn. Stat. §§ 245.61-245.69 to provide local mental health programs and services.

d. Mentally ill person: A person defined by Minn. Stat. § 253A.02, subd. 3.

e. Residential care facility: A living unit established primarily for the accommodation and treatment of mentally ill persons.

f. Social and rehabilitative services: Those activities provided to carry out the individualized treatment plan for each mentally ill person.

g. State agency: Minnesota Department of Public Welfare.

B. Standards for the awarding of grants.

1. The state agency will annually award the available funds primarily, but not necessarily exclusively, to one state hospital receiving district. The state agency shall determine which receiving district on the basis of the legislative record in 1975, the state agency's January, 1975 Comprehensive Plan, and the state agency's January, 1976 report to the Legislature on the closing of a state hospital.

2. The state agency may also allocate funds from this appropriation to the partial support of community-based residential care facilities initiated and formerly funded by a state hospital for the care and treatment of former mentally ill patients of that state hospital.

3. Effective on July 1, 1976, the state agency will prorate the funds available to the counties in the designated state hospital receiving district on the basis of the most current total population figures as provided by the Metropolitan Council. Unexpected funds may be reallocated after six months to the other counties in the designated receiving district if appropriate uses are demonstrated.

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4. These funds shall support additional programs and services and shall not replace the funding of the existing care and maintenance costs. To the extent that other available funds are inadequate, these funds will be used to carry out treatment plans for the individual.

5. Priority will be given to provision of services identified in individualized treatment plans. The funds are to be directed primarily toward programs and services for chronic, longstanding mentally ill persons. For these grants, chronic mental illness is defined as a condition that has required one or more prior hospitalizations for mental illness treatment.

6. Funding of services which will enable residential facilities to qualify for licensure may be allowed.

C. Service priorities.

1. Services eligible for funding under this rule include, but are not limited to:

a. Day programming (day activity, work and pre-work training, recreation and education).

b. Twenty-four hour social crisis intervention aimed primarily at aiding nonmedical crises of people who have had prior hospitalizations for problems of mental illness when those crises can be dealt with without resorting to medication and/or hospitalization, e.g., domestic or family quarrels, unexpected loss of a job, loss of a spouse or child, etc. This function may relate to medical emergency centers.

c. Independent living training unit which is for individuals or groups of individuals who need preparation and/or support in finding and maintaining housing, finding and keeping a job, managing money, developing suitable recreational activities, etc.

d. Drop-in centers for socialization and recreation where people with a history of mental illness may go for semi-structured activities and social support from others with similar backgrounds.

e. Staff/agency training in developing and carrying out individual treatment plans.

f. Residential living costs.

D. Application.

1. Applications for funds under this rule originating in any of the counties in the designated state hospital receiving district shall be jointly signed by the county welfare board and the community mental health center board, where they are separate boards. In the event that a human service board is established in any of these counties, that board shall sign the application.

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2. Applications are to be sent to the Commissioner, Department of Public Welfare, Attention: Director, Mental Health Program Division.

3. Applications are to include the following:

a. A narrative description of the proposed services, the number of mentally ill persons expected to use the services, an assurance that the individualized treatment programs document the need for the proposed services and a statement of the expected results.

b. A budget outlining the cost of the proposed services.

c. A design for evaluation of the project.

E. Reports to the state agency.

1. The state agency may require, at such times and in such form as the Commissioner of the state agency may establish, that those local boards and agencies receiving funds under this rule report to the state agency the number of persons served, costs of providing the services, results achieved, and other relevant data requested.

Effective Date–October 24, 1976.
(Cite 1 S.R. 521)

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§ 2.023 Community-based residential services for persons who are mentally retarded.

A. Introduction.

1. This rule governs state financing of the planning and placement of mentally retarded persons into appropriate community alternative programs.

2. Definitions.

a. Community mental health board: A board organized under the authority of Minn. Stat. §§ 245.61-245.69, to plan for and facilitate programs in mental retardation and assure delivery of services.

b. Human service board: A single county or multi-county board established under the authority of Minn. Stat. ch. 402, as amended.

c. County welfare board: A board established under the authority of Minn. Stat. ch. 393.

d. Mentally retarded person: Any person who has been diagnosed as having significantly subaverage intellectual functioning existing concurrently with demonstrated deficits in adaptive behavior such as to require supervision and protection for his or the public welfare (Minn. Stat. § 253A.02, subd. 5).

e. Residential facility: An out-of-family home setting for purposes of acquiring self-care, remedial, developmental or social skills, or for a long-term living arrangement.

f. State agency: Minnesota Department of Public Welfare.

g. State institution: State-operated residential facilities for mentally retarded persons.

h. Supportive services: Any non-residential services included in the treatment plan such as day activity centers, work activity program and homemaker services.

B. Purposes for the awarding of grants.

1. Joint application to the state agency for grants may be made by the county welfare board, community mental health board or human service board to pay local costs in planning developing alternatives, making appropriate placements, and financing residential and supportive services for mentally retarded persons in community-based programs after existing state and federal resources are fully utilized.

2. Applications may be made for the following purposes:

a. The placement of mentally retarded residents of state institutions into community-based residential facilities. This may include:

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(1) Staff and consultation costs for individualized program planning and the planning of appropriate services in cooperation with state institution staff.

(2) Costs per individual to the county after federal and state resources are utilized. This may include costs now paid by the county because of the following reasons:

(a) Reimbursement rate paid by the state agency is less than that authorized in law for placement of children under 12 MCAR § 2.030 (Cost of Care).

(b) Grant-in-aid paid by the state agency is less than authorized in law for daytime activity center (DAC) services.

(c) Federal Title XIX Medicaid and state supplementary appropriations do not pay all costs of ICF/MR placement. Remaining costs may be included after the federal share and the state supplement is paid.

b. The placement of mentally retarded residents of community based residential facilities into independent living. This may include costs of:

(1) Multi-disciplinary case planning in cooperation with residential facility operators.

(2) Financing of residential and supportive services costs.

(3) Reduction of inappropriate placements of mentally retarded persons in skilled nursing facilities (SNF), and general intermediate care facilities (ICF/general). This may include:

(a) Implementing the recommendations of the DPW study (Mentally Retarded Persons Reported to be in Non-MR Residential Placement in Minnesota - A Report to the Minnesota Department of Public Welfare), dated December, 1975.

(b) Assessing mentally retarded residents of certified SNF's, in order to determine whether they can be programmed more appropriately in a residential facility certified as an ICF/MR facility.

(c) To place mentally retarded persons in ICF/general facilities who are under 65 years of age into residential facilities certified as intermediate care facilities for mentally retarded (ICF/MR) if appropriate.

(d) Assessing the needs of mentally retarded residents of ICF/general facilities who are over 65 years of age, in order to determine whether debilitating conditions warrant continued residence in ICF/general, or whether ICF/MR placement would be more appropriate.

(e) To finance supportive services.

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C. Application.

1. All applications are to be made jointly between one or more county welfare boards and the community mental health board or human service board.

2. Applications are to be sent to the Commissioner, Department of Public Welfare, Attention: Director, Mental Retardation Division.

3. Applications are to include the following:

a. Identify the particular group of mentally retarded persons affected by the project application.

b. A narrative description of the proposed project and a statement of expected results.

c. A budget plan which will be reviewed for its appropriateness in relation to the group of persons to be affected. It is recognized that the types of persons addressed in B. 1. a. & c. are more difficult to place in the community and may require more intense programming and highly specialized staff.

d. The number of retarded persons expected to be affected in each of the project purposes.

e. A design for the evaluation of the project.

D. Evaluation.

1. A report to the state agency shall be made by the applicants receiving grants. Such evaluation shall be submitted within 30 days of termination of the project, describing the impact and results of the project upon individuals.

E. State agency criteria for determination of grant award.

1. Standards for the provision of services.

a. To provide the person who is mentally retarded with an existence as close to normal as possible. This includes making available the patterns and conditions of everyday life that are as close as possible to the norms and patterns of the mainstream of society.

b. To provide the person who is mentally retarded with an individual service plan designed so that new and progressively difficult skills are acquired. Such plan must take into consideration the presentation of learning and developmental experiences appropriate to his adaptive behavior levels, physical condition and degenerative status.

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The individual service plan for the mentally retarded person must be based on a comprehensive assessment of needs, and periodic evaluation to determine appropriateness and effectiveness of the individual service plan.

c. To implement the client's service plan, plans shall be made in a manner which least restricts personal freedom but carries out the goals and objectives for the individual. This shall mean:

(1) Providing assistance to enable him to live in his home.

(2) Providing a community-based residential facility with appropriate services when the mentally retarded person must leave his home for a specified purpose and period of time.

d. Providing placement in a state institution when the mentally retarded persons cannot be served at home or in a community facility for a specified purpose and period of time.

2. Relevance of the application to:

a. Priorities of the community mental health or human service board's plan for the mental retardation target population.

b. Priorities of the county welfare department's plan.

c. Implementation of the Community Alternatives and Institutional Reform (CAIR) report recommendations (Developmental Disabilities Program Office, Minnesota State Planning Agency, 550 Cedar Street, Room 110, St. Paul, Minnesota 55101).

d. Community placement of current state institution residents.

e. State receiving institution—priority shall be given to proposals in accord with the above standards and expectations, relating to mentally retarded persons in the Cambridge State Hospital or in its receiving district.

Effective Date—October 24, 1976.
(Cite 1 S.R. 522)

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Repealed 7 SR 1376 3-28-83

§ 2.024 Administration and implementation.

A. Statutory citation. Minn. Stat. ch. 254A establishes the authority of the Commissioner of Public Welfare to develop programs relating to treatment for alcohol and drug abuse; to provide for programs of prevention, intervention and treatment for employees and underserved groups; and to appropriate monies.

B. Introduction. This rule governs the development of chemical dependency prevention, identification and referral, and treatment programs for affected employees, youth and other underserved populations, and Native Americans who have need for such services.

C. Definitions.

1. Affected employee—an employee whose job performance is substantially affected by chemical dependency.

2. Citizen's Advisory Council—a council established pursuant to Minn. Stat. § 254A.04.

3. Commissioner—Commissioner of the Minnesota Department of Public Welfare.

4. Community Mental Health Board—a board established pursuant to Minn. Stat. §§ 245.61 through 245.69.

5. Indian Tribe—any Indian group currently recognized or previously recognized by the Federal Government and eligible for special programs and services provided by the United States government.

6. Native American—any Minnesota resident who is a member of a federally recognized American Indian Tribe or Band of the United States.

7. Native American Advisory Board--a board of Minnesota Native American people referred to in Minn. Stat. § 254A.03.

8. Other underserved populations—identifiable groups of significant numbers who do not have available sufficient programs and services designed to meet their special chemical dependency needs. This includes and is limited to:

a. persons age 65 and over

b. women ages 19 to 65 years

c. Blacks

d. Chicanos

e. Gay men and Lesbian women

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9. Participating Community Mental Health Board—a board established pursuant to Minn. Stat. §§ 245.61 through 245.69 which participates under this rule in the provision of services to chemically dependent persons.

10. Prevention—programs directed towards reducing the number of people requiring treatment services because of chemical abuse problems.

11. Purchase of service agreement—a contract between either the Community Mental Health Board or the State Agency and the service provider which specifies what services will be provided, the method of delivery, the staff to be employed and the evaluation design. The agreement may also include a personal services contract.

12. Services providers—any group, organization, or individual capable of planning, designing, developing, installing, providing training, or evaluating programs which carry out the intent of this rule.

13. Treatment—chemical dependency rehabilitation programs including counseling, non-residential and residential care and aftercare.

14. Youth—any person 18 years of age or under.

15. State Agency—Minnesota Department of Public Welfare (DPW).

D. Responsibilities.

1. Department of Public Welfare.

a. Design and implement a plan of affirmative outreach which will inform and facilitate the participation of the appropriate parties.

b. Establish time schedules within which the community mental health boards and service providers must perform to be eligible for participation under this rule.

c. Approve the community mental health board program plans for provision of services, including but not necessarily limited to:

(1) Design

(2) Implementation schedule and procedure

(3) Fund allocation

(4) Evaluation of the program

d. Provide technical assistance to community mental health board as requested or needed in the following areas:

(1) Plan design

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(2) Service design

(3) Procurement procedures

(4) Evaluation design

e. Disburse available funds to programs for Native Americans with the advice of the Native American Advisory Board. All design, planning, development, implementation, funding and evaluation of programs for Native Americans shall be done with the advice of the Native American Advisory Board.

f. Allocate available funds to participating community mental health boards for affected employee programs on the basis of numbers of persons in the work force in counties served by the community mental health boards.

g. Allocate available funds to the community mental health board for purposes of providing programs to youth and other underserved populations. In order to provide viable programs to Blacks, Chicanos and Gay Men and Lesbian Women, up to $325,000 of the FY 1977 allocation shall be allocated to Hennepin County Department of MH-MR and CD and Ramsey County Mental Health Board; other community mental health boards may contract for these programs with Hennepin County Department of MH-MR and CD and Ramsey County Mental Health Board. The balance of $1,031,000 for youth and underserved shall be allocated to all participating community mental health boards by:

(1) Totaling the numbers of persons state-wide who are:

(a) enrolled in elementary, middle and secondary schools

(b) unemployed females ages 19 through 65

(c) over age 65

(2) Dividing the sum of the totals from D.1.g.(1) of this rule into $1,031,000.

(3) Multiplying on a county by county or community mental health board by community mental health board basis, the quotient arrived at in D.1.g.(2) above by:

(a) the numbers of persons enrolled in elementary, middle and secondary schools residing in each county or community mental health board;

(b) the numbers of unemployed women aged 19 through 65 residing in each county or community mental health board; and

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(c) the numbers of persons age 65 and over residing in each county or community mental health board area.

(4) On either a county by county or a community mental health board by community mental health board basis take the products of D.1.g. (3)(a)(b)(c) above as they apply to each county or community mental health board area and add them together to determine the total youth and underserved population allocation to each county or community mental health board area.

h. Reallocation of unused funds.

(1) The state agency shall, on the basis of schedules set by DPW and responses received, determine which boards are participating. If all boards do not participate, funds tentatively allocated to non-participating boards may be reallocated to participating boards on the same basis as prior allocations.

(2) In the event that the community mental health board program is not approved or cannot be executed in accordance with this rule, or the board decides at a later date not to participate, the funds may be reallocated.

(3) Funds available under the provisions of this rule which are unexpended after six months may be reallocated.

i. Evaluation. The Commissioner shall directly or by contract provide the following evaluation services:

(1) Develop an evaluation design that can be applied to all programs developed under this rule.

(2) Integrate the evaluation design into an overall evaluation system for all chemical dependency programs.

(3) Design an evaluation system which shall be capable of providing process data one year after installation and outcome data two years after installation.

2. Community mental health boards are responsible for provision of the following services:

a. Any participating community mental health board may enter into a joint agreement with one or more other community mental health boards to provide programs on a multi-area basis.

b. All community mental health boards shall consult with county welfare boards regarding proposed programs prior to submission of program plans to the state agency.

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c. Each participating board, in order to qualify for funds to provide programs for affected employees shall demonstrate how the funds, used either separately or in conjunction with existing program efforts and/or other resources, will be used to provide comprehensive programming which includes the following:

(1) Methods that will be used to maximize employer participation in and utilization of the services provided, including a plan which requires the formation of a joint committee for each employer or consortium of employers consisting of representatives from management, various levels within the organization structure in non-union settings or organized labor if the employer has one or more collective bargaining agreements, consultants, and/or community care givers.

(2) Plan for transferring the responsibility and the cost of administering and maintaining the programs from the Community Mental Health Board to the employers within 24 months after installation.

(3) Method of gathering data to provide adequate information for the DPW approved program evaluation system.

(4) Plan for establishing appropriate personnel, and procedures in participating industries.

(5) Procedure outline development and written policy.

(6) Install adequate diagnostic and referral resources either at the employment site or in the community and a training program for persons serving in this function.

(7) Training and orientation programs for management, supervision and key labor representatives when appropriate.

(8) Ongoing communication and education related to the purpose and scope of the program to all employees and their families.

d. Each participating Community Mental Health Board in order to qualify for funds available for youth and other underserved populations, shall demonstrate how the funds, used either separately or in conjunction with existing program efforts and/or other resources, will be used to provide programs to youth, women and elderly persons. The community mental health boards shall determine how funds shall be used in providing programs to each of these groups respectively on the basis of:

(1) Problem manifestation by underserved group

(2) Current lack of programming effort to underserved group

(3) Needs assessment

(4) Definition of goals

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(5) Description of process

(6) Evaluation of progress

In addition, Hennepin and Ramsey counties shall also provide programs for Blacks, Chicanos, and Gay men and Lesbian women.

e. If, after examining all available alternatives, a community mental health board finds it is not feasible to provide programs for each of the three mandatory underserved groups and cannot enter into a joint multi-area effort with one or more other community mental health boards but can demonstrate an ability to provide a viable program to one or two of the three mandatory underserved populations, the Commissioner may grant a waiver.

f. In order to qualify for funds under this rule, the community mental health boards must have an evaluation system approved by DPW for each program developed that is capable of providing both process and outcome data.

g. The general program plan, which is to be submitted to the state agency should contain the following:

(1) A determination of early intervention, training and prevention service needs for affected employee, youth, and other underserved population programs.

(2) General descriptions of programs based on identified service needs.

(3) A budget.

(4) Description of program administration and monitoring including accounting, legal counsel, part time administration, etc.

(5) Statement that existing funds will not be supplanted or reduced and that existing program resources will be fully utilized.

(6) A timetable for program implementation.

(7) A statement of compliance with program evaluation requirements.

(8) A statement as to the expected general impact of programs on the total delivery system.

h. The community mental health board shall advertise and make public requests for proposals from vendors and must consider all submitted proposals which comply with the program plan and applicable regulations. Additionally the community mental health board shall establish award criteria prior to any proposal review. Proposals should address, but not necessarily be limited to the following:

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(1) Statement for program goals and objectives.

(2) Procedures for reaching goals and objectives.

(3) Schedule for performance by action step.

(4) System for reaching target population and estimated numbers to be served.

(5) Applicable rules, regulations, standards, and/or licensing requirements.

(6) Evaluation method.

(7) Where program is to be provided.

(8) Budget.

Non-compliance with the contents of this rule may result in the withholding of funds.

3. Service providers. All contracts between community mental health boards and service providers must conform with state affirmative action and equal employment opportunity programs and other applicable federal, state, and local laws and rules. In addition, contracts shall provide for the following:

a. Collection of program descriptive data including:

(1) Staffing patterns.

(2) The capacity of providing services, i.e., resources, community mental health boards or service providers.

(3) Target population: identification and actual contacts.

(4) Consequences of contacts.

b. Collection, recording and reporting of descriptive data on persons served by each program activity on a monthly basis.

c. Collection, recording and reporting of data describing what service was provided to clients on a monthly basis.

d. At the end of the funding period, provide the community mental health board with a report including:

(1) The program goals and objectives, the rationale for program activities, and the description of the target group(s) as stated in the original proposal.

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(2) An enumeration of services actually provided by the program.

(3) A self assessment of 1) whether program activities were a satisfactory means of attaining program goals (i.e., based on your experience, what would you do differently to reach your program goals) and/or 2) the attainment of the stated program goals.

e. Complete reports as requested by community mental health board.

f. Require service providers to demonstrate their capability to perform on the basis of experience and education.

Effective Date—October 4, 1976

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MINNESOTA CODE OF AGENCY RULES

RULES OF THE DEPARTMENT OF PUBLIC WELFARE

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Chapter 2. Mental Health

§ 2.026 County welfare board assistance to patients released from state hospitals for the mentally ill.

A. This rule provides methods and procedures relating to county welfare board assistance to patients (committed or voluntary) for whom release from a state hospital for the mentally ill has been recommended.

B. If the patient has relatives, the hospital shall find out their ability and willingness to carry out a satisfactory release plan. The hospital may request, and the the county welfare board shall give, assistance in making this determination. If the relatives are willing and able to carry out the release plan, the patient may be released to them; and the hospital shall notify the appropriate counties one week in advance of release, if practicable, or, in any event, within one week after release.

C. If the patient has no relatives or if the patient's relatives are unable or unwilling to provide for all the needs of the patient:

1. The hospital shall, as early as necessary to make sound release plans, write to the appropriate counties describing the patient's circumstances and needs and requesting the counties' services in meeting these needs when the patient is released.

2. The patient or his guardian of estate may apply for public assistance either before or after release from the institution.

3. The county welfare board of the county in which the hospital is located shall, on request, take the application for public assistance and obtain a social history and, upon consent of the medical director, such supporting data as are available from the hospital records and the patient.

4. When a patient is or will be in need of financial assistance upon release but is not eligible for, or requires assistance in addition to, Old Age Assistance, Aid to Families With Dependent Children, Aid to the Blind, Aid to the Disabled, or Medical Assistance, the county welfare board of the county of the patient's settlement for poor relief shall:

a. In a county that operates under the county system of relief, ascertain the amount of need and provide general relief upon the release of the patient.

b. In a county that operates under the township system of relief, ascertain the amount of need and pay necessary relief if the responsible political subdivision fails to do so upon the release of the patient.

5. When a patient is released from a state hospital and is in need of financial assistance but is not eligible for, or requires assistance in addition to, Old Age Assistance, Aid to Families With Dependent Children, Aid to the

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Blind, Aid to the Disabled, or Medical Assistance and there is a dispute about poor relief settlement or the patient has no poor relief settlement within this state, the county welfare board of the county of commitment or admission (voluntary) shall provide, on a temporary basis, the relief required by this rule, pending determination of settlement or acquisition of settlement by the patient within this state.

6. The county welfare board shall supervise the released patient and assist him in finding employment and suitable shelter and aid in his readjustment to the community. To carry out this function the county welfare board and the hospital shall collaborate in making release plans for the patient well in advance of his actual release.

7. The county welfare board shall maintain such records and make such reports about services and assistance to mentally ill persons as may be required by the Commissioner of Public Welfare.

Effective Date—September 18, 1963.

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ARCH55T

12 MCAR S 2.027 Reimbursement for cost of care of patients in a state hospital.

A. Application. Rule 12 MCAR S 2.027 governs the administration of the State Hospital Cost of Care Program in the Department of Public Welfare. The provisions of this rule are to be read in conjunction with Minnesota Statutes, sections 246.50 to 246.55 and other rules of the department. No person shall be denied state hospital services because of inability to pay the cost of care.

B. Definitions. For purposes of 12 MCAR S 2.027, the following terms have the meanings given them.

1. Business expense. "Business expense" means the cost of producing income from a business or farm. Capital expenditures and depreciation are not included as part of a business expense.

2. Capital expenditure. "Capital expenditure" means an investment made to purchase property or to make an improvement to property which has a useful life of more than one year.

3. Cost of care or per diem. "Cost of care" or "per diem" means the daily per capita cost of providing care to state hospital patients or the cost of outpatient services calculated in accordance with Minnesota Statutes, section 246.50, subdivision 5.

4. Department. "Department" means the Minnesota Department of Public Welfare.

5. Dependent. "Dependent" means an individual whom a person is entitled to claim as a dependent on the Minnesota state income tax return. An individual may not be claimed as a full unallocated dependent by more than one person. When two or more persons are entitled to claim the dependent, the dependent shall be allocated equally among the persons unless the persons choose another allocation.

6. Gross income or gross earnings. "Gross income" or "gross earnings" means all income received including in kind income.

7. Homestead. "Homestead" means the house owned and occupied by the patient as his dwelling place, together with the land upon which it is situated and an area no greater than two contiguous lots in a platted and laid out city or town or the smallest parcel allowed under applicable zoning regulations in unplatted land.

8. In kind income. "In kind income" means the annual sum of resources other than money received by a patient or dependent used to maintain the patient or the patient's family and having a value of more than $100.

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9. Inpatient. "Inpatient" means a person who occupies a bed in the hospital for the purpose of observation, care, diagnosis, or treatment.

10. Lump sum payment. "Lump sum payment" means income received at one time. It includes windfalls, repayment of debts, payments from sale of property, tax refunds, gifts, and inheritances.

11. Net income. "Net income" means the amount of income remaining after deductions and exclusions from gross income as provided in this rule.

12. Outpatient. "Outpatient" means a person who makes use of the services of the state hospital but does not occupy a regular hospital bed, as set forth in Minnesota Statutes, section 246.50, subdivision 5.

13. Patient. "Patient" means any individual receiving observation, diagnosis, care or treatment in a state hospital.

14. Patient's financial information file. "Patient's financial information file" means financial data collected for the purpose of determining ability of the patient or the responsible relative to pay the patient's cost of care.

15. Person. "Person" means a patient or responsible relative.

16. Personal property. "Personal property" means all property which is not real property.

17. Property. "Property" means everything owned by a person, including money.

18. Real property. "Real property" means land, including the buildings and improvements on it, and its natural assets, such as minerals and water.

19. Resource. "Resource" means any property or benefit that is available to pay for the cost of care of the patient.

20. Responsible relative. "Responsible relative" means the spouse, the parents of minor children, and in the case of the mentally ill, the adult children of a patient, in that order of liability for cost of care.

21. State hospital. "State hospital" means a state hospital for mentally ill, chemically dependent, or mentally retarded persons.

C. Determination procedure.

1. Time of determination.

a. Ability to pay the cost of care shall be determined

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when the patient is admitted, when there is a change in the patient's financial status, when a patient, responsible relative, guardian, conservator or representative payee reports a change in the financial status used in determining ability to pay, when the patient has been hospitalized for 120 days or more, when the patient is being discharged and when the financial status has not been reviewed for one year.

b. Within the six-year period after the date of a patient's discharge from the hospital, the department from time to time may, and upon request of the patient shall, reevaluate the patient's ability to pay any balance of the charge for cost of care.

2. Persons interviewed.

a. In all instances the patient shall be present at the interview to determine ability to pay unless the patient is a minor or the attending physician of the state hospital attests the patient's presence is medically contraindicated. The physician's signed statement shall be placed in the patient's financial information file.

b. The patient shall be the source of financial information to determine ability to pay except when the management of the patient's financial affairs is in the hands of another person. When the patient is not the source of financial information the reason shall be noted in the patient's financial information file.

c. When the patient is not able to act on his own behalf, the person interviewed shall be the patient's legal guardian, the conservator, the parents of a minor child, a spouse, a relative of the patient, a trustee, a representative payee, the patient's legal representative, or a county social worker.

d. If the patient is unable to pay the full cost of the per diem, the responsible relative shall be interviewed.

3. Financial interview. When a person is interviewed, the department shall:

a. Inform the person that he or she may choose an individual to assist in the determination process and any other contact with the department by authorizing such assistance in writing;

b. Provide the person with an informational pamphlet on cost of care and review with the person how the department determines the charges for the patient's cost of care;

c. Inform the person that financial information obtained from the person will not be released without the person's written consent except pursuant to Minnesota Statutes, sections 15.1611 to 15.1699;

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d. Inform the person of county, state, and federal financial programs which may assist in paying the cost of care and meeting personal and family needs; and

e. Request the person to complete and sign a financial information form provided by the department and to provide verification of financial information.

4. Verification required. This process shall be used to substantiate information entered on the signed financial information form. The reimbursement officer shall verify: the patient's income, insurance benefits, property, deductions allowed to pay previously incurred debts, and the number of dependents claimed.

5. Consent forms. The person shall provide the reimbursement officer with a separate signed consent form for each verification which must be obtained from a third party. The name, date, and the information authorized shall be on the consent form prior to the person's signature. A blanket authorization may be used for a group of related agencies such as banks or insurance companies.

6. Refusal to complete financial information form. Failure or refusal to complete and sign the required financial information form, apply insurance benefits received to pay the cost of care, or provide signatures required to assign third party benefits and release medical and financial information or verification within 30 days of the interview shall result in the determination that the person is able to pay the full cost of care permitted under Minnesota Statutes, section 246.51 until the person takes the required action.

7. Determination order. A determination order and notice of rate showing the per diem, the amount the person is ordered to pay and the right to a review and an appeal shall be sent by the department to the person, and the person's guardian, conservator or representative payee.

8. Review of determination. A person who disagrees with the department's determination of ability to pay may request that the department review its decision. The request shall be made in writing within 15 calendar days of the date the order was mailed. The request for review shall include the reasons for disagreeing with the determination order. When a person requests review as provided in this paragraph, the department's determination shall not become final until the department responds to the request for the review. The department shall send the person a notice of the decision after review and a final determination order.

9. Appeal of determination. A person may also appeal from the determination order pursuant to Minnesota Statutes, section 246.55.

D. Sources of income considered to be patient resources.

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1. In general. The patient's ability to pay shall be determined from insurance benefits, net income, and value of property owned.

2. Insurance benefits.

a. When the investigation of the patient's ability to pay discloses eligibility for insurance benefits, the patient shall be determined to be able to pay the cost of care provided to the full extent of insurance benefits available. The dollar amount of this coverage need not be specified in the determination order.

b. When the insurance benefits pay less than the per diem, the ability of the patient to pay the remaining part of the per diem shall be determined from the patient's net income and nonexcluded property.

3. Net income. The patient's entire net income remaining after the deductions from gross income have been made in accordance with E.4. shall be available to pay the cost of care and shall be converted to a daily amount.

4. Property. As long as the patient owns property not excluded under F., the patient shall be determined able to pay the full cost of care.

E. Net income; patient.

1. In kind income. The fair market value of in kind income included in the calculation of the patient's net income shall be established by any reliable means including, but not limited to, published reference documents, statements from merchants, or appraisals.

2. Lump sums. Lump sums, other than excluded property, shall be treated as income in the month received and thereafter shall be treated as property. The patient shall report the lump sum to the department within ten working days.

3. Seasonal income from business or farm. Average monthly amounts for gross income and the deductions allowed in 4. shall be used to calculate the net monthly income of farmers and other individuals who experience seasonal variations in income and business expenses.

4. Deductions from gross income to arrive at net income. The following items shall be deducted from the patient's monthly gross income:

a. State and federal income tax payments, including back assessments;

b. Payments made under the Federal Insurance Contributions Act and Supplemental Medical Insurance;

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c. Child care costs paid by the patient and not reimbursed from any source;

d. Support payments ordered by a court and actually paid. If this deduction is taken, the individual for whom support is paid shall not be included as a member of the patient's household in determining the monthly household living allowance in Exhibit 12 MCAR S 2.027 E.4.n.;

e. Guardianship fees;

f. Monthly payments on previously incurred bills for medical, dental and hospital care, car payments, house payments or rent, and utilities. The deduction allowed shall be the lesser of the sum of the actual monthly payments or $100 per month;

g. Personal expenses of employment, including mandatory retirement fund deductions, cost of transportation to and from work, work uniforms, union dues, dues of a professional association required for employment, and cost of tools and equipment used on the job. The amount deducted for costs of transportation to and from work shall be either the actual cost of public transportation or a per mile reimbursement as paid by the state to an employee using a personal car on state business for actual miles travelled;

h. Hospital and medical insurance premiums;

i. Business and farm expenses as reported on United States income tax returns. The cost of repairs and upkeep of income producing property which may be deducted shall be limited, on an annual basis, to two percent of the value of the property;

j. An allowance of $71 per month per boarder, $59 per month per roomer and $130 per month for each person who is both a roomer and boarder. This amount shall be updated periodically by the percentage the legislature authorizes for public assistance grants;

k. A personal needs and clothing allowance of the inpatient in the amount determined in accordance with Minnesota Statutes, section 256B.35 for persons receiving public assistance grants. In addition, a special personal allowance drawn solely from earnings from any productive employment under an individual plan of rehabilitation or work therapy shall be given to all patients in state hospitals. The special personal allowance shall not exceed $50 per month;

l. Sixty percent of the income earned from child care in one's own home or, if the patient chooses, the actual itemized business expenses incurred in providing child care subject to the limitations provided in B.1., B.2., and E.4.i.;

m. A housing allowance for inpatients. An inpatient

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without dependents living in his or her home shall be allowed the actual cost of his or her housing and utilities in the community for the month of admission and a period of three months of continuous hospitalization subsequent to that admission. An inpatient with dependents living in his or her home shall be allowed a pro rata share of his or her household's total actual housing costs during the month of admission and for a period of three months of continuous hospitalization subsequent to that admission. This housing allowance shall be available to the inpatient only twice in any one calendar year regardless of the number of times the patient is admitted to a state hospital in that calendar year;

n. A monthly household living allowance calculated according to the schedule in Exhibit 12 MCAR S 2.027 E.4.n.

Exhibit 12 MCAR S 2.027 E.4.n.

Number in Household	Monthly Household Living Allowance
1	$ 356
2	$ 534
3	$ 712
4	$ 890
5	$1,068
6	$1,246
over 6	$1,246 plus $178 for each additional person

The number in household of an inpatient shall be the number of dependents the patient claims. The number in household of an outpatient shall be the patient plus the number of dependents the patient claims. The housing allowance for the outpatient is included in the above budgets.

By July 1 of each year, the department shall adjust the monthly household living allowance to reflect the annual percentage change reported in the most recent consumer price index, for all urban consumers in the Minneapolis-St. Paul area. The consumer price index shall be as published by the Bureau of Labor Statistics, U.S. Department of Labor. The year 1967 is the "standard reference base period."

F. Property; patient. Property shall be available to pay for the cost of the patient's care to the extent owned by the patient, subject to the exclusions in 1.-6.

1. Real property.

a. The value of the patient's homestead shall be excluded from consideration as a resource if the patient remains in the hospital for less than 18 months, if the spouse or a minor child lives in it, or if it is rented while the patient is hospitalized.

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b. The value of real property owned by the patient which produces a net income shall be excluded from consideration as a resource. Real property which the patient is selling on a contract for deed and for which the patient receives payments shall be considered income producing property.

2. Personal property. The value of the following personal property shall be excluded from consideration as a resource:

a. The value of personal property other than stocks, bonds, and other investment instruments which is owned by the patient and which yields or contributes to the production of a net income, such as tools, farm implements, livestock, and business inventory and fixtures acquired prior to hospitalization;

b. Up to $2,000 in cash or liquid assets, for a single patient;

c. Up to $4,000 in cash or liquid assets, for a married couple;

d. Indian claim payments made by Congress to compensate for tribal land taken by the federal government;

e. Minnesota Housing Finance Agency loans for nine months after issuance;

f. One vehicle;

g. Household goods and furniture;

h. Clothing;

i. Mobile home used as a home by the patient or the patient's dependents;

j. Personal jewelry;

k. Bicycles;

l. Cameras;

m. Life insurance owned by the patient up to a cash surrender value of $1,500;

n. Trust funds. However trust funds are not excluded from consideration if the trustee is required or has discretion to use the funds for paying the cost of care or the funds are designated for care, support, maintenance, or medical care even if the trust requires that public funds must first be exhausted; and

o. Burial expenses, including a burial lot and a prepaid burial account up to $750 plus $200 accrued interest.

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3. Waiver of property as a resource.

a. The department shall waive consideration of property in excess of the exemptions when the patient's equity cannot be liquidated, the offered price is less than 80 percent of the market value given by two appraisers agreeable to both parties, or the cost of repairs necessary to meet the conditions of sale exceeds 35 percent of the offered price;

b. Each case shall be referred to the department's reimbursement division central office and decided on the merits of the facts recorded in the patient's financial information file to substantiate the circumstances;

c. The decision to waive the consideration shall be examined at least annually for changes in market value, opportunity for sale or mortgage, and other pertinent factors.

4. Transfer of property. The market value of any property transferred, less any value received, shall be treated as an available resource if the property is valued at more than $1,000 and if the transfer is for less than the market value and if the transfer is made:

a. During or after hospitalization in a state hospital; or

b. Prior to hospitalization in a state hospital, but with intent to avoid the use of the property to pay for hospital care or in determining ability to pay for hospital care; or

c. Prior to hospitalization in a state hospital but within 24 months of admission to the hospital.

5. Documentation required. When property described in 4. is transferred during the period between two years prior to admission to a state hospital and six years following discharge, the patient or the patient's representative shall provide documentation of the circumstances of the transfer.

6. Exemption. The provisions of 4. and 5. do not apply when the patient is not continuing to accrue charges and the full cost of care has been paid. The provisions of 4. and 5. do not apply to property excluded from consideration under other provisions of 12 MCAR S 2.027.

G. Ability to pay; responsible relative.

1. In general. When the patient is determined not to be able to pay the full cost of care, the department shall determine the ability of each responsible relative of the patient to pay the amount permitted by statute.

2. Interview. The responsible relative shall be interviewed to obtain and verify financial information.

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3. Insurance benefits. The responsible relative shall inform the department about dependent benefits from hospital and medical insurance carried by the relative.

a. Dependent benefits to a patient shall be considered the same as the patient's insurance.

b. Any difference between benefits to a patient and others covered by the responsible relative's policy shall be verified.

c. The responsible relative shall complete and sign the forms necessary to verify patient eligibility for benefits and assign benefits to pay the cost of care of the patient.

d. The amount of the premium paid by the responsible relative may be deducted from the responsible relative's total obligation to pay.

4. Liability of responsible relatives. When the sum of the benefits described in 3. and the patient's other resources pay less than the full cost of care, the ability of each responsible relative to pay shall be determined in the statutory order of liability for cost of care. When two or more responsible relatives have the same order of liability for cost of care, a determination shall be made for each one. This provision applies to parents of a minor child and to the adult children of a mentally ill patient.

5. Limitations on relative's ability to pay. The ability of a responsible relative to pay shall be determined from the annual gross earnings of the responsible relative subject to the limitations in a.-e.

a. A responsible relative who verifies annual gross earnings of less than $11,000 shall be determined not able to pay the cost of care.

b. No responsible relative who is a resident of Minnesota shall be ordered to pay more than ten percent of the cost of care for each patient.

c. The department shall require payment of the full cost of care for a child if the child's parents both live outside Minnesota and are financially able to pay as determined by G.7.

d. Only the annual gross earnings of the spouse of a patient shall be used to determine the spouse's ability to pay.

e. When a responsible relative is married to a person who is not a responsible relative, only the annual gross earnings of the responsible relative shall be used to determine the responsible relative's ability to pay.

6. Determination of relative's ability to pay.

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a. A responsible relative who provides the department a copy of the income tax return filed in the current year shall have his or her ability to pay determined from the table in Exhibit 12 MCAR S 2.027 G.7. For purposes of this table, household size consists of the responsible relative and the responsible relative's dependents living in the responsible relative's household, other than the patient.

b. A responsible relative who chooses not to provide the department a copy of the income tax return filed in the current year shall be assumed to have an income in excess of $11,000 and to be able to pay the statutory limit of ten percent of the cost of care. The relative shall be requested to sign an agreement to pay the balance of the patient's cost of care up to the ten percent limit.

7. Exhibit 12 MCAR S 2.027 G.7. shall be used to determine a relative's ability to pay, as described in 6.

Exhibit 12 MCAR S 2.027 G.7.

Daily Payment Based on Ability to Pay According to Household Size and Annual Gross Earnings of Responsible Relatives

Annual Gross Earnings of Responsible Relative	Household Size									
	1	2	3	4	5	6	7	8	9	10
11,000-11,999	.33	0								
12,000-12,999	.45	.33	0							
13,000-13,999	.57	.45	.33	0						
14,000-14,999	.72	.57	.45	.33	0					
15,000-15,999	.87	.72	.57	.45	.33	0				
16,000-16,999	1.05	.87	.72	.57	.45	.33	0			
17,000-17,999	1.23	1.05	.87	.72	.57	.45	.33	0		
18,000-										

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18,999	1.45	1.23	1.05	.87	.72	.57	.45	.33	0	
19,000-19,999	1.81	1.45	1.23	1.05	.87	.72	.57	.45	.33	0
20,000-20,999	2.26	1.67	1.45	1.23	1.05	.87	.72	.57	.45	.33
21,000-21,999	2.82	1.92	1.67	1.45	1.23	1.05	.87	.72	.57	.45
22,000-22,999	3.52	2.17	1.92	1.67	1.45	1.23	1.05	.87	.72	.57
23,000-23,999	4.41	2.45	2.17	1.92	1.67	1.45	1.23	1.05	.87	.72
24,000-24,999	5.51	3.06	2.45	2.17	1.92	1.67	1.45	1.23	1.05	.87
25,000-25,999	6.89	3.82	2.75	2.45	2.17	1.92	1.67	1.45	1.23	1.05
26,000-26,999	8.61	4.77	3.05	2.75	2.45	2.17	1.92	1.67	1.45	1.23
27,000-27,999	8.80	5.96	3.37	3.05	2.75	2.45	2.17	1.92	1.67	1.45
28,000-28,999	8.80	7.46	4.21	3.37	3.05	2.75	2.45	2.17	1.92	1.67
29,000-29,999	8.80	8.80	5.26	3.72	3.37	3.05	2.75	2.45	2.17	1.92
30,000-30,999	8.80	8.80	6.57	4.07	3.72	3.37	3.05	2.75	2.45	2.17
31,000-31,999	8.80	8.80	8.21	4.45	4.07	3.72	3.37	3.05	2.75	2.45
32,000-32,999	8.80	8.80	8.80	4.83	4.45	4.07	3.72	3.37	3.05	2.75
33,000-33,999	8.80	8.80	8.80	6.03	4.83	4.45	4.07	3.72	3.37	3.05
34,000-34,999	8.80	8.80	8.80	7.53	5.25	4.83	4.45	4.07	3.72	3.37
35,000-35,999	8.80	8.80	8.80	8.80	5.67	5.25	4.83	4.45	4.07	3.72
36,000-36,999	8.80	8.80	8.80	8.80	6.12	5.67	5.25	4.83	4.45	4.07
37,000-37,999	8.80	8.80	8.80	8.80	7.56	6.12	5.67	5.25	4.83	4.45
38,000-38,999	8.80	8.80	8.80	8.80	8.80	7.56	6.12	5.67	5.25	4.83
39,000-39,999	8.80	8.80	8.80	8.80	8.80	8.80	7.56	6.12	5.67	5.25
40,000-40,999	8.80	8.80	8.80	8.80	8.80	8.80	8.80	7.56	6.12	5.67
41,000-41,999	8.80	8.80	8.80	8.80	8.80	8.80	8.80	8.80	7.56	6.12
42,000-42,999	8.80	8.80	8.80	8.80	8.80	8.80	8.80	8.80	8.80	7.56
43,000-43,999	8.80	8.80	8.80	8.80	8.80	8.80	8.80	8.80	8.80	8.80

When the annual gross earnings exceed the amount shown in Exhibit 12 MCAR S 2.027 G.7., the daily payment shall be at the statutory limitation of ten percent of the per diem.

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8. Verification of financial information.

a. The annual gross earnings of a relative and the number of dependents of a relative shall be verified from the relative's Minnesota state income tax return or, in the case of a relative who is not a resident of Minnesota and does not file a Minnesota state income tax return, from the United States income tax return.

b. The amount of the premium paid by the relative to provide dependent hospital and medical insurance coverage for the patient shall be verified.

9. Clothing and personal needs allowance of a minor. The parents of a patient who is an unmarried, dependent child shall be responsible for meeting the patient's clothing and personal needs allowance in addition to the amount they are determined able to pay to meet the cost of care.

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CO6321

12 MCAR S 2.028 Community mental health services. This rule hereby repeals the existing Minnesota Rule, DPW Rule 28, effective March 10, 1961.

(a) This rule provides methods and procedures relating to the establishment and operation of area-wide comprehensive community-based, mental health-mental retardation-chemical dependency programs under state grant-in-aid as provided under Minnesota Statutes, sections 245.61 to 245.69. (Minnesota Statutes, sections 245.61 to 245.69 is entitled, The Community Mental Health Services Act. For purposes of this rule, community mental health services includes services to persons who have mental or emotional disorders or other psychiatric disabilities, mental retardation, and chemical dependency, including drug abuse and alcoholism.)

The community mental health board has the responsibility for ensuring the planning, development, implementation, coordination and evaluation of the community comprehensive mental health program for the mentally ill/behaviorally disabled, mentally retarded and chemically dependent populations in the geographic area it serves. It also has the responsibility for ensuring delivery of services designated by statute.

Rescinded 15K888 6-27-83

Rule 28 also sets forth definitions of community mental health centers and community mental health clinics. ~~The definitions of centers and clinics constitutes the standards for the commissioner's "approval" of a program for purposes of Laws of Minnesota 1975, chapter 89, which requires certain group insurance policies and plans to provide benefits to nonhospitalized persons for mental health diagnosis, treatment and consultation services.~~

(b) A community mental health center means an agency which includes all of the following:

(1) Established under the provision of Minnesota Statutes, sections 245.61 to 245.69.

(2) Provide as a minimum the following services for individuals having mental or emotional disorders, mental retardation, alcoholism, drug abuse, and other psychiatric conditions. The extent of each service to be provided by the center shall be indicated in the program plan, which is to reflect the problems, needs and resources of the community served.

(aa) collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, mental retardation, alcoholism, drug abuse and other psychiatric disorders.

(bb) informational and educational services to schools, courts, health and welfare agencies, both public and private.

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(cc) informational and educational services to the general public, lay and professional groups.

(dd) consultative services to schools, courts, and health and welfare agencies, both public and private.

(ee) out-patient diagnostic and treatment services.

(ff) rehabilitative services, particularly for those who have received prior treatment in an in-patient facility.

(3) Provides or contracts for detoxification, evaluation and referral for chemical dependency services (Minnesota Statutes, section 254A.08).

(4) Provides specific coordination for mentally ill/behaviorally disabled, mentally retarded, and chemical dependency programs. (Minnesota Statutes, sections 254A.07 and 245.61).

(5) Has a competent multidisciplinary mental health/mental retardation/chemical dependency professional team whose members meet the professional standards in their respective fields.

(6) The professional mental health team is qualified by specific mental health training and experience and shall include as a minimum, the services of each of the following:

(aa) a licensed physician, who has completed an approved residency program in psychiatry; and

(bb) a doctoral clinical, counseling, or health care psychologist, who is licensed under Minnesota Statutes, sections 148.87 to 148.99; and one or both of the following

(cc) a clinical social worker with a master's degree in social work from an accredited college or university; and/or

(dd) a clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. (The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health nursing with mental health major, maternal and child health with mental health major, etc.)

(7) The multidisciplinary staff shall be sufficient in number to implement and operate the described program of the center. In addition to the above, this team should include other professionals, paraprofessionals and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner. If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the center, provided that the board and director can show

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evidence acceptable to the commissioner that they are making sincere, reasonable and ongoing efforts to acquire such staff and show evidence of how the specialized functions of the required professionals are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

(c) A community mental health clinic is an agency which devotes, as its major service, at least two-thirds (2/3) of its resources for outpatient mental health diagnosis, treatment and consultation by a multidisciplinary professional mental health team. The multidisciplinary professional mental health team is qualified by special mental health training and experience and shall include as a minimum the services of each of the following:

(1) A licensed physician, who has completed an approved residency program in psychiatry; and

(2) A doctoral clinical, or counseling or health care psychologist who is licensed under Minnesota Statutes, sections 148.87 to 148.99; and one or both of the following

(3) A clinical social worker with a master's degree in social work from an accredited college or university; and/or

(4) A clinical psychiatric nurse with a master's degree from an accredited college or university and is registered under Minnesota Statutes, section 148.171. (The master's degree shall be in psychiatric nursing or a related psychiatric nursing program such as public health with a mental health major, maternal and child health with a mental health major.)

The multidisciplinary team shall be sufficient in number to implement and operate the described program of the clinic. In addition to the above, this team should include other professionals, paraprofessionals and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the commissioner.

If any of the minimum required professional staff are not immediately available, the commissioner may approve and make grants for the operation of the clinic, provided that the board and director can show evidence acceptable to the commissioner that they are making sincere, reasonable and ongoing efforts to acquire such staff and evidence of how the specialized functions of the required professional positions are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

(d) On or before the date designated by the commissioner, each year the chairman of the community mental health board or director of the community mental health program, provided for in Minnesota Statutes, section 245.62, shall submit an annual plan identifying program priorities in accordance with state grant-in-aid guidelines, and a budget on prescribed report forms

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for the next state fiscal year, together with the recommendations of the community mental health board, to the commissioner of public welfare for approval as provided under Minnesota Statutes, section 245.63.

(e) Other providers of community mental health services may affiliate with the community mental health center and may be approved and eligible for state grant-in-aid funds. The state funding for other community mental health services shall be contingent upon appropriate inclusion in the center's community mental health plan for the continuum of community mental health services and conformity with the state's appropriate disability plan for mental health, mental retardation or chemical dependency. Fiscal affiliates (funded contracting agencies) providing specialized services under contract must meet all regulations and standards that apply to the services they are providing.

(f) The program director of the community mental health program shall provide the commissioner of public welfare with such reports of program activities as the commissioner may require.

(g) All state community mental health funding shall go directly to the community mental health board or to a human service board established pursuant to Laws of Minnesota 1975, chapter 402, which itself provides or contracts with another agency to provide the community mental health program. Such programs must meet the standards and regulations for community mental health programs as enunciated in this rule in accordance with chapter 402.

(h) When the governing authority of the community mental health program operates other programs, services or activities, only the community mental health center program shall be subject to the regulations in this rule.

(i) New applications for state assistance or applications for renewal of support must be accompanied by an agreement executed by designated signatories on behalf of the participating counties that specifies the involved counties, the amount and source of local funds in each case, and the period of support. The local funds to be used to match state grant-in-aid must be assured in writing on DPW forms by the local funding authority(ies).

(j) Funds utilized by the director as authorized by the community mental health board to match a state grant-in-aid must be available to that director for expenditures for the same general purpose as the state grant-in-aid funds.

(k) The director of the community mental health program shall, within 20 days after the end of the quarter, submit quarterly prescribed reports to the commissioner of public welfare (controller's office), containing all receipts, expenditures, and cash balance, subject to an annual audit by

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the commissioner or his/her designee.

(l) Payments on approved grants will be made subsequent to the department's receipt of the program's quarterly reporting forms, unless the commissioner of public welfare has determined that funds allocated to a program are not needed for that program. Payments shall be in an amount of at least equal to the quarterly allocation minus any unexpended balance from the previous quarter providing this payment does not exceed the program grant award. In the event the program does not report within the prescribed time, the department will withhold the process of the program's payment until the next quarterly cycle.

(m) No fees shall be charged until the director with approval of the community mental health board has established fee schedules for the services rendered and they have been submitted to the commissioner of public welfare at least two months prior to the effective date thereof and have been approved by him/her. All fees shall conform to the approved schedules, which are accessible to the public.

(n) The commissioner of public welfare may make supplemental awards to the community mental health boards.

(o) The commissioner of public welfare may withdraw funds from any program that is not administered in accordance with its approved plan and budget. Written notice of such intended action will be provided to the director and community mental health board. Opportunity for hearing before the commissioner or his/her designee shall be provided.

(p) Community mental health boards may make budget transfers within specified limits during any fiscal year without prior approval of the department. The specified limit which can be transferred in any fiscal year between program activity budgets, shall be up to ten percent or up to $5,000 whichever is less. Transfers within an activity can be made into or out of line items with a specified limit of up to ten percent or up to $5,000 whichever is less. No line item can be increased or decreased by more than $5,000 or ten percent in a fiscal year without prior approval of the commissioner. Transfers above the specified limits can be made with prior approval from the commissioner. All transfers within and into program budget activities and/or line items must have prior approval by the community mental health board and this approval must be reflected in the minutes of its meeting, it must be reported to the commissioner with the reasons therefore, including a statement of how the transfer will affect program objectives.

(q) Budget adjustments made necessary by funding limitations shall be made by the commissioner and provided in writing to the director and board of the community mental health center.

(r) Every community mental health board receiving state funds for a community mental health program shall have a center director, who is the full-time qualified professional staff

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member who serves as the executive officer. To be considered qualified, the individual must have professional training to at least the level of graduate degree in his/her clinical and/or administrative discipline, which is relevant to MH-MR-CD and a minimum of two years experience in community mental health programs. The center director is responsible for the planning/design, development, coordination, and evaluation of a comprehensive, area-wide program and for the overall administration of services operated by the board.

The center director shall be appointed by the community mental health board and shall be approved by the commissioner of public welfare.

Repealed 7 SR 1858 6-27-83

~~(s) Within 30 days of receipt of an application for "approval status" as a center or clinic under Law of Minnesota 1975, chapter 89, the commissioner shall approve or deny the request.~~

The commissioner shall approve or deny, in whole or in part, an application for state financial assistance within 90 days of receipt of the grant-in-aid application or by the beginning of the state fiscal year, whichever is the later.

~~(t)~~ An appeal of the commissioner's denial of grant application or "approval" status as community mental health center or community mental health clinic under Law of Minnesota 1975, chapter 89, is available under the procedures set forth in the state Administrative Procedures Act, Minnesota Statutes, sections 15.01 et seq.

~~(u)~~ To assist the community mental health board in meeting its responsibilities as described in Minnesota Statutes, section 245.68 and to provide opportunity for broad community representation necessary for effective comprehensive mental health, mental retardation and chemical dependency program planning, each community mental health board shall appoint a separate advisory committee in at least the three disability areas of mental health, mental retardation and chemical dependency.

(1) The advisory committees shall consist of residents of the geographic area served who are interested and knowledgeable in the area governed by such committee.

(2) Nominations for appointments as members of the advisory committees are to be made to the community mental health board from agencies, organizations, groups, and individuals within the area served by the community mental health center. Appointments to the advisory committees are made by the community mental health board.

(3) One community mental health board member shall serve on each advisory committee.

(4) Each advisory committee shall have at least one-half of its membership composed of individuals who are not providers

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of services to the three disability groups.

(5) Membership of each advisory committee shall generally reflect the population distribution of the service delivery area of the community mental health center.

(6) The community mental health board shall appoint a chairperson for each advisory committee. The chairperson shall not be a community mental health board member nor a staff member. The power to appoint the chairperson may be delegated by the community mental health board to the individual advisory committee.

(7) Each advisory committee shall be directly responsible to the community mental health board. Direct communication shall be effected and maintained through contact between the chairperson of the particular advisory committee, or his/her designee, and the chairperson of the community mental health board, or his/her designee.

(8) Staff shall be assigned by the director to serve the staffing needs of each advisory committee.

(9) Each advisory committee may appoint study groups and task forces upon consultation with the community mental health board. It is strongly recommended that specific attention be given to the aging and children and youth populations.

(10) Each advisory committee shall meet at least quarterly.

(11) Each advisory committee must make a formal written and oral report on its work to the community mental health board at least annually.

(12) Each advisory committee shall submit copies of minutes of their meetings to the community mental health board and to the Department of Public Welfare (respective disability group program divisions).

(13) The advisory committees shall be charged by the community mental health board with assisting in the identification of the community's needs for mentally ill/behaviorally disabled, mental retardation and chemical dependency programs. The advisory committee also assists the community mental health board in determining priorities for the community programs. Based on the priorities, each advisory committee shall recommend to the community mental health board ways in which the limited available community resources (manpower, facilities and finances) can be put to maximum and optimal use.

(14) The advisory committee recommendations made to the community mental health board shall be included as a separate section in the grant-in-aid request submitted to the Department of Public Welfare by the community mental health board.

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(15) The advisory committees shall assist the community mental health board in assessing the programs carried on by the community mental health board, and make recommendations regarding the reordering of priorities and modifying of programs where necessary.

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Repealed 75R 1396
3-28-83

§ 2.030 Reimbursement for cost of care of mentally retarded or epileptic or emotionally handicapped children.

A. Pursuant to Minn. Stat., § 252.27, this rule governs the administration of reimbursement to county welfare boards and human services boards for the cost of boarding care outside state institutions for children who are mentally retarded or epileptic or emotionally handicapped.

B. Definitions: For the purpose of these regulations, the following definitions shall be used:

1. "Child or Children" shall mean a person under 18 years of age.

2. "Emotionally Handicapped Child" shall mean any child having a psychiatric or other emotional disorder which substantially impairs his mental health and who requires 24-hour treatment or supervision.

a. The determination of a psychiatric or other emotional disorder shall be the judgment of a psychiatric/mental health nurse with a master's degree, or social worker, or psychologist, or a consulting psychologist, or a psychiatrist.

b. Juvenile status offenses, such as the findings of juvenile delinquency, truancy, or runaway, shall not alone constitute a psychiatric or other emotional disorder.

c. A diagnosis of chemical dependency by reason of habitual and excessive use of intoxicating liquors, narcotics, or other drugs, shall not be the sole basis of a determination of a psychiatric or other emotional disorder.

3. "Mentally Retarded" shall mean any person who has been diagnosed mentally retarded consistent with the provisions of 12 MCAR § 2.185.

4. "Epileptic" means a person diagnosed as an epileptic by a licensed physician.

5. "State Agency" means the Commissioner of Public Welfare.

6. "County Agency" means county welfare boards and human services boards operating under and pursuant to the provisions of Minn. Stat. ch. 393 and 402.

7. "County of Financial Responsibility" means the county having the financial responsibility determined pursuant to Minn. Stat., § 256D.18.

8. "Social Worker" means any qualified person who is employed, whether on a full-time or part-time basis, to render professional social services to individuals, families, groups or communities.

9. "Cost of Care" includes all costs of the necessary care, treatment

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and training of the child that are appropriately provided in the boarding care facility. These shall include care, board and room, training and treatment, supervision, medical, and miscellaneous expenses which are an integral part of the child's individual program plan and which are nonreimbursable pursuant to § F. 5 of this rule.

10. "Parent" means a father or mother, natural or adoptive. It also includes legal guardian appointed where the natural or adoptive parents are deceased or where their parental rights have been legally terminated.

11. "Temporary Care" means the placement, in a licensed facility for purposes of diagnostic services or boarding care, of a mentally retarded or epileptic child requiring 24-hour care and treatment, for a temporary period of time not to exceed 90 days within a 12-month period of time.

C. Parental financial responsibility.

1. Parents shall be responsible for reimbursing the county making payments for cost of care. The amount of reimbursement shall be based on the annual gross income of the parents as adjusted by household size. The monthly amount to be paid by the parent shall be fixed by the following fee schedule:

	HOUSEHOLD SIZE								
	2	3	4	5	6	7	8	9	10
$11,000 to 12,999	$15	$10	$ 5	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
13,000 to 14,999	30	25	20	15	10	5	0	0	0
15,000 to 16,999	45	40	35	30	25	20	15	10	5
17,000 to 18,999	60	55	50	45	40	35	30	25	20
19,000 to 20,999	75	70	65	60	55	50	45	40	35
21,000 to 22,999	90	85	80	75	70	65	60	55	50
23,000 to 24,999	105	100	95	90	85	80	75	70	65
25,000 to 26,999	120	115	110	105	100	95	90	85	80
27,000 to 28,999	125	125	125	120	115	110	105	100	95
29,000 to 30,999	125	125	125	125	125	125	120	115	110
31,000 and Over	125	125	125	125	125	125	125	125	125

2. Annual Gross Income shall mean income, prior to any deductions, received from wages or salary; net income from self-employment; net farm income; Social Security payments; dividends, interest, rent received, or royalties; pensions and annuities; unemployment compensation; worker's compensation; alimony; child support; veteran's pensions; or any combination of the above sources of income.

3. The child in out of home care, the parents and other dependent children living in the parental home shall be counted as members of the household when determining the monthly fee to be charged to the financially responsible parent. Only one monthly fee shall be charged regardless of the number of children in out of home care from each household. No parents

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having a combined annual gross income of less than $11,000 shall be required to pay a fee. Parents may pay a greater amount. In addition to the monthly fee, parents shall be responsible for meeting the child's clothing and personal needs.

Exceptions.

(a) If the child has income or resources of his own, an amount not to exceed $30 per month from the child's income shall be used to meet the child's clothing and personal needs, and parents are relieved of this responsibility.

(b) If the parents' sole source of income is from receipt of Public Assistance, and the child has no income or resources of his own to meet his clothing and personal needs, $30 per month for clothing and personal needs may be charged to miscellaneous expenses under cost of care expenditures.

4. Parents shall cooperate with the county agency in matters pertinent to their child's eligibility for receipt of benefits under all federal programs and in efforts to recover insurance benefits. Third party reimbursements available to the parents on behalf of the child for costs incurred in training and treatment shall be paid to the county paying the cost of care.

5. In such cases where the child is placed in an Intermediate Care Facility for Mentally Retarded and is eligible under the Title XIX Medical Assistance Program, with a continuing spend-down requirement in excess of the parent's cost of care assessment pursuant to the cost of care fee schedule, the parent shall have the choice of applying for Title XIX or cost of care.

D. Child's financial responsibility.

1. If the child has unearned income or resources of his own, such as but not limited to Social Security, Supplemental Security Income (SSI), Veteran's Benefits, Railroad Retirement Benefits, Tribal Benefits, Military Serviceperson's Contributions, Union Benefits, or other retirement benefits, the parents, and/or the representative payee on behalf of the child, shall be responsible for reimbursing the county making payments for boarding care. Consistent with Minn. Stat. § 252.27, in no case shall the child be responsible to reimburse the county making payments for boarding care an amount greater than $125 per month. The amount paid by the child does not relieve the parents of their financial responsibility.

Exception: if the child has unearned income or resources of his own, an amount not to exceed $30 per month shall be excluded when determining the financial responsibility of the child to reimburse the county making payments for boarding care. This excluded $30 per month shall be allowed to meet the child's monthly clothing and personal needs.

2. If the child has earned income from employment, the county agency shall allow the following deductions from the child's net earnings:

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a. actual costs related to earnings, such as transportation to and from work, special uniforms and shoes if required by the employer;

b. $30 per month for clothing and personal need items;

c. one-third of the child's earnings, after the deductions provided above, shall be excluded;

d. the remaining balance of available net income of the child shall be paid to the county making payment for the cost of care. In no case shall this payment from earned income exceed $125 per month.

E. Individual program and services plan.

1. The county agency shall document in the child's case record a program and services plan for the child. This plan shall document:

a. that the child's residential, training, and treatment needs have been determined based on an evaluation of the child's capacities, his problems, and his needs considered in relationship to the family and community resources;

b. The reasons for removal of the child from the family home;

c. that the licensed facility selected for the child has a program plan directed toward meeting the child's needs;

d. the goals to be achieved within a specified period of time.

2. Continuance away from the family and the child's continued treatment needs shall be assessed annually and shall be recorded in the child's case record.

F. Reimbursement requirements. Cost of care reimbursement shall be made to a county agency for mentally retarded, epileptic, or emotionally handicapped children who meet the following requirements:

1. the child has been diagnosed as mentally retarded, epileptic or emotionally handicapped on the basis of criteria herein defined;

2. the child is under 18 years of age;

3. the child lives in or has legal settlement in the State of Minnesota;

4. the child's parent, as herein defined, resides in the State of Minnesota or pays Minnesota Income Taxes;

5. the child is ineligible for payment of all or part of his boarding care costs through other resources such as Medical Assistance (Title XIX), General Assistance Medical Care (GAMC), AFDC, Title XX, Division of Vocational

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Rehabilitation, local school district, insurance, and the child and the parent fees as defined in §§ C. and D. of this rule fail to cover the total cost of the boarding care. Reimbursement shall not be made for items reimbursed by other such programs or resources;

6. boarding care is provided in a licensed facility as herein defined;

a. for mentally retarded or epileptic children, the boarding care is provided in a facility licensed pursuant to 12 MCAR §§ 2.001 and 2.034;

b. for emotionally handicapped children, the boarding care is provided in a facility licensed pursuant to 12 MCAR §§ 2.005 and 2.008, and subject to the priorities contained in § H. 7. of this rule;

c. for mentally retarded, epileptic or emotionally handicapped children placed in out-of-state facilities, the county agency shall verify, through contact with the State Agency, that the out-of-state facility meets proper licensing and program requirements;

7. when a child is under such dual commitments as might both be reimbursable, the reimbursement shall be on the basis of the earlier commitment. For example, in the case of a state ward of the Commissioner of Public Welfare placed in 24-hour care, reimbursement shall be from the guardianship account;

8. a redetermination of eligibility for reimbursement has been completed at least annually and recorded in the case record;

9. the costs of care for mentally retarded, epileptic, or emotionally handicapped children shall be paid by the county of financial responsibility as herein defined. The rate to be paid for boarding care shall be negotiated between the county agency and the licensed facility where the child is placed, except where the State Agency sets rates under the provisions of 12 MCAR § 2.052. This agreed upon rate shall be reduced to writing in the form of a placement agreement signed by both parties. This placement agreement shall be filed in the child's case record and may be renewed or negotiated on an annual basis;

10. in cases of "temporary care", all provisions of this rule shall apply the same as if the child were in long-term placement. The day of admission and the day of discharge may be counted as a day of care and treatment;

11. if the local agency elects to pay the licensed facility or other vendors for nonreimbursable items, it shall be the responsibility of the local agency to recover those costs from sources other than the appropriations covered by this rule.

G. Provisions governing claims for reimbursement. Claims for reimbursement shall be processed in the following manner.

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a. actual costs related to earnings, such as transportation to and from work, special uniforms and shoes if required by the employer;

b. $30 per month for clothing and personal need items;

c. one-third of the child's earnings, after the deductions provided above, shall be excluded;

d. the remaining balance of available net income of the child shall be paid to the county making payment for the cost of care. In no case shall this payment from earned income exceed $125 per month.

E. Individual program and services plan.

1. The county agency shall document in the child's case record a program and services plan for the child. This plan shall document:

a. that the child's residential, training, and treatment needs have been determined based on an evaluation of the child's capacities, his problems, and his needs considered in relationship to the family and community resources;

b. The reasons for removal of the child from the family home;

c. that the licensed facility selected for the child has a program plan directed toward meeting the child's needs;

d. the goals to be achieved within a specified period of time.

2. Continuance away from the family and the child's continued treatment needs shall be assessed annually and shall be recorded in the child's case record.

F. Reimbursement requirements. Cost of care reimbursement shall be made to a county agency for mentally retarded, epileptic, or emotionally handicapped children who meet the following requirements:

1. the child has been diagnosed as mentally retarded, epileptic or emotionally handicapped on the basis of criteria herein defined;

2. the child is under 18 years of age;

3. the child lives in or has legal settlement in the State of Minnesota;

4. the child's parent, as herein defined, resides in the State of Minnesota or pays Minnesota Income Taxes;

5. the child is ineligible for payment of all or part of his boarding care costs through other resources such as Medical Assistance (Title XIX), General Assistance Medical Care (GAMC), AFDC, Title XX, Division of Vocational

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Rehabilitation, local school district, insurance, and the child and the parent fees as defined in § § C. and D. of this rule fail to cover the total cost of the boarding care. Reimbursement shall not be made for items reimbursed by other such programs or resources;

6. boarding care is provided in a licensed facility as herein defined;

a. for mentally retarded or epileptic children, the boarding care is provided in a facility licensed pursuant to 12 MCAR § § 2.001 and 2.034;

b. for emotionally handicapped children, the boarding care is provided in a facility licensed pursuant to 12 MCAR § § 2.005 and 2.008, and subject to the priorities contained in § H. 7. of this rule;

c. for mentally retarded, epileptic or emotionally handicapped children placed in out-of-state facilities, the county agency shall verify, through contact with the State Agency, that the out-of-state facility meets proper licensing and program requirements;

7. when a child is under such dual commitments as might both be reimbursable, the reimbursement shall be on the basis of the earlier commitment. For example, in the case of a state ward of the Commissioner of Public Welfare placed in 24-hour care, reimbursement shall be from the guardianship account;

8. a redetermination of eligibility for reimbursement has been completed at least annually and recorded in the case record;

9. the costs of care for mentally retarded, epileptic, or emotionally handicapped children shall be paid by the county of financial responsibility as herein defined. The rate to be paid for boarding care shall be negotiated between the county agency and the licensed facility where the child is placed, except where the State Agency sets rates under the provisions of 12 MCAR § 2.052. This agreed upon rate shall be reduced to writing in the form of a placement agreement signed by both parties. This placement agreement shall be filed in the child's case record and may be renewed or negotiated on an annual basis;

10. in cases of "temporary care", all provisions of this rule shall apply the same as if the child were in long-term placement. The day of admission and the day of discharge may be counted as a day of care and treatment;

11. if the local agency elects to pay the licensed facility or other vendors for nonreimbursable items, it shall be the responsibility of the local agency to recover those costs from sources other than the appropriations covered by this rule.

G. Provisions governing claims for reimbursement. Claims for reimbursement shall be processed in the following manner.

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1. The county agency shall, on a quarterly basis, and on a form prescribed by the State Agency, submit the following information regarding each child for whom a claim of reimbursement is made:

a. name of child;

b. birthdate of child;

c. child's social service eligibility code;

d. name of licensed facility;

e. period of out-of-home care covered;

f. expenditures for cost of care;

g. parent fee charged;

h. child fee charged;

i. date of latest determination of eligibility or board action;

j. amount of claim which shall be shown as the reimbursable expenditures minus fees charged to parent and child;

k. net claim which shall be shown as the amount of the claim less any applicable recoveries. Applicable recoveries shall include parent and child contributions in excess of the fees due, insurance payments, prior overpayments, canceled checks, and other receipts as specified by the county agency and approved by the State Agency.

2. The county agency shall apply recoveries in the following priority:

a. parent and child fees due;

b. reimbursable costs;

c. nonreimbursable costs.

3. The county agency shall submit this quarterly report to the State Agency within 15 days of the end of each quarter, specifically no later than October 15, January 15, April 15, and July 15. Quarterly claims shall include only expenditures for services provided during the current fiscal year. Retroactive rate increases shall be considered current expenditures in the fiscal year in which they are granted by the State Agency. By August 31, the county agency shall submit any claims for expenditures for services provided during the prior fiscal year not previously reported.

4. The State Agency shall determine the rate of reimbursement in the following manner:

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a. calculate total first quarter net reimbursable claims;

b. estimate total net claims for the year by multiplying the amount determined in "a." above by five;

c. for each account, established pursuant to § G. 6., divide the total appropriation by the estimate in "b." above;

d. reimburse the first, second, and third quarter net claims at the percentage determined in "c." within 45 days of the end of each quarter;

e. calculate total net claims for the year, the total allowable reimbursement, and make final settlement payments within 120 days of the close of the state fiscal year.

5. All local agencies shall be reimbursed at the same rate provided that reimbursement shall not exceed 70 percent of eligible costs claimed.

6. The State Agency shall maintain separate accounts for the Cost of Care appropriations: Cost of Care for Mentally Retarded/Epileptic; and Cost of Care for Emotionally Handicapped.

7. For purposes of the boarding care of emotionally handicapped children, facilities licensed under 12 MCAR § 2.008 shall be reimbursed only after cost of care expenditures of children in 12 MCAR § 2.005 licensed facilities have been reimbursed.

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§ 2.031 Organization and operation of daytime activity centers for the mentally retarded.

A. Minn. Stat., §§ 252.21 through 252.26, establishes the authority of the Commissioner of Public Welfare to make grants to licensed daytime activity centers for the mentally retarded, supervise the operation thereof, and establish such rules and regulations as are necessary to carry out the purpose of these statutes. These rules, therefore, carry the force and effect of law.

B. The terms used in this rule shall mean:

1. Commissioner—The Commissioner of Public Welfare.

2. Center—Daytime activity center for the mentally retarded.

3. Board—The governing body of the daytime activity center.

4. Director—The staff member appointed by the board to direct the activity center.

5. Applicant for grant-in-aid—Any city, village, town, county, or nonprofit corporation, or any combination thereof, may apply to the Commissioner of Public Welfare for assistance in establishing and operating a licensed daytime activity center program for mentally retarded.

6. Licensed daytime activity center—Those programs duly licensed and meeting requirements of 12 MCAR § 2.003 (Standards for Group Day Care, etc.).

C. Board.

1. There shall be a designated board for the center.

2. Where a private nonprofit corporation is the applicant for a grant, there shall be a minimum of nine members on the board. Representation shall be balanced among:

a. Parents of the retarded.

b. Professional persons interested in and having responsibility for services to the mentally retarded. These professional persons may be representative of local health, education, and welfare departments; medical societies; area mental health-mental retardation program offices; state hospitals serving the mentally retarded; and associations concerned with handicapping conditions.

c. Groups representing the community at large.

3. When the primary function of the applicant agency is to provide

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services other than a daytime activity center, the operation of the center shall be designated as a separate function, with a separate advisory board or committee, established for this purpose. This board shall conform with C.2. above. The operating rules of this board must be approved by the Commissioner. Separate bookkeeping records shall be established for the sole purpose of administering daytime-activity-center funds.

4. Each board shall submit copies of the minutes of all board meetings to the Commissioner. In addition, all centers shall submit such other reports as the Commissioner may require.

5. The daytime-activity-center board is responsible for cooperative planning with other agencies in the community, such as special education, sheltered workshops and vocational training, county welfare departments, and the area mental health-mental retardation program board.

6. On or before April 1 of each year, the board and the director shall submit to the Commissioner for approval an annual application and budget for the next fiscal year, using prescribed forms.

7. Each center board shall submit a statement of purposes and goals of the program to the Commissioner.

D. Finances.

1. New applications for state assistance and applications for renewal of support must contain the rationale for estimates of local income.

2. Any transfers by the boards that increase or decrease a major line item of the approved center budget by more than ten per cent, or $1,000, whichever is greater, must have the advance approval of the Commissioner.

E. Staff.

1. Every board shall appoint a director. Other personnel necessary to conduct the program shall be hired by the director with approval by the board. The director, or a staff member named by him, shall attend all regular meetings of the board of the center.

a. Minimum qualifications for the director shall be a bachelor's degree, with an appropriate major; however, a combination of training and experience approved by the Commissioner may be substituted for this requirement. (Other rules pertaining to subsequent required training are stated in 12 MCAR § 2.003.)

b. Written personnel practices, to include statements of duties, responsibilities, job specifications, and salary schedules for the director and other professional positions, shall be submitted to the Commissioner for approval prior to application for funding of these positions.

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c. Newly appointed center directors and staff shall take part in pre-service or in-service training, as designated by the Commissioner.

F. Admissions—Terminations.

1. The board and the director shall develop, and make available to the public, a statement of eligibility requirements for participants in the activities of the center. These requirements must be consistent with Minn. Stat., § 252.23. A copy shall be filed with the Department of Public Welfare.

a. There shall be no categorical exclusions on the basis of orthopedic and neurological handicaps, sight or hearing deficits, lack of speech, and severity of retardation, toilet habits, behavior disorders, or failure of participant to make progress, except where appropriate services are available to persons with such problems from other community agencies. Individual exclusions can be made when participation in the activities of the center would be clearly detrimental to the participant, staff, or others. When such exclusions are made, the reasons shall be entered into the record.

b. When an individual is refused admission to or excluded from a center, the parents or guardians shall be notified in writing of their right to appeal to the board, with final recourse to the Commissioner.

2. School-age mentally retarded children, as defined by Minn. Stat., § 120.03, and regulations of the State Board of Education, may be served by the center when:

a. A child is excluded, excused, or expelled from attendance in public schools under provisions of Minn. Stat., § 120.10, subd. 3 (1) and 4, and § 127.071, provided that the center board has verification of the fact that the proceedings called for in those sections have taken place and that approval of the Commissioner of Public Welfare is obtained.

b. Or, when it is not in the best interests of the child to initiate proceedings referred to in a. above, the child may be enrolled in the center; providing approval is obtained from the Commissioners of Education and Public Welfare.

3. Admissions procedures shall include a written application for services and reports of medical examinations, appropriate psychological examinations, and social evaluation.

a. All requests and applications for services shall be brought before the board or its admission committee. No applicant for service may be refused, nor may any participant currently receiving services from the center be excluded, without board approval and referral to the county welfare department.

b. A report shall be attached to the board minutes that shall include:

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(1) Names of applicants accepted.

(2) Names of applicants refused services, or participants terminated, and reasons for such action.

(3) Efforts made to assist those applicants not accepted, or excluded, to find other services.

G. Case records.

1. There shall be a record for each participant in the center, including:

a. Admissions information and statement of goals to be accomplished at the center.

b. Current medical and psychological information.

c. A plan for training, education, and treatment.

d. Periodic individual progress evaluations.

e. A plan for family involvement and conference records.

f. Referral and termination information.

H. Fee policy.

1. No fees shall be charged until the board has established a fee policy for the center. This policy shall be submitted to the Commissioner for approval at least one month prior to the effective date. In no case may a retarded person be excluded from enrollment or continued attendance because of inability to pay the approved fees.

2. The board shall take advantage of all income resources available to the center, including those to the retarded person, families, guardians, or referring agency. Such resources may include:

a. Local tax funds authorized.

b. Public welfare programs.

c. Federal Social Security insurance benefits.

d. Private insurance benefits.

e. Gifts and contributions.

f. Other appropriate resources.

3. When none of the aforementioned are determined adequate or avail-

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able, direct charges to parents shall not exceed the fee provisions of the center's approved policy.

I. If compliance with these rules is found to cause excessive hardship, to the extent that services will be curtailed or terminated, the board may apply to the Commissioner for an exception. Such an exception may not exceed one year, and its granting will not be considered a precedent for other center boards.

J. The effective date of this rule is July 1, 1971.

Effective Date—July 1, 1971.

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12 MCAR S 2.032 Department of Public Welfare rule for the licensing and operation of receiving center facilities for intoxicated persons.

(a) Minnesota Statutes, sections 245.78 to 245.82, establishes the authority of the commissioner of public welfare to license day-care and residential facilities and services for the inebriate and establish such rules, regulations, and guidelines as are necessary to carry out the purpose of the statute. These rules, therefore, carry the force and effect of law.

(b) The terms used in this rule shall mean:

(1) Commissioner - the commissioner of public welfare.

(2) Intoxicated person - an individual with markedly diminished physical and mental control as a consequence of drug or alcohol use.

(3) Triage - the process of sorting out the degree of health needs to determine the level of care required. This process is based on determining the priorities of needs and services to meet these needs.

(4) Continuum of care for inebriates:

(aa) Receiving center - a social rehabilitation setting that provides access to care, evaluation, counseling, information, and referral and rehabilitation through detoxification and the development of an individual comprehensive social service plan for persons who are ambulatory and free from severe physical and/or psychiatric complications. The facility shall be under medical supervision and have available the services of a licensed physician for medical emergencies.

(bb) Primary rehabilitation center - provides on a residential basis intensive rehabilitation services to chemically dependent persons who are free from marked physical problems or those who cannot benefit from outpatient programs.

(cc) Extended rehabilitation center - provides long-term assistance in major life style changes through therapeutic milieu with highly specialized and facilitative rehabilitation services; it is located near or connected to a short-term treatment or other mental health facility.

(dd) Halfway house - provides a program of re-socialization in the community. The service components combine didactic and group approaches with emphasis on mutual self-help and involvement of other community resources in assisting individuals to solve community transition problems.

(ee) Day care - provides a program to individuals

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living in the community who require pretreatment and/or post treatment planning, counseling and support. The primary objective is to maintain family ties and prevent future institutionalization.

(c) All receiving centers must be licensed by the department of public welfare and comply with rules of the Department of Health.

(1) Receiving centers operating prior to the effective date of this rule must comply to the rule provisions on its effective date.

(d) The receiving center shall submit those forms and reports required by the commissioner.

(e) Population served - those persons with alcohol or other drug intoxications (type may be specified by the receiving center) who are ambulatory and not in need of major emergency medical or psychiatric care as determined by the established triage. The receiving center shall also provide the individual with access to continuing care of rehabilitation services.

(f) Health management shall be provided by:

(1) Nursing staff, operating with the regime established by the contracting physician(s). Such staff shall be responsible for the actual surveillance of each client's physical condition. Written and signed standing orders on detoxification will be carried out by the individual(s) charged with health surveillance.

(2) Contracting physician(s), to be accountable for the provision of screening (triage), medical referral, and detoxification regimes. Each of these functions may be executed by an appropriately trained and/or experienced nurse. Provision of medical consultation will also be the responsibility of the contracting physician(s).

(3) Medical facilities, available by contract or formal agreement, for referral of clients in cases of acute health problems that are not amenable to the receiving center's program for both applicants and residents. The supporting facility will have available on a 24-hour basis the required space, equipment, and personnel for emergency care of the receiving center's clients. These supporting facilities shall be licensed by the state board of health.

(g) Staffing requirements are as follows:

(1) The receiving center is required to:

(aa) Provide for the services of at least one attending physician licensed by the state of Minnesota.

(bb) Have a senior staff person properly designated as

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accountable for the operation of the facility.

(cc) Have a registered nurse designated as director of nursing services. This does not preclude this person from also serving as the center director. Nurse coverage shall be provided by a registered nurse or a licensed practical nurse 24 hours per day whenever there are intoxicated persons in residence.

(dd) Have aid or orderly assistance on call in the proportion of one per each ten admissions that could be anticipated during any shift. There shall be at least one such person on duty whenever there are intoxicated persons in residence.

(ee) Have drug-dependency specialists or services of drug-dependency counselors provided at a minimum ratio of one per 15 residents.

(ff) Have services of a clerk typist and/or admitting clerk based on the number of residents served.

(2) Free-standing receiving centers of four beds or fewer may be operated under supervision of an area mental health board. For the purposes of this rule, such a facility shall be designated a receiving center-foster home. These receiving centers are required to:

(aa) Provide for the services of at least one attending physician licensed by the state of Minnesota.

(bb) Provide services of a registered nurse, available for admission interview and health-care management.

(cc) Provide at least one staff person on duty whenever intoxicated persons are in residence.

(dd) Have a trained counselor available.

(h) A uniform record form established by the department of public welfare must be maintained on each intoxicated person admitted for service.

(1) The receiving center license application shall include a copy of the program plan, triage, admission policies, and physician's standing orders. The commissioner shall also be notified of any subsequent change in the above.

(i) Maximum involvement of a wide range of helping agencies and volunteers in the community is required of the receiving center as support services to its residents. Prior to a resident's discharge, one or more staff members shall confer or consult with him in an effort to help him evaluate his problem of inebriety or dependence on alcohol, narcotics, or other drugs and also to assist him in getting into a meaningful follow-up program that offers help toward recovery from chemical

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dependency. Since the receiving center represents only one element in the social rehabilitation of inebriates, formal agreements shall be initiated with other community resources outlining in detail the coordination of follow-up services.

(j) The building in which the receiving center is housed shall conform to the state building code and fire safety code of either the state or the unit of government in which it is located.

(k) Furnishings and equipment for care are as follows:

(1) Each resident shall be provided with a comfortable and suitable bed. Clean bedding and bed linen shall be kept on hand for use at all times. Clean sheets and pillow cases shall be furnished with each new admission. The bed linen shall be changed whenever soiled or unsanitary. Waterproof sheeting or other moisture-proof protection shall be provided for mattresses as necessary.

(2) First-aid supplies shall be maintained in a place known to and readily available to all personnel responsible for the health or well-being of residents. Separate locked cabinets within the nursing supply area shall be made available for drugs and similar supplies.

(l) Day-room facilities of sufficient area for recreation, visiting, therapy, and other such purposes shall be provided and shall be available for residents and for visitors.

(m) Food service and general sanitation shall meet requirements of the State Board of Health regulations for food and beverage establishments.

(n) The receiving center financing plan and fee policies shall be submitted for approval to the commissioner when the license application is made. Subsequent changes shall be submitted to the commissioner for approval.

(o) The local share of receiving center costs for service to intoxicated persons from nonaffiliating or noncontracting counties shall be paid by the county welfare department of legal settlement. When legal settlement is determined to be in other than a contracting county, the county of responsibility must be notified within three working days following admission to the receiving center. The local share of cost for providing services to intoxicated persons not having legal settlement in the state of Minnesota shall be prorated among counties contracting with the receiving center.

(p) Each application and reapplication for a license to operate a receiving center, within the meaning of sections (b)(4)(aa) and (g)(2) shall be accompanied by a fee to be determined by the number of beds available for persons accommodated: those with four or less beds shall pay a fee of $25; those with five or more and fewer than 50 beds shall pay a

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fee of $75; those with 50 beds or more shall pay a fee of $150. No such fee shall be refunded. All licenses shall be effective for a 12-month period, with annual reapplication. An application for renewal of a license shall be filed at least 30 days prior to expiration date. All such fees received by the state Department of Public Welfare shall be paid into the state treasury.

(q) If compliance with these rules is found to cause excess hardship, to the extent that services will be curtailed or terminated, the receiving center may apply to the commssioner for an exception. Such an exception willbe reviewed annually and its granting will not be considered a precedent for other receiving centers.

(r) Effective date of this rule is January 1, 1972.

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12 MCAR S 2.034 Standards for the operation of residential programs and services for persons who are mentally retarded.

A. General provisions.

1. Scope.

a. This rule governs the operation of any residential program engaged in, or seeking to engage in, the provision of residential or domiciliary service for mentally retarded individuals, and it sets forth the requirements necessary for such a residence to be licensed.

b. Cost of boarding care outside of home or state institution is reimbursable by the state for care of children under 18 years of age in facilities licensed by the Department of Public Welfare. All participating facilities serving more than four mentally retarded children must be licensed under these regulations prior to participation.

c. Federal programs under the Social Security Act, as amended, require certification of participating facilities. All participating facilities serving more than four mentally retarded persons must be licensed under these regulations prior to certification.

2. Purpose.

a. The purpose of this rule is to establish the minimum standards for the operation of residential programs and services for mentally retarded persons residing in licensed supervised living facilities.

b. The purpose of Minnesota Statutes, section 252.28 and this rule is to establish and protect the human right of mentally retarded persons to a normal living situation, through the development and enforcement of minimum requirements for the operation of residential programs. Moreover, this rule serves an educational purpose in providing guidelines for quality service.

3. Statutory basis.

a. Minnesota Statutes, section 256.01 charges the commissioner of public welfare with general responsibility for service to mentally retarded persons.

b. Minnesota Statutes, section 245.072 creates a mental retardation division in the Department of Public Welfare to "coordinate those laws administered and enforced by the commissioner of public welfare relating to mental retardation and mental deficiency which the commissioner may assign to the division."

c. Minnesota Statutes, section 252.28 charges the

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commissioner of public welfare with the responsibility for licensing of residential facilities and services for mentally retarded persons.

4. Procedure for licensing.

a. Application shall be made to the commissioner of public welfare, who may determine the need, location, and program of facilities and services seeking to be licensed or relicensed under these regulations. In making this determination, the commissioner shall be guided by this rule and other state agency rules promulgated under Minnesota Statutes, section 252.28, subdivision 1., including 12 MCAR S 2.185.

b. Applicants shall submit such materials and information as may be required to make a proper determination of the nature and adequacy of the residential program to be provided.

c. Applicants must have, or have applied for, a supervised living facility license from the state Department of Health, Minn. Reg. MHD 391-401; and, in the case of a commissioner approved extension of the residential program for family homes of four or fewer residents, a foster home license or certification from the Department of Public Welfare.

d. A residential program desiring to renew its license shall submit an application at least 45 days prior to expiration of the license. A renewal license may be issued for a period of up to two years at the discretion of the commissioner.

e. Provisional license shall be granted by the commissioner under terms of Minnesota Statutes, section 245.783, subdivision 3.

f. A residential program may request in writing a variance of a specific provision of the rule. The request for a variance must cite the provision of the rule in question, reasons for requesting the variance, the period of time not to exceed one year the licensee wishes to have the provision varied and the equivalent measures planned for assuring that programmatic needs of residents are met. Variances granted by the commissioner shall specify in writing the time limitation and required equivalent measures to be taken to assure that programmatic needs are met. Variances denied by the commissioner shall specify in writing the reasons for the denial. No variance shall be granted that would threaten the health, safety or rights of residents.

5. Refusal or revocation of license.

a. Failure to comply with these regulations or applicable state laws shall be cause for refusal or revocation of license.

b. Failure to be licensed as a supervised living

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facility by the Minnesota Health Department (Chapter Twenty-Three: MHD 391-401, or its successor) shall be cause for refusal or revocation of license.

c. Revocation, suspension or denial of a license may be appealed pursuant to Minnesota Statutes, chapter 15.

6. Definitions.

a. Ambulatory - The ability to walk independently and at least negotiate any barriers, such as ramps, stairs, corridors, doors, etc., without assistance as may be necessary to get in and out of the facility.

b. Executive officer - The individual appointed by the governing body (see below) of a residential program to act in its behalf in the overall management of the facility. Job titles may include, but are not limited to, superintendent, director and administrator.

c. Governing body - The policy-making authority, whether an individual or a group, that exercises general direction over the affairs of a residential program and establishes policies about its operation and the welfare of the individuals it serves. The governing body is responsible for the operation of the residential program and for compliance with this rule.

d. Interdisciplinary team - A team consisting, at a minimum, of the resident, the resident's legal guardian (if any), local social service agency representative and the program director or program staff member. Other persons relevant to a particular resident's needs may be included. The interdisciplinary team is responsible for the development and evaluation of the resident's individual program plan and determination of need for the residential program.

e. Legal incompetence - The legal determination that a resident is unable to exercise his full civil and legal rights and that a guardian (see parent below) is required.

f. Living unit - A resident-living unit that houses the primary living group (see below) and provides access to bedroom, living room, recreation/activity room, dining room, kitchen, and bathroom.

g. Living unit staff - Individuals who conduct the resident-living program; resident-living staff.

h. May - Indicates that the provisions or practices stated in this rule are permitted.

i. Mental retardation - Refers to persons who have been diagnosed as having significantly subaverage intellectual functioning existing concurrently with demonstrated deficits in adaptive behavior, and manifested during the developmental

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period.

j. Mobile - Ability to move independently from place to place with the use of devices such as walkers, crutches, wheelchairs, wheeled platforms, etc.

k. Multiple-handicapped - In addition to mental retardation, an orthopedic, incoordinative, or sensory disability that culminates in significant reduction of mobility, flexibility, coordination, or perception and that interferes with an individual's ability to function independently.

l. Nonambulatory - Inability to walk independently.

m. Nonmobile - Inability to move independently from place to place.

n. Normalization principle - The principle of letting persons who are mentally retarded obtain an existence as close to the normal as possible, making available to them patterns and conditions of everyday life that are as close as possible to the norms and patterns of the mainstream of society.

o. Parent - The general term used in this rule to refer to the natural parent, or other person who fills the legal or social role of the natural parent (i.e., represents the rights and interests of the mentally retarded persons as if they were his own). May include an advocate as one who acts on behalf of a resident to obtain needed services and the exercise of his full human and legal rights; legal guardian as one appointed by a court; guardian of the person as one appointed to see that the resident has proper care and protective supervision in keeping with his needs; guardian of the property as one appointed to see that the financial affairs of the resident are handled in his best interests; guardian ad litem as one appointed to represent a resident in a particular legal proceeding; public guardian as a public official empowered to accept court appointment as a legal guardian (i.e., the commissioner of public welfare or his agent); or testamentary guardian as one designated by the last will and testament of a natural guardian.

p. Primary-living group - That group characterized by face-to-face relations that are personal, spontaneous, and typically (although not necessarily) long lasting. Members of a primary group are drawn together by the intrinsic value of the relations themselves rather than by a commitment to an explicit goal. The family is an example of a primary group.

q. Program - The general term used in this rule to refer to all people, events, and environments that lead to a purposeful outcome (goal or objective) for the individual resident. These programs include, but are not limited to, training and maintenance of the individual; the design, furnishing, and use of space; staff and staffing patterns; and professional and volunteer services.

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r. Resident - The general term used in this rule to refer to an individual who receives service in a residential program (see below), whether or not such individual is actually in residence in the facility. The term thus includes individuals who are being considered for residence in a facility and individuals who were formerly in residence in a facility. (A residential program, on the other hand, may use the term "resident" to refer only to those individuals actually in residence.)

s. Referring agency - The general term used in this rule to refer to the local social service agency responsible for establishment and implementation of case management plans for individuals and particular families with mental retardation problems and for the provision of specific financial or case-work services to these individuals and families. In Minnesota, the county board is charged with administrative responsibility for these duties. Responsibility for these duties may be delegated to the local social service agency.

t. Resident-living - Pertaining to residential or domiciliary services.

u. Residential program - A general term used in this rule to refer to the program of services to residents of a supervised living facility or of a licensed or certified foster home approved by the commissioner as an extension of the residential program which has an administrative organization and/or structure for the purpose of providing care, food, lodging, training, supervision, habilitation and treatment as needed for more than four mentally retarded individuals on a 24-hour per day basis. Residential programs may also be known as, but are not limited to group homes, child-caring institutions, boarding-care homes, nursing homes, state hospitals, public institutions, and regional centers.

v. Restraint - Any physical device that limits the free and normal movement of body or limbs. Chemical substances administered for the purpose of controlling maladaptive behavior are deemed restraints. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered restraints.

w. Rhythm of life - Relating to the normalization principle (see above), under which making available to mentally retarded persons patterns and conditions of everyday life that are as close as possible to the norms and patterns of the mainstream of society means providing a normal rhythm of the day (in relation to arising, getting dressed, participating in play and work activities, eating meals, retiring, etc.) normal rhythm of the week (differentiation of daily activities and schedules), and normal rhythm of the year (observing holidays, days with personal significance, vacations, etc.).

x. Seclusion - Involuntary removal from social contact with others, in a separate room.

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y. Shall - Indicates that the requirement, provision, or practice stated in this rule is mandatory.

z. Supervised living facility - A general term used in this rule to refer to the facility licensed by Minnesota Health Department, in accordance with Minnesota Statutes, section 144.56 (1971).

aa. Time-out - Time out from positive reinforcement. A behavior modification procedure in which, contingent upon the emission of undesired behavior, the resident is removed from the situation in which positive reinforcement is available.

B. The resident-living unit.

1. Grouping and organization of living units.

a. The resident-living unit (subsequently called living unit) shall be small enough to ensure the development of meaningful interpersonal relationships among residents and between residents and staff.

(1) The living unit is that unit which houses the primary living group. It may be a group home, foster home, ward, wing, floor, etc.

(2) The living unit shall contain bedroom, living room, bathroom, recreation room, and connecting areas. It may contain dining room and kitchen. Facilities with more than four mentally retarded persons in residence on November 17, 1972 shall be deemed to be in substantial compliance with this provision, except that the living unit shall contain bedroom and living room areas.

(3) The living unit shall be physically, socially and functionally differentiated from areas for developmental and remedial services (see part C. of this rule) and shall simulate the arrangements of a home in order to encourage a personalized atmosphere for residents.

(4) The size of the living unit shall be based upon the needs of the residents, but the living unit shall provide for not more than 16 residents.

b. The living unit or complex of such units shall house both male and female residents to the extent that this conforms to the prevailing cultural norms and unless contraindicated by program plan. Such living arrangements shall include provision for privacy and for appropriate separation of male and female residents.

c. The living unit shall not be a self-contained program unit unless contraindicated by program plans of the particular residents being served, and living unit activities shall be coordinated with developmental and remedial services in which residents engage outside the living unit.

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d. Residents shall be allowed free use of all space wihin the living unit, with due regard for privacy and personal possessions.

e. Each resident shall have access to a quiet, private area where he can withdraw from the group.

f. Outdoor active play or recreation areas shall be readily accessible to all living units.

g. Interior and exterior doors shall not be locked except to protect the resident from clear and present danger, or in conjunction with a behavior modification program (see part B.3.i. of this rule). In no case shall locked doors be a substitute for program or staff interaction with residents.

2. Physical plant.

a. Design.

(1) The living unit shall be physically self-contained. Walls defining the living unit shall extend from floor to ceiling.

(2) The interior design of the living unit shall simulate the functional arrangements of a home to encourage a personalized atmosphere for a small group of residents unless it has been demonstrated that another arrangement is more effective in maximizing the development of specific residents being served.

(a) Space shall be arranged to permit residents to participate in different kinds of activities, both in groups and singly.

(b) Space shall be arranged to minimize noise and permit communication at normal conversation levels.

(c) Walls defining each room in the living unit shall extend from floor to ceiling.

(3) Bedrooms shall accommodate from one to four residents.

(4) Door to bedrooms:

(a) Shall not have vision panels.

(b) Shall not be capable of being locked, except where residents may lock their own bedroom doors, as consistent with their program.

(5) There shall be provision for residents to mount pictures on bedroom walls.

(6) Space outside the bedroom shall be provided for equipment for daily out-of-bed activity for all residents not

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yet mobile, except those who have a short-term illness or those for whom out-of-bed activity is a threat to life.

(7) Toilet areas shall be located in such places as to facilitate training toward maximum self-help by residents.

(a) Water closets, showers, bathtubs, and lavatories shall approximate normal patterns found in homes, unless specifically contraindicated by program needs.

(b) Toilets, bathtubs, and showers shall provide for individual privacy unless specifically contraindicated by program needs.

b. Furnishings and equipment.

(1) Furnishings shall be appropriate to the physiological, emotional and developmental needs of each resident.

(2) Dining areas shall:

(a) Be furnished to stimulate maximum self-development, social interaction, comfort, and pleasure.

(b) Promote a pleasant and home-like environment and be attractively furnished and decorated and of good accoustical quality.

(c) Be equipped with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident.

(3) Each resident shall have access to drinking water in the living units.

(4) Equipment shall be provided for toilet training, as appropriate, including equipment for use by the multiple-handicapped.

c. Safety.

(1) Residents shall receive appropriate instruction in safety precautions and procedures.

(2) First-aid equipment, approved by a physician, shall be maintained on the premises in a readily available location, and staff shall be instructed in its use.

(3) Applicable requirements of the state fire marshal or his agent shall be met.

3. Staff-resident relationships and activities.

a. The objective in staffing each living unit shall be to maintain reasonable stability in the assignment of staff,

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thereby permitting the development of a consistent interpersonal relationship between each resident and one or two staff members. Provisions shall be made to ensure that the efforts of the staff are not diverted from these responsibilities by excessive housekeeping and clerical duties, or other nonresident-involved activities.

b. The primary responsibility of the living-unit staff shall be to devote their attention to the care and development of the residents.

(1) Living-unit staff shall be responsible for the development and maintenance of a warm, family, or home-like environment that is conducive to the achievement of optimal development by the resident.

(2) Living-unit staff shall train residents in activities of daily living and in the development of self-help and social skills.

c. Living-unit staff shall participate in assessment, program planning, and evaluation activities relative to the development of the resident (see part C. of this rule). A program plan for each resident shall be available to staff in each living unit.

d. The rhythm of life in the living unit shall resemble the cultural norm for the residents' nonretarded age peers unless a departure from this rhythm is justified on the basis of maximizing the residents' human qualities.

(1) Residents shall be assigned responsibilities in the living units commensurate with their interests, abilities, and program plans, in order to enhance feelings of self-respect and to develop skills of independent living.

(2) Multiple-handicapped and nonambulatory residents shall:

(a) Spend a major portion of their waking day out of bed.

(b) Spend a major portion of their waking day out of their bedroom areas.

(c) Have planned daily activity and exercise periods.

(d) Be rendered mobile by various methods and devices.

(3) All residents shall have planned periods out-of-doors on a year-round basis.

(4) Except as limited by program plan, residents shall be instructed in how to use, and shall be given

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opportunity for freedom of movement.

(5) Birthdays and special events should be individually observed.

e. Residents' views and opinions on matters concerning them shall be elicited and given consideration in defining the processes and structures that affect them.

f. Residents shall be instructed in the free and unsupervised use of communication processes. Except as denied individual residents by program plan, this may include:

(1) Having access to telephones for incoming and local outgoing calls.

(2) Having access to pay telephone, or the equivalent, for outgoing long distance calls.

(3) Opening their own mail and packages and generally doing so without direct surveillance.

(4) Not having their mail read by staff, unless requested by the resident.

g. Residents shall be permitted personal possessions, such as toys, books, pictures, games, radios, arts and crafts material, religious articles, toiletries, jewelry, and letters.

h. Regulations shall permit normal possession and use of money by residents.

(1) Residents shall be trained in the use of money.

(2) Allowance or opportunities to earn money shall be available to residents.

i. There shall be provisions for prompt recognition of behavior problems, as well as appropriate management of behavior in the living unit. These provisions shall be subject to review by a research, review, and/or human rights committee (see E.2.d.(2) of this rule).

(1) There shall be a written statement of policies and procedures for the control and discipline of residents that:

(a) Is directed to the goal of maximizing the growth and development of the residents.

(b) Is available in each living unit.

(c) Is available to parents.

(d) Provides for resident participation, as appropriate, in the formulation of such policies and procedures.

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(2) Corporal punishment shall not be permitted.

(3) Residents shall not discipline other residents, except as part of an organized self-government program that is conducted in accordance with written policy.

(4) Restraint shall be employed only when absolutely necessary to protect the resident from injury to himself or to others; and restraint and seclusion shall not be employed as punishment, for the convenience of staff, or as a substitute for program.

(a) The facility shall have a written policy that defines the uses of restraint, the staff members who may authorize its use, and a mechanism for monitoring and controlling its use.

(b) This policy shall be available in each living unit.

(c) Totally enclosed cribs and barred enclosures shall be considered restraints.

(5) Each use of restraint and seclusion shall be recorded in the resident's record. This record shall include:

(a) A description of the precipitating behavior.

(b) Expected behavioral outcome.

(c) Actual behavioral outcome.

(6) Rooms used for seclusion:

(a) Shall be furnished with a bed and bedding, a chair, a commode, and a lavatory.

(b) Shall afford proper access to drinking water.

(7) Chemical restraint shall not be used excessively, as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with a resident's program. Each use of a behavior-controlling drug shall be recorded in the resident's record. This record shall include:

(a) A description of the behavior to be modified.

(b) Expected behavioral outcome.

(c) Possible side or secondary effects.

(d) Date for review or termination.

(e) Actual behavioral outcome.

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(8) Behavior modification programs involving the use of time-out devices or the use of noxious or aversive stimuli shall be conducted only with the consent of the affected resident's parent and shall be described in written plans that are kept on file in the facility.

4. Health, hygiene, and grooming.

a. General.

(1) Procedures shall be established for:

(a) Monthly weighing of residents, with greater frequency for those with special needs.

(b) Quarterly measurement of height, until the age of maximum growth.

(c) Maintenance of weight and height records. Every effort shall be made to ensure that residents maintain normal weights.

(2) Provisions shall be made to furnish and maintain in good repair, and to train residents in the use of, dentures, eyeglasses, hearing aids, braces, etc., prescribed by appropriate specialists.

b. Residents shall be trained to exercise maximum independence in health, hygiene, and grooming practices, including bathing, brushing teeth, shampooing, combing and brushing hair, shaving, and caring for toenails and fingernails.

(1) Each resident shall be assisted in learning normal grooming practices with individual toilet articles that are appropriately available to that resident.

(2) Living unit staff shall be instructed in each resident's daily oral care program and shall be responsible to see that it is carried out.

(a) Whenever possible, the resident shall be instructed in, and learn to carry out, his own program of daily oral care.

(b) Dental care practices should include the use of newer equipment, such as electric toothbrushes and oral water irrigators or lavages as prescribed.

(c) Individual brushes shall be properly marked, used, and stored.

(d) Teeth shall be brushed daily with dentifrice.

(3) Hair cutting and styling, in an individualized manner consistent with current style, shall be accessible to all residents.

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(4) For residents who require such assistance, cutting of toenails and fingernails by trained personnel shall be scheduled at regular intervals.

(5) Each resident shall have a shower or tub bath as needed.

(a) Residents' bathing shall be conducted at the most independent level possible.

(b) Residents' bathing shall be conducted with due regard for privacy.

(c) Individual washcloths and towels shall be used.

(6) Female residents shall be helped to attain maximum independence in caring for menstrual needs. Menstrual supplies shall be of the same quality and diversity available to all women.

c. Residents shall be instructed in the use of drinking units.

(1) Those residents who cannot use the unit shall be given the proper daily amount of fluid at appropriate intervals adequate to prevent dehydration.

(2) A drinking unit shall be available to, and usable by, mobile nonambulatory residents, as needed.

(3) Special cups and noncollapsible straws shall be available when needed by the multiple-handicapped.

(4) If the drinking unit employs cups, only single-use, disposable types shall be used.

d. Every resident who does not eliminate appropriately and independently shall be engaged in a toilet training program. Residents who are incontinent shall be immediately bathed or cleansed, upon voiding or soiling unless specifically contraindicated by a plan for toilet training; and all soiled clothing shall be changed.

5. Clothing.

a. Each resident shall have an adequate allowance of neat, clean, fashionable, and seasonable clothing.

(1) Each resident shall have his own clothing that is, when necessary, inconspicuously marked with his name, and he shall use this clothing.

(2) Such clothing shall make it possible for residents to go out of doors in inclement weather and to make a normal appearance in the community.

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(3) Nonambulatory residents shall be dressed daily in their own clothing, including shoes, unless contraindicated by program plan.

(4) Washable clothing shall be designed for multiple-handicapped residents being trained in self-help skills.

(5) Clothing for incontinent residents shall be designed to foster comfortable sitting, crawling and/or walking, and toilet training.

b. Residents shall be trained and encouraged to:

(1) Select and purchase their own clothing as independently as possible, preferably utilizing community stores.

(2) Select their daily clothing.

(3) Dress themselves.

(4) Change their clothes to suit the activities in which they engage.

(5) Maintain (launder, clean, and mend) their clothing as independently as possible.

6. Food service.

a. Food services shall recognize and provide for the physiological, emotional, cultural and developmental needs of each resident.

(1) There shall be a written statement of goals, policies, and procedures that governs food service.

(2) The diet provided shall include foods that stimulate chewing, unless contraindicated by program plan.

b. Residents shall have opportunity to be trained and participate in food preparation and service.

c. All residents, including the mobile nonambulatory, shall eat or be fed in dining rooms, except when contraindicated by program plan.

(1) All residents, including the mobile nonambulatory, shall eat at a table.

(2) Dining arrangements shall be based upon a plan to meet the needs of the residents and the requirements of their programs.

(a) Dining and serving arrangements shall provide for a variety of eating experiences (e.g., cafeteria and family style), and, when appropriate, for the opportunity to make food selections with guidance.

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(b) Unless justified on the basis of meeting the program needs of the particular residents being served, dining tables shall seat small groups of residents (typically four to six at a table) and include both sexes.

(3) Dining rooms shall be supervised and staffed for the direction of self-help eating procedures and to ensure that each resident receives an adequate amount and variety of food.

(4) Staff members shall be encouraged to eat with those residents who have semi-independent or independent eating skills.

(5) For residents not able to get to dining areas, food service practices shall permit and encourage maximum self-help and shall promote social interaction and a pleasant mealtime experience.

d. Residents shall be provided with systematic training to develop eating skills, utilizing adaptive equipment when it serves the developmental process.

(1) A plan for the remediation of eating problems shall be implemented for all residents with special disabilities. This plan shall be consistent with the individual's developmental needs.

(2) Living-unit staff shall be trained in and shall utilize proper feeding techniques when a resident must be fed.

(a) Residents shall be fed in an upright position.

(b) Residents shall be fed in a manner consistent with their developmental needs (for example, infants shall be fed in arms).

(c) Residents shall be fed at normal consumption rates, and the time allowed for eating shall be such as to promote the development of self-feeding abilities, to encourage socialization, and to provide a pleasant mealtime experience.

C. Developmental and remedial services.

1. General provisions.

a. In addition to resident-living services detailed in B. of this rule, residents shall be provided with developmental and remedial services called for by individual assessment and program plan. These services may be provided in two ways:

(1) Within the facility and by staff employed by the residential program, except that developmental services, as here defined, shall not be provided in the living unit unless contraindicated by the assessed needs of the particular residents being served.

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(2) Outside of the facility and by agreement between the facility and other agencies or persons.

b. All developmental and remedial services, as here defined, shall be rendered outside of the facility, whenever possible, and when rendered in the facility, such services must be at least comparable to those provided in the community.

2. Assessment. Residential program staff shall participate in regular - at least annual - assessment of each resident. The assessment shall cover behavioral and physical status of the resident and shall be conducted by an interdisciplinary team.

a. Behavioral assessment.

(1) Shall utilize objective description to the greatest degree possible.

(2) Shall include the resident, when he is capable of participation, and data supplied by his parents, when appropriate, and by living unit staff.

(3) Shall include, but not be limited to, the following areas:

(a) Educational assessment. All school-age children shall be assessed annually in accordance with guidelines of a properly designated school authority, in order to determine eligibility for public school class. School-age is defined as four years to 21 years for mentally retarded children and shall not extend beyond secondary school.

(b) Self-care skills.

(c) Economic skills.

(d) Language development.

(e) Number and time concepts.

(f) Domestic occupation.

(g) Vocational skills.

*(h) Maladaptive behavior and emotional disturbances.

*A residential program shall be in substantial compliance with these provisions when the American Association of Mental Deficiency Adaptive Behavior Scale, or the Minnesota Developmental Programming System (MDPS), is used for behavioral assessment.

b. Physical assessment.

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(1) Physical assessment for children shall be performed as recommended by the council on pediatrics.

(2) Physical assessment for adults shall be performed at least annually and shall include, but not necessarily be limited to:

(a) Physical examination.

(b) Blood count.

(c) Urinalysis.

(3) Drug assessment: A resident who receives daily medications for a chronic condition shall have a planned and recorded schedule for examination and review of his medication regimen. Use of prescribed medications shall not be continued past the scheduled time for examination. Persistent deviancy in use of a drug by a resident, or adverse reaction to a drug, shall be considered in adjustment of the resident's program plan.

(4) Physical and motor assessment shall be performed at least annually for persons under 16 years of age, and as needed thereafter.

(5) Speech and language assessment shall be performed annually for persons under 16 years of age, and as needed thereafter.

(6) Vision assessment shall be performed annually.

(7) Hearing assessment shall be performed annually for persons under ten years of age, and thereafter when a hearing change is suspected.

(8) Dietary assessment shall be performed at least every 90 days for residents receiving a therapeutic diet.

(9) Psychological assessment shall be performed at least every three years for persons under 16 years of age, and as needed thereafter. Current psychological assessment data (less than one year old) available from the referring agency may be utilized to comply with this requirement.

3. Program and treatment plan. Residential program staff shall participate with an interdisciplinary team including daytime developmental staff, in the formulation of an individualized program and treatment plan for each resident. Facility staff shall be responsible for implementation of the plan.

a. General provisions: The formulation of individualized program and treatment plans shall:

(1) Define specific and time-limited objectives for behavioral and physical development.

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(2) Consider the proper exercise of the residents' and parents' civil and legal rights, including the right to adequate service.

(3) Define needed services without consideration of the actual availability of desirable options.

(4) Investigate and weigh all available and applicable services.

(5) Determine the resident's need for remaining in the facility.

(6) Consider the need for (continued) guardianship or conservatorship or restoration to capacity of the resident.

b. Developmental services: All developmental services utilized by residents shall be provided by persons, facilities, or services licensed or certified to provide these services.

(1) Developmental services shall be utilized to promote the intellectual, physical, affective, and social development of each individual, and may include:

(a) Developmental achievement services.

(b) Educational services.

(i) All school-age children shall attend public school class unless specifically excluded by the responsible school district. A school program operated by the facility shall meet the standards of the State Department of Education and the local school district.

(c) Recreational services.

(d) Religious services.

(e) Sheltered-workshop services.

(f) Social-work services.

(g) Vocational-training and placement services.

c. Health services:

(1) Health services shall be utilized:

(a) To maintain an optimal general level of health for each resident.

(b) To maximize function, prevent disability, and promote optimal development of each resident.

(2) Residents who are members of an organized religious group opposed to any health practices may be excused

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from regulations applying to personal health upon written request by the resident or his parents; but they shall be subject to requirements for control of outbreaks of infectious disease.

4. Evaluation. Residential program staff shall participate with an interdisciplinary team in the evaluation of all services utilized by residents as reflected by each resident's level of functioning.

a. This evaluation shall include evaluation of resident movement toward objectives stated in the program plan.

b. The evaluation shall include the views of the resident and his parents.

c. The evaluation shall include the views of the program advisory committee (see part E.2.) and appropriate agencies.

D. Admission and release procedures.

1. General provision.

a. No resident shall be admitted to a residential program prior to its being licensed.

b. The number of residents admitted to the program shall not exceed its licensed program capacity.

c. The residential program shall make descriptive information available to the public that includes, but is not limited to:

(1) Preadmission and admission services and procedures.

(2) Limitations of age, length or place of residence, and type or degree of handicap.

(3) Developmental and remedial services provided by program staff.

(4) Developmental and remedial services provided by agreement with other agencies or persons.

(5) Means for individual programming for residents in accordance with need.

(6) The plan for grouping residents into living units.

(7) Release and follow-up services and procedures.

d. The residential program shall have an admission and release committee (see E.2.d.(3) of this rule) that shall:

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(1) Include consumers and their representatives, interested citizens, and relevantly qualified professions.

(2) Review all applications and advise the administration of the residential program on selection, admission, and release of residents.

e. The laws, regulations and procedures on admission, readmission, and release shall be summarized and available for distribution.

f. Admission and release procedures shall:

(1) Encourage voluntary admission upon application of the resident or his parent.

(2) Give equal priority to persons of comparable need, whether application is voluntary or by a court.

(3) Facilitate emergency, partial, and short-term care when feasible.

(4) Ensure the rights and integrity of the resident and his parent.

(5) If respite care services are provided, there shall be a written policy defining respite care which includes:

(a) Minimum and maximum time limit.

(b) Conditions and procedures for admission (emergency; vacations; etc.).

(c) Age and developmental level. Respite care admissions must approximate the standard admission criteria.

(d) Description of services provided.

(e) Type of services to be provided.

(f) Charges for respite care.

(6) Ensure the resident the maximum opportunity to participate in admission and release decisions.

(7) Ensure the resident is informed of the right to appeal the suspension, reduction, termination or denial of services to the commissioner of public welfare pursuant to Minnesota Statutes, section 256.045 as a social service appeal.

g. Upon determination of the possible inadmissability of a resident, the residential program shall consult with the referring agency and with his parents.

2. Selection and eligibility.

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a. The residential program shall provide information on eligibility requirements and application materials upon all requests.

b. Residents and their parents shall be free to apply directly to the program for service. However, placement for service shall be made by the responsible local social service agency.

c. Residential programs shall admit residents without regard to race, creed, or national origin, and accord equal treatment to all persons.

d. When admission is not an optimal measure, but must, nevertheless, be implemented, its inappropriateness shall be clearly acknowledged; and plans shall be initiated for the continued and active exploration of alternatives.

e. The determination of legal incompetence shall be separate from the determination of the need for services, and admission to the program shall not automatically imply legal incompetence.

3. Admission.

a. For each resident admitted, there shall be a written program plan stating the services he needs or a written statement of the procedure and timetable for development of the program line.

b. Prior to admission, the resident and his parent shall be counseled on the relative advantages and disadvantages of admission to the program.

c. Prior to admission, the resident and his parent shall be encouraged to visit the program and the living unit in which the resident is likely to be placed.

d. Prior to admission of a school-age child, residential program staff shall notify the local school district.

e. Upon admission, each resident shall be placed in his living unit, and he shall be isolated only upon medical orders issued for specific medical reasons.

4. Release.

a. Planning for release, the residential program staff shall involve the referring agency, the resident, and his parent.

b. At the time of release, a summary of findings, progress, and plans shall be recorded and transmitted with the resident.

c. Procedures shall be established so that:

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(1) A parent who requests the release of a resident is counseled about the advantages and disadvantages of such release.

(2) The court or other appropriate authorities are notified when a resident's release might endanger either the individual or society.

d. At the time of release, physical examination for signs of injury or disease shall be made in accordance with procedures established by the residential program.

e. Except in an emergency, release shall be made only with the prior knowledge, and ordinarily the consent, of the referring agency, the resident, and his parents.

E. Administrative policies and practices.

1. The residential program shall have a written statement clearly defining its philosophy, purpose, and function.

a. This statement shall be consistent with the current status of knowledge and information available on residential services.

b. This statement shall be consistent with the principle of normalization.

2. The residential program shall have a written statement defining its administrative and organizational structure.

a. The governing body shall exercise general direction and establish policies on the operation of the program and the welfare of the residents.

b. The governing body shall appoint an executive officer of the program.

(1) The qualification of the executive officer shall be determined by the governing body and be consistent with the training and education needed to meet the stated goals of the program.

(2) The governing body shall delegate to the executive officer the authority and responsibility for management of the affairs of the program.

c. The residential program shall be administered and operated in accordance with sound management principles.

(1) The type of administrative organization of the program shall be appropriate to the program needs of the resident.

(2) The program shall have a table of organization that shows the governing and administrative responsibilities of

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the program.

d. The residential program shall provide for meaningful and extensive consumer representation and public participation in its operation. If consumer representatives, interested citizens, and relevantly qualified professionals are not represented on the governing body, an advisory body composed of such representation shall be appointed by the governing body.

(1) The advisory body shall sit ad hoc to the governing body and to the chief executive officer and provide consultation and assistance as appropriate.

(2) The advisory body may function as the program research review and human rights committee.

(3) The advisory body may function as the admission and release committee. (See part D.1.d. of this rule.)

3. Personnel policies, practices, and staff to resident ratios.

a. Personnel policies.

(1) There shall be written personnel policies, which shall be made available to each staff member.

(a) The hiring, assignment, and promotion of employees shall be based on their qualifications and abilities, without regard to sex, race, creed, age, disability, marital status and ethnic or national origin.

(b) Personnel policies shall include but not be limited to:

(i) Qualifications, job description, salary schedule, and benefits for all positions.

(ii) A policy prohibiting mistreatment, neglect, or abuse of residents, and mandating the report of any mistreatment, neglect or abuse to the executive officer.

(iii) Procedure for suspension and/or dismissal of an employee for cause.

(c) There shall be a staff person responsible for implementation of these policies.

b. Staff assignments.

(1) There shall be sufficient, appropriately qualified, and adequately trained personnel to provide program service in accordance with program's statement of services provided (see part C. of this rule) and with the standards specified in this document.

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(a) There shall be staff on duty or call at night to ensure adequate care and supervision.

(b) There shall be staff on duty or call to assist all residents in an emergency.

(c) There shall be staff on duty or call so that provision of residential service is not dependent upon the use of unpaid residents or volunteers.

(i) Residents shall not replace staff or be used in lieu of staff in any area of work unless they are reimbursed commensurate with ability and production.

(ii) Residents shall not be involved in the care (feeding, clothing, and bathing), training, or supervision of other residents unless they are adequately supervised, have the requisite humane judgment, and have been specifically trained in necessary skills.

(d) All staff shall be administratively responsible to a person whose training and experience is appropriate to the program.

(e) The title applied to all staff shall be appropriate to the kind of residents with whom they work and the kind of interaction in which they engage.

(2) The use of volunteers shall be encouraged to strengthen services in a manner consistent with the purposes of the program.

c. Staff training.

(1) There shall be a staff-training program that is appropriate to the size and nature of the program and that includes, but is not limited to:

(a) Orientation for all new employees, to acquaint them with the philosophy, organization, program, practices, and goals of the residential program.

(b) Induction training for each new employee, in order that his skills in working with the residents are increased.

(c) Continuing in-service training to update and improve the skills and competencies.

(2) There shall be a record of all staff training on file.

d. Staffing needs.

(1) The determination of staff needs shall include consideration of staff members' experience and training, as well

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as the overall ratio of staff to residents.

(2) The number of available direct care resident living staff shall be related to each resident's degree of handicap and his training needs.

(3) Staff to resident ratios during peak programming hours (evening and weekends) shall be optimized by appropriate scheduling around residents' day programs.

4. The residential program shall have a written statement outlining a plan of financing that gives assurance of sufficient funds to enable it to carry out its defined purposes.

a. Budget management shall be in accordance with sound accounting principles.

b. A residential program charging for services shall have a written schedule of rates and charge policies, which shall be available to the resident, his parent, referring agencies, and the public.

5. An individual record shall be maintained in the facility for each resident.

a. All information contained in the resident's records shall be handled in a manner consistent with the Government Data Practices Act. The resident shall have access to his record upon request.

b. All entries in the resident's record shall be legible, dated and authenticated by the signature and identification of the individual making the entry.

c. All records shall contain basic demographic information, to be entered at the time of admission, including reason for referral and individual program plan.

d. Recorded information shall be in sufficient detail and adequate to:

(1) Plan and evaluate the resident's program.

(2) Provide a means of communication among all persons contributing to the resident's program.

(3) Furnish documentary evidence of the resident's progress or regression and of his general response to his program.

(4) Serve as a basis for study, evaluation, and development of services provided by the residential program.

(5) Protect the legal rights of the resident, his parent, the residential program, and staff.

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(6) Serve as a basis for evaluation of all services utilized by residents.

e. When it is necessary for residential program staff to supervise the use of personal funds, a record of these funds shall be maintained as a part of the resident's record.

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§ 2.035 Department of Public Welfare rule for the licensing operation of all residential programs for inebriate and drug dependent persons.

Statutory citation–Minn. Stat., §§ 245.78 through 245.82, establishes the authority of the Commissioner of Public Welfare to license all residential facilities providing programs for five or more inebriate, and drug-dependent persons, and establish such rules, regulations, and guidelines necessary to carry out the purpose of the statute. These rules, therefore, carry the force and effect of law.

A. Statement of purpose.

1. This rule is designed to aid in the development of a system of residential programs for inebriate and drug dependent persons which:

a. Promotes the greatest degree of independence possible for the resident and at the same time guards against overdependency on the program.

b. Enhances the ability of each resident to cope with his environment.

c. Maximizes and fosters the human qualities of each resident.

d. Provides a home-like atmosphere where the resident is recognized as an individual whose personal interests are maintained and developed and whose personal dignity is respected and safeguarded.

e. Elicits and maintains behavior that allows for the maximum degree of individual behavioral differences compatible with community laws.

f. Provides appropriate treatment and rehabilitation programs and staff.

2. The rule encourages residential programs to organize services differently, consistent with the needs of individual residents and with quality outcomes.

3. The rule mandates that the residents be provided care and services appropriate to their needs, whether those services are provided in the facility or in the community.

4. The rule mandates that sufficient information about the program and services be given to residents and referrants to enable comparisons among programs.

5. The rule provides specific criteria so that, in combination with other sources of information, the licensing agency can evaluate the program.

6. The rule mandates careful and realistic individual planning at all stages, including admission, occupancy, post-occupancy, and transfer.

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B. Definitions–for the purposes of this rule, the following terms shall mean:

1. Applicant–any person, agency, or organization applying for a license or renewal license under this rule.

2. Commissioner–the Commissioner of the Department of Public Welfare or a designated representative of the Commissioner.

3. "Department"–the Department of Public Welfare.

4. "Drug-Dependent Person"–any inebriate person or any person incapable of managing himself or his affairs or unable to function physically or mentally in an effective manner because of the use of a psychological or physiological dependency producing drug including alcohol.

5. "Inebriate Person"–any person incapable of managing himself or his affairs by reason of habitual and excessive use of intoxicating liquors, narcotics or other drugs.

6. "License"–the certificate issued by the Commissioner that validates compliance with this rule, and authorizes the applicant to operate a residential program.

7. "Program Director"–the staff member responsible for planning and implementing all aspects of the program. The Program Director may delegate specific functions to other staff members, but the director shall be held accountable for the functioning of the program and compliance with these rules and regulations.

8. "Provisional License"–the certificate issued by the Commissioner, prior to or in lieu of the issuance of a license. A provisional license may be issued to an applicant when compliance with all provisions of the rule cannot be made, but, in the opinion of the Commissioner, the applicant will nevertheless provide adequate care, treatment, or rehabilitation to its residents. A provisional license will be valid for a period not to exceed six months, and may be renewed for one additional period of six months. A residential program holding either a license or a provisional license shall be considered a duly licensed residential program.

9. "Residential Program"–a planned and purposeful set of conditions and events for the care of inebriates and drug-dependent persons which in the normal course of that program provides care and treatment for five or more inebriate or drug-dependent persons on a 24-hour basis. Excluded from the definition are receiving (detoxification) centers for intoxicated persons as defined in Minn. Stat. 1971, ch. 892, and contained in 12 MCAR § 2.032, "Residential Programs" include:

a. "Residential Primary Treatment Program"–a social rehabilitation setting that provides, on a residential basis, relevant intensive rehabilitation services for the treatment of inebriate or drug-dependent persons.

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b. "Extended Rehabilitation Program"—a social rehabilitation setting that provides long-term assistance in major life-style changes through therapeutic milieu with highly specialized facilitative rehabilitation services.

c. "Halfway House"—a social rehabilitation setting that provides a program of services to assist in making transition from treatment to responsible community living in a supportive environment with a home-like atmosphere.

d. "Hospital"—any medical facility licensed under provisions of Minn. Stat., §§ 144.50-144.58, Minnesota State Hospital; US Public Health Service Hospital; Veterans Administration Hospital; or any medical or psychiatric facility which is equipped to provide intensive medical treatment and care to inebriate and drug-dependent persons with acute and critical health needs.

C. Licensure:

1. Every residential program must have a current and valid license or provisional license to operate in the state of Minnesota. The license shall prescribe the maximum number of residents to be cared for and the location of the program.

2. Every residential program must apply to the Commissioner within 60 days of the effective date of this rule and comply with the provisions of the rule to obtain and maintain a license. Application for renewal of license shall be made each year 45 days prior to the date of expiration. Application and reapplication shall be made on forms furnished by the Commissioner.

3. A license shall be valid for one year after the date of issuance. A license may not be transferred from one program or location to another. Changes in the membership of the governing body or advisory board or program director must be reported in writing to the Commissioner within 20 days of the change.

4. Any changes in the maximum number of residents to be cared for or the location of the program must have prior written approval of the Commissioner.

5. Every residential program shall hold or have applied for a facility license from the Minnesota Department of Health.

6. Every applicant shall be furnished with a copy of these rules.

7. If the Commissioner determines that the applicant or the licenseholder is not complying with the provisions of this rule, or that the public interest is not served by granting or continuing the license, the license may be denied, revoked, or not renewed after notice to the applicant or licenseholder. The denial, revocation, or failure to renew shall proceed in accordance with the provisions of Minn. Stat., ch. 15.

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8. There shall be a review team appointed by the Commissioner, made up of no fewer than five persons. The review team shall be staffed by the Department. At least one member of the review team shall be a consumer.

It shall be the responsibility of the review team to examine the application for a new residential program and to conduct whatever inquiries are appropriate and necessary to make a recommendation to the Commissioner concerning issuance or denial of a license.

The review team shall submit a written report to the Commissioner and the applicant at the same time. This report shall contain the review team's findings and recommendations about licensure, provisional licensure, or denial of license. The report shall take into account the cultural and life-style interests of the persons to be served. The Commissioner shall consider the recommendations of the review team before final action is taken on the application.

9. Prior to the issuance of a license or provisional license, the following steps shall be completed:

a. The need for the program shall be determined under Area Board coordination. A mechanism for the determination of local need shall be established on the basis of guidelines set by the Commissioner.

b. A completed application shall be submitted to the Commissioner.

c. A written report with recommendations about licensing or not licensing the prospective program shall be submitted to the Commissioner by the review team.

d. The fee for license shall be paid. An annual license fee of not less than $25.00 and not more than $150.00 shall be set by the Commissioner.

10. Licensing policies and procedures shall be available to the public.

11. A specific regulation may be waived for not more than one year with the approval of the Commissioner, provided that the health and safety of residents is assured. The granting of a waiver shall not constitute a precedent.

12. No resident shall be discriminated against in relation to admissions, terminations, or treatment on the basis of race, creed, color, national origin, or religion.

D. Minimum standards for issuance of a license to a residential program.

1. Governing body or advisory board—each residential program shall have a board of directors, a board of trustees, and/or an advisory board. Every such body shall have a community representative as a member, or document that it has made reasonable efforts to secure local community involvement. Every such body shall include a resident of the program.

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2. Director—every residential program shall have a director who shall be responsible and accountable for meeting the requirements of this rule. This Director shall:

a. Be at least 18 years of age.

b. Have at least one year of work experience in the field of chemical dependency, and demonstrated ability based on experience, in administration and personnel supervision.

c. Have completed training in a chemical dependency program approved by the Commissioner or be currently registered or involved in such a program with the prospect of completion within one year, or have knowledge of chemical dependency gained through other education and/or experience.

d. If the director has a documented history of dependency on alcohol or drugs, he must provide evidence to satisfy the Commissioner that he has been free of dependency for at least two years.

3. Staffing requirements—there shall be present at all time at the facility at least one responsible adult with skills appropriate to the program, who shall be responsible for the operation of the program.

a. Prescription medication shall be administered by qualified personnel as specified by the Minnesota Department of Health.

b. At least one trained counselor shall be available in the facility for services to each 40 residents. A trained counselor for the purposes of this rule is defined as an individual who has demonstrated competency at counseling chemically dependent persons. Such competence may be demonstrated by a minimum of one year work experience in counseling chemically dependent persons or appropriate training or education as determined by the Commissioner. If the individual has a documented history of dependency on alcohol or drugs, that individual must provide evidence satisfactory to the Commissioner that he has been free of dependency for at least two years.

4. Staff qualifications—personnel involved in the direct service to residents shall demonstrate skills in the area of human relations. Skills may be demonstrated as the result of past experience in areas related to chemical dependency treatment and/or mental health, educational experience and training, or in-service training provided by the residential program.

a. If the individual has a documented history of dependency on alcohol or drugs, that individual must provide evidence to satisfy the director of the program that he is free of dependency.

b. If the individual has not completed a training program approved by the Commissioner that individual must work under the supervision of a staff member who has the qualifications of a director.

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5. Personnel policies—the original application and all renewal applications shall describe the nature and extent of the training and qualifications of the staff and shall include a description of the staff organization.

a. The applicant shall maintain personnel policies including the qualifications, performance, and evaluation standards, rules, remuneration and fringe benefits for each staff position. These policies shall include procedures governing hiring, suspension, dismissal, assignment, promotion, grievance procedures, and other appropriate policies.

b. These policies shall be maintained and communicated to the staff, prospective staff, volunteers, and prospective volunteers of the program.

c. These policies are to be carried out without regard to sex, race, religion, creed, marital status, unrelated job disability, color or national origin.

6. Staff training—each program shall provide or arrange for a staff development program which includes orientation and training of new staff, continuing development of staff skills and abilities through a defined in-service program, and/or participation in other training programs. Volunteers shall be included in staff development programs.

7. Evaluation—all residential programs shall develop an evaluation system adequate to reflect the program and administrative functioning.

a. The evaluation system shall show the adequacy of the care, treatment, and rehabilitation services provided by the applicant in light of the purpose, goals, and methadology of the program as described in the application.

b. Every applicant shall submit a completed evaluation to the Department with his application for renewal of license.

8. Administration and management—every residential program shall have written administrative and management policies governing the administration and supervision of the operations, the program, and the physical facilities. Such policies shall include:

a. An admission procedure including a description of the referral process, and a copy of a physical examination report. Said examination shall be conducted no more than thirty days prior to, or three days following admission to the facility. The admission procedure shall specify the role and responsibility of community agencies.

b. An individual, confidential record shall be maintained for each resident of the facility, and shall include:

(1) a written individual treatment plan, with specific goals.

(2) a statement signed by the resident and the director outlining

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the expectations, responsibilities, and legal rights of the resident and the facility.

(3) written consent of the resident or guardian for any release of information to persons not otherwise authorized to receive it.

(4) a written medical and social history of the resident.

(5) written progress notes.

(6) a written discharge summary.

All entries in the resident's record shall be legible, dated, and authorized by the signature and identification of the individual making the entry. The record keeping system shall be structured and located so as to provide a means of communication both in and out of the facility and to furnish documentary evidence of the resident's response to the program. Every resident shall have access to his records, unless the director documents reasons acceptable to the Commissioner for denying such access.

c. A program plan including a statement of purpose, intake policies, maximum number of residents to be served, description of population served, description of treatment design and methadology including a documentation of availability of the following services: medical, family, psychiatric, psychological, social work, educational, religious, financial assistance, and vocational and recreational rehabilitation.

d. A description of discharge policies concerning provision for housing, relationships with family, finances, employment and follow-up. The discharge policy shall specify the role and responsibility of community agencies.

e. Financial records including an annual budget, records of income and expenditure, fee policies, and a record of audit. New programs must document in writing assurances of funding sufficient to meet total projected program costs for a period of at least three months, plus start-up costs.

f. Statistical records shall be kept on a continuing basis that accurately reflect the number and dates of residents accepted and rejected, number and dates of resident discharges, length of stay, and what happens to residents upon leaving the program.

g. Annual reports to the governing and/or advisory body covering overall status and operation of the facility. The reports shall be available to the Commissioner and contractors of service upon request.

h. A description of provisions for emergency medical and/or psychiatric care.

i. When it is necessary for staff to supervise the use of personal funds or property, the system for such supervision shall be submitted in writing along with the application for approval by the Commissioner.

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j. Written documentation of insurance coverage in an amount sufficient to protect the interests of the residents and staff.

k. If physical or chemical restraints are used, the program shall submit with its application a copy of its policies in these areas. No physical or chemical restraints may be used except as outlined in such a policy, approved by the Commissioner.

l. A description of the methods by which residents' legal, civil, and human rights will be protected. This shall include the procedures for handling complaints and grievances by residents, their relatives, and/or guardians.

E. Explanation of program—all residential facilities shall at the time of admission clearly explain their program and policy to those applying or being considered for treatment.

F. Right to entry—the Commissioner shall be free to enter any residential program.

G. Confidentiality—confidential information regarding a resident shall not be released to any person or agency, except pursuant to Minn. Stat. 1973, ch. 572, § 16.

H. Issuance of license to a residential primary treatment program—Beyond compliance with the above stated regulations, if an applicant wishes to be licensed as a residential primary treatment program as defined in B. 9. a. of this rule, the following minimum standards must be met:

1. Director—the director shall:

a. Have three years work experience in the field of chemical dependency, and have demonstrated ability based on experience in administration and personnel supervision.

b. If the director has a documented history of dependency on alcohol or drugs, that individual shall provide sufficient evidence to satisfy the Commissioner that he has been free of dependency for at least three years.

2. Staffing requirements—Beyond E. 3. of the rule there shall be:

a. A written contractual arrangement for medical examination, routine medical care, emergency medical services, and medical reporting (at least at the time of admission and discharge) for all residents of the facility.

b. At least one registered nurse or licensed practical nurse shall be on duty a minimum of forty hours a week. One such person shall be responsible to the director for the level of nursing care to the residents.

c. At least one trained counselor as defined in E. c. b. of this rule for each fifteen residents.

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d. A Board-certified or Board-eligible psychiatrist and licensed psychologist either on staff or by written contractual agreement who shall be available, at the discretion of the director, when needed, for psychiatric and psychological services and consultation.

3. Administration and management—Beyond E. 8. of this rule, policies concerning administration and management shall include:

a. Maintenance of face sheet with application and admission information, written report of a physical examination, and if deemed applicable by the director, a written report of psychiatric or psychological interviews and/or psychological testing.

b. Quarterly report to the governing or advisory body covering the overall status and operation of the facility. The reports shall be available to the Commissioner and contractors of service upon request.

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12 MCAR S 2.036 Licensing of residential facilities for adult mentally ill persons.

A. Applicability.

1. Rule 12 MCAR S 2.036 applies to all providers offering residential care and program services to five or more adult mentally ill persons at one time for more than 30 days in any 12-month period and is based, in part, on Minnesota Statutes, section 245.782, subds. 6 and 9. This rule applies to mental health residential programs which are Category I programs as defined in B.3. and semi-independent or supportive group living programs which are Category II programs as defined in B.4. This rule applies to mental health residential programs for the adult mentally ill within state hospitals, and adult foster homes with five or more adult residents who are mentally ill. These entities must be licensed as either Category I or Category II.

2. Rule 12 MCAR S 2.036 does not apply to programs located within a licensed hospital, except state institutions under the control of the commissioner; nor does it apply to programs located within a licensed nursing home.

B. Definitions. As used in 12 MCAR S 2.036, the following terms have the meanings given them.

1. Applicant. "Applicant" means an individual, organization, association, partnership, corporation or unit of a state institution which submits an application for licensure under 12 MCAR S 2.036.

2. Case management services. "Case management services" means the arranging and coordinating of direct services for a resident with the involvement of the resident. These direct services include, but are not limited to: assuring a diagnosis, assessing the resident's strengths and weaknesses in order to determine the resident's needs, developing an individual treatment plan, and evaluating the plan's effectiveness.

3. Category I program. "Category I program" means a mental health residential program which provides program services in which there is an emphasis on services being offered on a regular basis within the facility with the use of community resources being encouraged and practiced.

4. Category II program. "Category II program" means a mental health residential program which provides either a transitional semi-independent living arrangement or a supervised group supportive living arrangement for mentally ill persons. This type of program offers a combination of in-house and community resource services with emphasis on securing community resources for most daily programming and employment.

5. Commissioner. "Commissioner" means the Commissioner of the Department of Public Welfare or a duly authorized

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representative.

6. Community representative. "Community representative" means an individual who represents citizens' interests and who is neither an employee or board member, nor has any other official affiliation with the mental health residential program.

7. Crisis services. "Crisis services" means a set of activities designed to respond to medical, situational, and psychiatric emergencies.

8. Department. "Department" means the Department of Public Welfare.

9. Full-time. "Full-time" means work time equalling at least 37-1/2 hours per week.

10. Independent living skills training. "Independent living skills training" means services which both emphasize development of an individual's skills required to perform increasingly independent daily living functions and which are appropriate to the needs of the individual.

11. Individual program plan. "Individual program plan" or "individual treatment plan" means a written plan of intervention and treatment developed on the basis of assessment results and revised, if necessary, at certain intervals. The plan specifies goals and objectives and a means for their accomplishment, and also identifies responsible staff persons.

12. License. "License" has the meaning given it in Minnesota Statutes, section 245.782, subdivision 11.

13. Living unit. "Living unit" means a set of rooms which are physically self-contained, which have the defining walls extending from floor to ceiling, and which include bedrooms, living rooms or lounge areas, bathrooms and connecting areas.

14. Mental health counselor. "Mental health counselor" means an individual who, under the supervision of a mental health therapist or program director, provides treatment for mentally ill residents in a mental health residential program and who meets the requirements of P.7. The specific title of the individual employed in this position is at the discretion of the program as long as the title selection fairly reflects the responsibilities defined in 12 MCAR S 2.036 for a mental health counselor.

15. Mental health residential program. "Mental health residential program" or "program" means a planned combination of living conditions, services, and resources for the treatment and rehabilitation of five or more mentally ill adults on a 24-hour per day basis.

16. Mental health therapist. "Mental health therapist"

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means an individual skilled in providing mental health therapy in a mental health residential program and who meets the requirements of P.6. The specific title of the individual employed in this position is at the discretion of the program as long as the title selection fairly reflects the responsibilities defined in 12 MCAR S 2.036 for a mental health therapist.

17. Mental health therapy. "Mental health therapy" means various treatment modalities which may reasonably be expected to improve the resident's condition.

18. Mental health worker. "Mental health worker" means an individual who, under the supervision of a mental health counselor, mental health therapist, or program director, provides care, support, or assistance to mentally ill residents in a mental health residential program and who meets the requirements of P.8. Possible job titles for this staff position are resident manager, human services technician, independent living skills worker, and licensed practical nurse. The specific title of the individual employed in this position is at the discretion of the program as long as the title selection fairly reflects the responsibilities defined in 12 MCAR S 2.036 for a mental health worker.

19. Mentally ill person. "Mentally ill person" means a person who has been diagnosed by a physician, a licensed psychologist, or a licensed consulting psychologist as having a condition which results in an inability to interpret the environment realistically and in impaired functioning in primary aspects of daily living such as personal relations, living arrangements, work and recreation; or which is listed in the International Classification of Diseases (ICD-9-CM), code range 290, 293-302.9 or 306-314.9, or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III), Axes I, II or III.

20. Motivation and remotivation services. "Motivation and remotivation services" means a set of activities which encourages the development of positive attitudes and self-concept, and which encourages the resident to develop goals and to use available community resources.

21. Program director. "Program director" means a person who is responsible for the development and implementation of the mental health residential program and who meets the requirements of P.5.

22. Provisional license. "Provisional license" has the meaning given it in Minnesota Statutes, section 245.782, subdivision 12.

23. Recreation and leisure time services. "Recreation and leisure time services" means a set of activities designed both to meet a resident's personal and therapeutic needs of self-expression, social interaction, and entertainment, and to develop skills and interests that lead to enjoyable and

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satisfying use of leisure time. An objective of these services is the integration of residents into the recreational mainstream of the community.

24. Restraint. "Restraint" means any physical device that limits the free and normal movement of body and limbs.

25. Seclusion. "Seclusion" means involuntary removal into a separate room which prevents social contact with other persons.

26. Socialization services. "Socialization services" means a set of activities in which residents learn interpersonal relationship and communication skills.

27. Social services. "Social services" may include psychosocial evaluation; counseling based on social work problem-solving methods; activities designed to assist residents in dealing with tasks of daily living; utilization of community resources; psychotherapy for individuals, families and groups; and education, planning, and advocacy for the social needs of residents.

28. Support group services. "Support group services" means a group process designed to allow residents to participate with other individuals in sharing feelings, experiences, and constructive feedback.

29. Vocational services. "Vocational services" means a set of activities emphasizing development of skills required to perform work functions in a competitive, semi-competitive or volunteer work setting.

C. Licensing process.

1. License required. No mental health residential program shall operate in Minnesota unless it has a current and valid license or provisional license as required by Minnesota Statutes, sections 245.781 to 245.812.

2. Information furnished. Upon written request, each individual, organization, or agency shall be furnished with a copy of 12 MCAR S 2.036 and other pertinent materials such as an application form and instructions for obtaining a license.

3. Application. Persons interested in obtaining licensure under 12 MCAR S 2.036 shall submit to the commissioner an application on forms supplied by the department. The applicant shall either document compliance with all applicable building codes, fire and safety codes, health rules, zoning ordinances, and other applicable rules and regulations or submit documentation that appropriate variances have been granted.

4. Decision. The commissioner shall make a decision on licensure after completion of the following steps:

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a. a review of the application;

b. a visit to the program site; and

c. interviews with staff and a sample of residents.

5. Fee. Each applicant shall pay to the commissioner a nonrefundable fee not to exceed $150 for the costs of processing the license application. Information regarding the specific amount and the timing of the payment shall be made available to the applicant.

6. Renewals. Application for renewal of a license shall be made on forms furnished by the department at least 30 days prior to the date of expiration of the license.

D. License changes; report. Any changes in the following areas shall be reported in writing to the department at least 20 days prior to the change:

1. a change in licensed capacity;

2. the location of the program;

3. a change in program director;

4. a change in ownership; or

5. major changes in programming. Major changes in programming include such areas as a change in the target population or shifting from the internal provision of services to the external provision of services through a purchase of service contract. Changes in programming which do not have to be reported include such changes as the addition of staff, reassignment of staff, and establishing new groups.

E. Program policy and procedures manual. Each mental health residential program shall develop a written policy and procedures manual. The manual shall contain all materials required by F.-M. The manual shall be available for inspection by the department.

F. Statement of purpose and policies. The manual shall contain a complete statement describing the mental health residential program's philosophy and goals. This statement shall include, but not be limited to, a description of:

1. the geographical area to be served;

2. the design and methodology of program services; and

3. the scope of services offered.

G. Program organization and administration.

1. Advisory committee. Each program shall have an

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advisory committee which provides for community representation and public participation in its operation. The advisory committee shall have a core group which comprises a quorum. The core group shall include at least one program resident, the facility's administrator, and a community representative. The advisory committee shall document the procedure whereby residents are assured access to the advisory committee. The committee shall meet at least quarterly. Minutes of the meetings shall be recorded and kept on file at the facility. Each program shall provide to the department a list of names and titles of the members of the advisory committee who are members at the time of submitting an application or renewal of a license under 12 MCAR S 2.036.

2. Governing body. All programs shall have a governing body which is accountable for, and has authority over, the policies and activities of the program. In the case of a program owned by a proprietor or partnership, the proprietor or partners shall be regarded as the governing body for the purpose of this part. Each program shall provide to the department a list of names and titles of the members of its governing body.

3. Designated authority. A program operating within Minnesota with headquarters outside of the state shall have a duly authorized representative with decision-making responsibility designated within this state.

H. Required documentation and reports.

1. Insurance coverage. Each program shall have written documentation of insurance coverage in an amount sufficient to protect the interests of residents and staff. Each program must document the specific types and amounts of coverage and the carrier or carriers.

2. Bonding. Each program shall have written documentation that all employees are bonded or otherwise appropriately insured if they have access to or responsibility for handling money.

3. Financial information. Each program shall make available to the commissioner an annual fee schedule. A new program shall document in writing a plan of funding sufficient to meet total projected program costs for a period of at least one year in addition to start-up costs.

4. Maintenance. Each program shall document that the maintenance and upkeep of the facility is being done by staff hired by the program or through a written working agreement with an outside person or firm.

5. Non-discrimination policy. Each program shall have a written policy which requires that no resident be discriminated against in admission, termination, or the provision of program services on the basis of race, creed, color, national origin, religion, physical handicap, sexual preference, public

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assistance status or marital status.

6. Each applicant shall document compliance with provisions of Minnesota Statutes, section 626.557.

7. Accident reports. Each program shall have a written policy regarding accidents and missing persons. Each program shall maintain in central files at the facility reports regarding accidents or missing persons if the reports pertain to facility residents.

8. Annual comprehensive report. Each program shall give a comprehensive annual report to its governing body, its advisory committee and to the host county. The report shall also be available to the commissioner. The report shall include documentation in at least the following areas:

a. a current organizational chart listing the number of full-time equivalent positions in each job class;

b. training, staff development, and continuing education activities of staff;

c. administrative policy and procedure changes;

d. program evaluation as required in 9.; and

e. a financial report.

9. Program evaluation.

a. Process required. Each program shall institute an evaluation process to be conducted on an ongoing basis. The evaluation process shall be outcome-based and consistent with the emphasis of 12 MCAR S 2.036 on individual treatment planning. In a format developed by the commissioner, the data and documentation required by b., c., and d. shall be submitted to the commissioner on an annual, aggregate basis for state-wide summaries and for planning the use of state resources.

b. General data. Each program shall systematically collect data that includes, but need not be limited to: resident demographic data, program service data, and data on concurrent services. Each program shall submit the data to the host county for combination with follow-up data collected by county case workers.

c. Individual data. Each program shall also, for the purpose of examining the program's impact, assess the progress of each resident relative to the resident's individual treatment plan. Progress shall be assessed by rating each resident within 30 days of admission and thereafter at the time of quarterly review on uniform level of functioning scales determined by the commissioner.

d. County technical assistance. Each program shall

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collaborate with available county technical assistance staff to examine the evaluation results, to assess the overall progress of residents in the program, and to document how the results are used in administrative and program development.

e. Data restrictions. Each program shall collect the statistical data described in 9. for the purpose of program evaluation. The categories of data shall be compatible with the evaluation requirement of the Community Social Services Act, Minnesota Statutes, chapter 256E, and shall not require duplicate data collection. Dissemination shall be in accordance with provisions of the Minnesota Government Data Practices Act, Minnesota Statutes, sections 15.1611 to 15.1699, and all applicable federal rules or laws.

I. Personnel policies and procedures.

1. General requirements. Each program shall have a written personnel policy and shall make a copy of it available to each employee upon employment and to the department for review. Personnel policies shall be carried out in accordance with affirmative action policies and equal employment opportunity regulations.

2. Job description. The personnel policy shall contain job descriptions for each position specifying responsibilities, degree of authority to execute job responsibilities, standards of job performance, and qualifications.

3. Job evaluation. The personnel policy shall provide for job performance evaluations conducted on a regular and ongoing basis with a written annual review. As part of the annual performance review, each staff member shall have a growth and development plan. Each program shall develop a policy and establish procedures for resident input into staff evaluations.

4. Conditions of employment. The personnel policy shall describe the employees' conditions of employment, including their benefits, hours of work, methods of promotion and the general conditions which constitute grounds for dismissal and suspension.

5. Organizational chart. The personnel policy shall also include a chart or definition of organizational structure indicating lines of authority.

6. Grievance procedure. The personnel policy shall describe a grievance procedure for use by staff. This procedure shall allow the aggrieved party to bring the grievance to the highest level of authority in the operation of the facility. A list of other community resources, such as the Health Facilities Complaint Office in the Department of Health, the Licensing Division in the Department of Public Welfare, and the Department of Human Rights, shall be made available to staff by the facility.

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7. Personnel data. Program employee personnel data shall be accessible to the department.

8. Staff orientation. The personnel policy shall include a program of orientation for all new staff and the orientation shall be based on a written plan. At a minimum, the plan of orientation shall provide for training related to the specific job functions for which the employee was hired, facility policies and procedures, and the needs of mentally ill persons.

9. Staff training. The program shall have a staff development plan, including continuing education opportunities. The plan shall be reviewed annually. The plan shall be relevant to the facility's program and resident population. There shall be at least 15 hours of continuing education annually for each staff person working directly with mentally ill persons. The training shall include, but need not be limited to, the following areas:

a. first-aid training;

b. crisis intervention training for psychiatric emergencies;

c. problems and needs of mentally ill persons and their families;

d. community resources locally available to mentally ill adults;

e. psychotropic medications and their side effects;

f. resident rights;

g. cultural awareness training;

h. rules governing the operation of residential facilities for adult mentally ill persons;

i. staff stress or burnout; and

j. other topics, such as case management, individualized goal planning, chemical use and abuse, health and nutrition, and services for multiple disability residents.

10. Training for non-direct care staff. Personnel of the program not referenced in this rule shall receive continuing education as appropriate to their role and function within the program.

J. Personnel files.

1. Central training file. The orientation and continuing education required by I. shall be documented by each program in a central training file. The file shall be available to the department for review. Documentation shall include, but need

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not be limited to: the date, the subject, the name of the person who conducted the training, the names of staff attending, and the number of hours attended.

2. Individual files. Each program shall maintain a separate personnel file for each employee. The files shall be available to the department for review. Employees shall be able to review their own personnel files, subject to the provisions of the Minnesota Government Data Practices Act, Minnesota Statutes, sections 15.1611 to 15.1699. At a minimum, each file shall contain the following:

a. an application for employment or a resume;

b. verification of employee's credentials;

c. an annual job performance evaluation;

d. an annual growth and development plan;

e. documentation of orientation; and

f. a record of training and education activities during employment.

K. Admission, discharge, and transfer policies.

1. Admission criteria. Each program shall develop admission criteria delineating the types and characteristics of persons who can and cannot be served by the program. Intake policies and procedures shall be developed including the role of community resources.

2. Discharge and transfer policies. Each program shall develop detailed discharge and transfer policies and procedures. The policies and procedures shall include:

a. a planned discharge or transfer conference with the resident, staff representatives, and others requested by the resident if possible;

b. identification of community resources which directly relate to the continuing needs of the resident;

c. a description of the process by which a discharged or transferred resident would or would not have access to the staff and other residents in order to facilitate readjustment in the community.

L. Program services. The following services shall be offered either by the program or through a working agreement with other community resources:

1. case management services;

2. crisis services;

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3. independent living skills training;

4. mental health therapy;

5. motivation and remotivation services;

6. recreation and leisure time services;

7. socialization services;

8. support group services;

9. social services;

10. vocational services; and

11. other services if their need is indicated by the resident assessment.

M. Policies and procedures guaranteeing resident rights.

1. Explanation of rights. A written statement of residents' rights and responsibilities shall be developed encompassing 2.-11. Program staff shall explain to each resident the resident's rights and responsibilities. A written statement of residents' rights and responsibilities shall be given to each resident, and to his or her responsible party if the resident has a legal guardian, on admission. A list of residents' rights and responsibilities shall be posted in a place accessible to the residents and shall be available to the department for review.

2. Grievance procedure. Upon admission each resident shall be informed of grievance procedures available to the resident, and a copy of the procedures shall be posted in a place accessible to the resident. The grievance procedures shall include the following:

a. An offer of assistance by the program staff in development and process of the grievance; and

b. A list of internal resources for use by the resident, such as the resident council or a grievance committee, and a list of community resources available to the resident, such as the health facilities complaint office in the Department of Health, the Licensing Division in the Department of Public Welfare, and the Department of Human Rights.

3. Resident council. Each program shall have a resident council through which residents have an opportunity to express their feelings and thoughts about the program and to affect policies and procedures of the program. Minutes of council meetings shall be recorded and made available to the program director.

4. Personal funds policy. Staff will not supervise the

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use of residents' personal funds or property, unless policies governing the supervision have been written and unless the resident has signed a consent form prior to the exercise of supervision indicating an awareness of and consent to procedures governing the use of the resident's personal funds. In order to encourage independent living skills, any restriction of a resident's personal funds must be documented in the individual treatment plan. Resident fund accounts shall be maintained separately from program fund accounts.

5. Resident compensation. A resident who performs labor other than labor of a housekeeping nature shall be compensated appropriately and in compliance with applicable state and federal labor laws, including minimum wage and minimum wage reduction provisions. Labor of a housekeeping nature shall be limited to household chores which a person living in his or her own residence in the community would normally perform.

6. Physician appointments. A resident shall be allowed to see his or her physician at any reasonable time.

7. Photographs of residents. A resident shall not have his or her photograph taken for any purpose beyond identification unless he or she consents.

8. Telephone use. Residents shall have access within the facility to a telephone for incoming, local outgoing, and emergency calls. They shall have access within the facility to a pay phone or its equivalent for outgoing long distance calls. Any restriction on resident access to telephones shall be documented in the individual treatment plan.

9. Mail. Residents shall be allowed to receive and send uncensored mail. Any restrictions shall be documented in the individual treatment plan.

10. Restraints. The facility shall have a written policy that defines the uses of restraint, seclusion, and crisis medications as a treatment mode; the staff members who may authorize its use; and a mechanism for monitoring and controlling its use. Physical restraint and seclusion shall be used only when absolutely necessary to protect the resident from injury to himself or to others. Restraint, seclusion, and medications shall not be used as punishment, for the convenience of staff, or as a substitute for a program.

11. Visitors. Residents shall be allowed to receive visitors at reasonable times. They shall be allowed to receive visits at any time from their personal physician, religious advisor, and attorney. The right to receive visitors other than those specified above may be subject to reasonable written visiting rules and hours established by the head of the facility for all residents. The head of the facility may impose limitations on visits to an individual resident only if he or she finds the limitations are necessary for the welfare of the resident and if the limitation and reasons are fully documented

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in the resident's individual treatment plan.

N. Resident records.

1. Individual program plan development. The mental health residential program staff shall, within ten days after admission, write short-term goals with each resident in order to address the resident's immediate needs. The program staff shall, within 30 days of admission, write an individual program plan which contains the components specified in 2. Medical, social, psychological, and psychiatric histories of the resident shall be used in the development of the plan. The plan shall be developed by an interdisciplinary team including the resident, the program staff, a representative of the referring agency and other appropriate resources, such as family, concerned others, and health care providers requested by the resident. Each resident shall be actively involved in developing his or her plan, unless contraindicated. The persons involved in the development of the individual program plan shall be noted on the plan. The extent of the resident's participation in developing the program plan shall also be noted on the plan. The plan and documentation related to it shall be kept in the facility where the mental health program is located.

2. Plan contents. An individual program plan shall contain at least the following components:

a. an assessment, including a strength and need list, of the resident in at least the following areas of life: social, medical, legal, family, leisure and recreation, spiritual or religious, psychological, financial, vocational and educational;

b. the specific problems to be resolved;

c. a list of goals in order of priority;

d. specific, measurable, and time-limited objectives which relate directly to the goals;

e. specific methods, strategies, and resources, including medications, to be used by the staff in assisting the resident to accomplish the goals and objectives;

f. the names of community resource personnel, program staff, or other persons designated to assist the resident in implementing the various components of the plan; and

g. notes indicating progress in achieving the goals and objectives.

3. Progress report. A quarterly review of the resident's response to the individual treatment plan and his or her involvement in the facility's overall program shall be written. Copies of this report shall be given to the resident and shall be sent to the representative of the referring agency and other persons deemed appropriate by the program director and

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resident. The resident's level of participation in the development and the review of the report shall be documented. The report shall be kept at the facility.

4. Discharge or transfer summary. A discharge or transfer summary shall be written for each person transferred or discharged. The summary shall include at least the following information:

a. a brief review of the resident's problems, strengths and needs while a resident of the program;

b. the response of the resident to his or her individual treatment plan and to the facility's overall program;

c. an aftercare plan which identifies the persons, including at least the resident, a program staff member, and a representative of the referring agency, who participated in the development of the aftercare plan; goals and objectives for the first three months after discharge or transfer; and individuals or agencies who will be working with the resident after discharge or transfer; and

d. a forwarding address and telephone number for follow-up contacts.

5. Accidents and missing persons. A copy of any report regarding accidents and missing persons must be documented in the individual's resident record if the resident is involved in the report.

6. Release of information. Private data regarding a resident shall not be used or released by the facility to any person or agency, except pursuant to the Minnesota Government Data Practices Act. The facility shall use written consent forms for any release of resident information or data.

O. Living unit requirements.

1. Furnishings. Each living unit shall include furnishings appropriate to the psychological, emotional, and developmental needs of each resident.

2. Ratios. For each program, there shall be one living room or lounge area per living unit for up to 25 residents.

3. Program space. There shall be space available for program services as indicated in the individual treatment plans such as an area for learning recreation and leisure time skills, and an area for learning independent living skills, such as laundering and cooking.

4. Gender of residents. The unit or complex of units shall house both male and female residents insofar as this conforms to prevailing cultural norms, unless contraindicated by the facility's overall program plan. The unit shall provide for

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appropriate separation of male and female residents.

5. Privacy. The living unit shall allow for individual privacy and group socialization. Each resident shall have the opportunity for privacy during assessment, interviews, counseling sessions and visitations.

6. Storage space. Each facility shall provide to each resident storage space for clothing and other personal property, including a secure place for valuables. Each facility may exclude particular kinds of personal property from the facility for reasons of space limitations or safety. Any exclusions shall be documented and included in the policies and procedures manual of the facility.

P. Additional requirements for Category I programs. In addition to the requirements of A.-O., Category I programs shall meet the requirements of 1.-9.

1. Capacity. Applicants with facilities existing as of July 1, 1980, with a capacity exceeding 25 beds, shall have a three-year grace period from the effective date of 12 MCAR S 2.036 to reduce capacity to 40 beds or fewer, or to divide the facility into living units which do not exceed 25 beds. Applicants with facilities existing as of July 1, 1980, with a capacity exceeding 25 beds per living unit, shall not increase the total capacity of the facility. New facilities shall not exceed a maximum capacity of 25 beds.

2. Department of Health licensing standards. The facility shall be licensed as a supervised living facility, a boarding care home, or a hospital.

3. Intake information. Each facility shall maintain in the facility documentation that:

a. a prospective resident has been diagnosed as being mentally ill and requires treatment;

b. the diagnoses are based on medical, social, psychological, and psychiatric information; and

c. medical, social, psychological and psychiatric histories were obtained for each resident.

4. Administrator. An individual shall be designated as administrator of the mental health residential program. The administrator shall be responsible for continuous overall operation, including maintenance and upkeep of the facility. In the administrator's absence, a staff member who is familiar with operations of the organization shall be designated to assume the responsibilities of the administrator. An individual who is functioning as administrator but not as program director shall meet qualifications determined by the governing body which are consistent with the training and education needed to meet the stated goals of the program.

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5. Program director. An individual shall be designated as the program director. The positions of program director and administrator may be filled by the same person. This individual shall meet at least the following qualifications:

a. a master's degree in the behavioral sciences or related field with at least two years of work experience providing services to mentally ill persons, or a bachelor's degree in the behavioral sciences or related field with a minimum of four years of work experience providing services to mentally ill persons; and

b. one year of experience or training in administration or supervision.

6. Mental health therapist. If mental health therapy is provided within the mental health residential program, a mental health therapist shall be hired. Persons employed as mental health therapists prior to the effective date of 12 MCAR S 2.036 shall not be required to meet the qualifications of a. and b. Persons employed as mental health therapists after the effective date of 12 MCAR S 2.036 shall be required to meet the qualifications of a. and b. The mental health therapist shall be qualified in at least the following ways:

a. a bachelor's degree; and

b. a master's degree in the behavioral sciences or related field or two years of advanced level, certificate training in mental health therapy.

7. Mental health counselors. If program services other than mental health therapy are provided within the mental health residential program, they shall be provided by mental health counselors or mental health workers, or both. Persons employed as mental health counselors prior to the effective date of 12 MCAR S 2.036 shall not be required to meet any specific education requirements. Persons employed as mental health counselors after the effective date of 12 MCAR S 2.036 shall have at least an Associate of Arts degree in one of the behavioral sciences or a related field or a registered nurse degree.

8. Mental health workers. Persons employed as mental health workers after the effective date of 12 MCAR S 2.036 shall meet the qualifications as determined by the governing body to be consistent with those needed to meet the stated goals of the program.

9. Staffing ratios. The program shall have sufficient staff to provide the required program services and implement the individual program plans. Staffing patterns shall be developed to ensure 24-hour coverage within the mental health residential program and to reflect the need for more staff per number of residents during hours of concentrated programming. The hours of the day devoted to concentrated programming shall be

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identified. The following minimum staff-to-resident ratios shall be maintained. The requirements of b. represent full-time equivalencies and may be prorated based on licensed resident capacity.

a. The number of work hours performed by the program director shall be prorated based on resident capacity with a ratio of 40 hours per week to 40 residents. With this ratio, applicants shall be allowed to use one program director to direct more than one program and shall be allowed to use one full-time program director for programs with less than a 40-bed resident capacity. With this ratio, applicants shall not be required to have more than one full-time program director for programs with more than a 40-bed resident capacity. However, applicants or programs with more than a 40-bed capacity shall describe whatever additional assistance they intend to provide for the program director function.

b. The number of work hours performed by the mental health therapist and mental health counselor and mental health worker may be combined in different ways, depending on program needs, to achieve a ratio of one full-time equivalent position for each five residents (1:5 F.T.E., averaged weekly). When the work hours are combined, the facility shall have written documentation that supervision is provided.

Q. Additional requirements for Category II programs. In addition to the requirements of A.-O., Category II programs shall meet the requirements of 1. to 8.

1. Capacity. Facilities existing as of July 1, 1980, with a capacity exceeding 25 beds shall have a three-year period from the effective date of 12 MCAR S 2.036 to divide the facility into living units which do not exceed 25 beds. Facilities existing as of July 1, 1980, with a capacity exceeding 25 beds per living unit shall not increase the total capacity of the facility. New facilities shall not exceed a maximum capacity of 25 beds.

2. Department of Health licensing standards. The facility shall have a board and lodging license from the Minnesota Department of Health or its equivalent from a local health department or a health care license.

3. Intake information. Each facility shall maintain in the facility documentation that:

a. a mental health assessment or reassessment has been completed to determine appropriateness of admission; and

b. medical, social, psychological and psychiatric histories were obtained for each resident.

4. Medical information. Each program with a board and lodging license shall require that a physical exam be done 30 days prior to admission or within three days following

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admission. Each resident shall have an annual physical and dental examination. Records shall be kept of annual medical and dental examinations, including records on all prescription medications the resident is taking. Records shall also be maintained regarding the general medical condition of the resident, including any disabilities and limitations.

5. Administrator. An individual shall be designated as administrator of the mental health residential program. The administrator shall be responsible for continuous overall operation, including maintenance and upkeep of the facility. In the administrator's absence, a staff member who is familiar with operations of the organization shall be designated to assume the responsibilities of the administrator. An individual who is functioning as administrator but not as program director shall meet qualifications determined by the governing body which are consistent with the training and education needed to meet the stated goals of the program.

6. Program director. An individual shall be designated as the program director. The positions of program director and administrator may be filled by the same person. This individual shall meet at least the following qualifications:

a. a master's degree in the behavioral sciences or related field and at least one year of work experience providing services to mentally ill persons, or a bachelor's degree in behavioral sciences or related field with a minimum of two years' work experience providing services to mentally ill persons; and

b. one year of experience or training in administration or supervision.

7. Mental health therapists, counselors and workers. If program services are offered within the facility, they shall be provided by mental health therapists, mental health counselors, or mental health workers. The minimum qualifications for these positions shall be consistent with those of Category I specified in P.6., P.7. and P.8.

8. Staffing ratios. The facility shall have sufficient staff to provide the required program services and implement the individual program plans. Staffing patterns shall be developed to ensure 24-hour coverage within the mental health residential program and to reflect the need for more staff per number of residents during hours of concentrated programming. The hours of the day devoted to concentrated programming shall be identified. The following minimum staff-to-resident ratios shall be maintained. The requirement of b. represents a full-time equivalency and may be prorated based on licensed resident capacity.

a. The number of work hours performed by the program director shall be prorated based on resident capacity with the ratio of 40 hours per week to 40 residents. With this ratio,

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applicants shall be allowed to use one program director to direct more than one program and shall be allowed to use one full-time program director for programs with less than a 40-bed resident capacity. With this ratio, applicants shall not be required to have more than one full-time program director for programs with more than a 40-bed resident capacity. However, applicants or programs with more than a 40-bed capacity shall describe whatever additional assistance they intend to provide for the program director function.

b. The number of work hours performed by the mental health therapist, mental health counselor, and mental health worker may be combined to achieve a ratio of one full-time equivalent staff position for each ten residents (1:10 F.T.E., averaged weekly). When the work hours are combined, the facility shall have written documentation that supervision is provided.

R. Variances. A residential program may request in writing a variance of a specific provision of 12 MCAR S 2.036. The request for a variance must cite the specification of the rule in question; reasons for requesting the variance; the period of time, not to exceed one year, the licensee wishes to have the provision varied; and the equivalent measures planned for assuring that programmatic needs of residents are met. Variances granted by the commissioner shall specify in writing the time limitation and required equivalent measures to be taken to assure that programmatic needs are met. The commissioner shall specify in writing the reasons for the denial of a variance. No variance shall be granted that would threaten the health, safety, or rights of residents.

S. Appeals. Revocation, suspension or denial of a license may be appealed pursuant to Minnesota Statutes, chapter 15.

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§ 2.037 Department of Public Welfare rule for the administration of grants in aid to residential facilities for the mentally retarded and cerebral palsied.

A. Minn. Stat., ch. 673, 1973 Legislative Session, established the authority of the Commissioner of Public Welfare to make grants to aid in the purchase, construction of remodeling of community residential facilities for the mentally retarded and cerebral palsied persons.

B. The terms used in this rule shall mean:

1. Commissioner—The Commissioner of Public Welfare.

2. Board—The governing body of the proposed residential facility.

3. Application for grant—Any city, village, town, county, or non-profit corporation, or any combination thereof, may apply to the Commissioner for a grant under provision of ch. 673. Applicants must qualify according to licensing provision of Minn. Stat. § 252.28, 12 MCAR § 2.034, and Minnesota Health Department Standards for Supervised Living Facilities. The determination of need and location of proposed facility shall follow the criteria and procedures developed by the Commissioner of Public Welfare.

C. Statement of purpose.

1. This rule is designed to aid in the development of community residential services for mentally retarded and cerebral palsied persons which:

a. Provide appropriate alternatives for such persons, including those currently in state institutions and nursing homes.

b. Allow such persons to live in a homelike atmosphere near their families.

c. Comply with the provisions of Minn. Stat. § 252.28, 12 MCAR § 2.034, and Regulations of the Minnesota State Board of Health for the Licensing of Health and Safety Component of Supervised Living Facilities when implemented.

2. This rule governs the making of grants to nonprofit organizations, municipalities or local units of government.

D. Board.

1. There shall be a designated board for the facility.

2. Where a private nonprofit corporation is the applicant for a grant, there shall be sufficient representation balanced among:

a. Parents of the residents.

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b. Professional persons interested in and having responsibility for services to the mentally retarded. These professional persons may be representative of local health, education, and welfare departments; medical societies; area mental health-mental retardation program boards; state hospitals serving the mentally retarded, and associations concerned with handicapping conditions.

3. Where a public or government board is the applicant for a grant 12 MCAR § 2.034, Part E. 2. d., is applicable:

The facility shall provide for meaningful and extensive consumer representation and public participation in its operation. If consumer representatives, interested citizens, and relevantly qualified professionals are not represented on the governing body, an advisory body composed of such representation shall be appointed by the governing body.

4. Each board shall submit such reports as the Commissioner may require.

5. Each facility board is responsible for cooperative planning with other agencies in the community, such as special education, sheltered workshops, vocational training, county welfare departments, the area mental health-mental retardation program boards, state institutions and daytime activity centers.

6. Application shall be made on forms supplied by the Department of Public Welfare, which includes a statement of purpose and goals of the program.

E. Finances and budget.

1. Applicants shall submit statements concerning the source of all funding for the construction, purchasing or remodeling of the facility, including federal grants, local government funds, gifts, charitable sources, mortgages, and other information as required by the Commissioner.

2. Grants may be awarded to provide up to 25 per cent of the cost of construction, purchasing or remodeling, of which one-fifth of the grant may be used for equipment and initial staff costs.

F. Criteria for grant awards.

1. Grant awards will be based on additional considerations, which include:

a. How grant money would work conjunctively with other funding sources.

b. How grant money would generate other funding sources (i.e., matching with federal funds, local tax contributions, community projects).

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c. Compliance with provisions for residents to live in homelike atmosphere, near their families, in facilities for no more than 16 persons, and no more than two such facilities located together.

d. Whether the application presents new, innovative, pilot or demonstrational ideas regarding developmental programs, types of persons to be served, administrative organization or other services to be provided to the community.

G. An advisory board will be appointed pursuant to provisions of ch. 673.

Effective date—February 4, 1974.

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006329

12 MCAR S 2.043 Standards for outpatient treatment programs for people with alcohol and other drug problems.

A. Statutory citation. This rule is promulgated pursuant to Minnesota Statutes, sections 62A.149, 245.781 to 245.813, 254A.02, subdivision 2, 254A.03, subdivision 1, and 254A.10.

B. Statement of purpose. The purpose of this rule is to establish a basis for approving or licensing outpatient treatment programs for people with alcohol and other drug problems.

C. Definitions.

1. Applicant: any person, agency or organization applying for a license or renewal license under this rule.

2. Client: an individual whose physical, social or psychological status allows him/her to function in the usual community environment, but whose alcohol and/or drug related behavior causes problems to himself/herself and/or others in the home, employment or community setting and who is receiving services in an outpatient treatment program covered by this rule. This may include the family of and/or others significant to that person.

3. Commissioner: the Commissioner of the Department of Public Welfare or a designated representative of the commissioner.

4. Department: the Department of Public Welfare.

5. License: the certificate issued by the commissioner that validates compliance with this rule, and authorizes the applicant to operate an outpatient treatment program.

6. Program director: the applicant staff member responsible for planning, implementing and directing the operation of all aspects of the program.

7. Direct counseling staff: all staff employed by the facility and who provide treatment and/or related services to clients.

8. Outpatient treatment program: a treatment program with a defined regimen serving at one time five or more persons experiencing problems related to alcohol or other drugs for the main purpose of providing primary or post-primary treatment care. The regimen must provide a minimum of ten hours of total service time scheduled at a minimum of one hour per week and must provide time-limited therapeutic services on a non-residential basis employing individual treatment plans to clients.

Programs not covered by this rule are those whose primary

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functions are: Information and referral, diagnosis, education, support group services, self-help groups.

D. Licensure.

1. No outpatient treatment program shall operate without a current and valid license or provisional license to operate in the state of Minnesota. The license shall prescribe the person or organization operating the program and the location of the program.

2. Outpatient treatment programs which are housed within a hospital, licensed by the Department of Health are excluded from these regulations under Minnesota Statutes, section 245.791 (1977 supplement), but the program has the option of voluntarily seeking approval if it is requested.

3. All existing outpatient treatment programs must apply to the commissioner within 60 days of the effective date of this rule and comply with the provisions of the rule to obtain and maintain a license. New programs must obtain a license prior to accepting clients. Application for renewal of license shall be made 45 days prior to the date of expiration. Application and reapplication shall be made on forms furnished by the commissioner.

4. An initial license shall be valid for up to one year after the date of issuance. A renewal license may be issued for up to two (2) years at the discretion of the commissioner. A license may not be transferred from one operator to another or from one primary location to another.

5. Every applicant shall be furnished with a copy of this rule.

6. If the commissioner determines that the applicant or the operator is not complying with the provisions of this rule, the license may be denied, revoked, suspended, made probationary or not renewed after notice to the applicant or operator. The denial, revocation, suspension, probation, or failure to renew shall proceed in accordance with the provisions of applicable Minnesota laws and rules. The applicant or operator shall, in any appeal of the commissioner's determination, use procedures authorized by Minnesota Statutes, sections 15.0411 to 15.0426, the state Administrative Procedures Act.

7. Prior to the issuance of a license or provisional license, the following steps shall be completed:

a. The commissioner shall determine the need for the program based in part on a recommendation which shall be obtained from the Area Board/Human Service Board. The recommendation on need from the board shall be accompanied by documentation explaining the basis for determination.

b. A completed application shall be submitted to the

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commissioner prior to issuance of a license from the Department of Public Welfare.

c. The fee for license shall be paid to the commissioner.

8. Licensing policies and procedure shall be available to the public.

9. If a determination is made that all applicable laws, rules, and regulations cannot be met immediately, consideration of a provisional license shall be in accordance with the provisions of Minnesota Statutes, section 245.783, subdivision 3.

10. Each applicant must provide assurance that no person shall be discriminated against in relation to admission, discharge or treatment on the basis of sex, race, creed, color, national origin, religion, disability, or sexual preference.

11. All facilities where outpatient treatment programs are conducted must meet all applicable local and state codes relative to fire, safety, building zoning and health standards, and documentation of that must be provided prior to granting a license.

E. Right to entry.

1. Authorized representatives of the commissioner may visit the program at any time during the hours of operation for purposes of licensing study and inspection. Inspections may be made without prior notice to the applicant and program director.

F. Confidentiality.

1. No information regarding a client shall be released to any person or agency, except pursuant to applicable state and federal regulations.

a. There shall be a written plan describing methods and procedures used to ensure confidentiality of case records.

b. This written plan shall include but not be limited to methods and procedures for release of information to and obtaining information from outside agencies and resources, as governed by appropriate state or federal statute regulations.

G. Minimum standards for issuance of a license to an outpatient treatment program.

1. Governing and advisory boards.

a. Each outpatient treatment program must be responsible to a governing body, or to an Area Board/Human Service Board which directly operates an outpatient treatment program. The governing body must have written documentation of its source of authority which the governing body, directly or

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through its legal representative:

(1) Is legally and financially responsible for the operation of the program or agency.

(2) Operates the program in compliance with all appropriate state and federal laws.

(3) Approves all additions or deletions of services provided by the program which affects the implementation of the individualized treatment plans; additions or deletions must be submitted for approval to the commissioner within 60 days after implementation.

(4) Documents the adoption of a schedule of meetings and attendance requirements, and shall keep minutes of all meetings.

(5) Provides accessibility of all policies and procedures mandated in this rule to all staff.

(6) Reviews and approves fiscal plan on an annual basis to include review and approval of annual operating budget, fee schedule, and annual audit.

(7) Reviews and approves all revisions to the fiscal plan.

b. Each outpatient treatment program must have an advisory board which consists of at least five members and:

(1) Provides a system for client input regarding the program.

(2) Provides a system for community input regarding the program.

(3) Has at least one community representative as a member who has no other affiliation with the program.

(4) Includes a former participant of the program or some other outpatient treatment program as defined by this rule.

(5) Provides input to governing board and direction to program director regarding all additions or deletions of services provided by the program which affects the implementation of the individualized treatment plans.

c. The program director must as a minimum make written quarterly reports to the governing body or its legal representative and the advisory board and shall not be an official member of either the governing body or the advisory board.

d. Any governing body which elects not to have an advisory board must itself meet the requirements for a governing

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board and an advisory board as specified in G.1.a. and b.

2. Director -- every outpatient program shall have a director who shall:

a. Be at least 18 years of age.

b. Document three years of general work experience in administration and/or personnel supervision, and (1) at least one year experience in direct service to persons with alcohol and other drug problems or (2) one year of experience in the management or administration of direct services to people with alcohol or other drug problems; or document holding of bachelor's degree and (1) at least one year experience in direct service to persons with alcohol and other drug problems or (2) one year of experience in the management or administration of direct services to people with alcohol or other drug problems.

c. Have no current problems related to alcohol or other drugs which negatively affects his/her job or program performance.

3. Staffing requirements.

a. Programs must demonstrate staffing capability to provide services at the levels identified within the program plan. To this end the following minimal requirements must be satisfied:

(1) For each one hour of individual, group or family unit counseling and each admission and discharge interview, a minimum of 1.25 hours of counselor time must be allocated.

b. Direct counseling staff must be at least 18 years of age.

c. Staff must not have current problems related to alcohol or other drugs which negatively affects their job or performance.

d. Direct counseling staff must have at least one year experience/or education in behavioral health or human services.

e. Direct counseling staff must have at least one year supervised clinical experience in a residential primary treatment, outpatient treatment or aftercare setting.

f. Personnel files of all direct counseling staff must include documentation of individual competencies in the following areas:

(1) Designing individualized treatment plans based on the needs of each client.

(2) Conducting an assessment interview and listing the client's specific strengths and problems related to chemical

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use, physical and emotional functioning, family and other cultural issues.

(3) Implementing individualized treatment plans utilizing internal and/or external program services including: vocational, education, spiritual, family, financial, recreational, health, legal, chemical.

(4) Maintaining client recordkeeping systems.

(5) Developing evaluative outcome criteria for each problem area identified in the individualized treatment plan.

(6) Identifying the variety of chemical use problems that exist in the community to be served by the program:

(a) Pharmacological and behavioral effects of various chemicals.

(b) Age and cultural aspects.

(c) Short and long term treatment implications of (a) and (b) above.

(7) Staff may be subject to an interview by the licensing authority regarding documentation.

g. Volunteers acting as direct counseling staff must meet the requirements of section G.3.

4. Personnel policies - the original application and all renewal applications shall describe the nature and extent of the training and qualifications of the staff and shall include a description of the staff organization, which defines the roles and responsibilities of all personnel and lines of authority.

a. The applicant shall maintain personnel policies including: job descriptions, qualifications, performance and evaluation standards, remuneration and fringe benefits for each staff position. These policies shall include procedures governing hiring, suspension, dismissal, assignment, promotion, grievance procedures, and other appropriate policies. Performance reviews of staff including the director, shall be made at least annually.

b. These written policies shall be maintained and communicated to the staff, prospective staff, and volunteers of the program. Policies shall be reviewed and updated annually.

c. These policies shall be implemented without prejudice regarding sex, race, creed, color, national origin, religion, disability, or sexual preference and include an affirmative action plan.

5. Medical services.

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a. Documentation of availability of a licensed physician and/or nurse practitioner or registered nurse for necessary medical care, emergency medical services, and medical reporting for all clients of the program.

b. Documentation of availability of board-certified or board-eligible psychiatrist and/or licensed consulting psychologist who shall provide at the discretion of the director, when needed, psychiatric and psychological evaluation services for clients admitted to the program.

c. Prescription medication when administered on the premises of the program shall be administered by qualified personnel as specified by the Minnesota Department of Health.

6. Staff development - each program shall provide documentation of a written staff development program for direct service and supervisory personnel. There shall be a minimum of 12 hours/year for each full time equivalent staff. The program shall include orientation and training of all staff, continuing development of staff skills and abilities through a defined in-service program and/or participation in other training programs. If volunteers are utilized, they shall be included in staff development programs. The person responsible for the staff development program shall be identified. This plan shall be reviewed annually.

7. Evaluation - all programs shall develop procedures to monitor how well their program's administration and service goals (see G.8.b.) are being met.

a. For each objective specified in the application, there shall be a separate procedure for monitoring progress towards reaching that objective. These procedures shall be specified to the department at time of application.

b. For each objective specified in the application, there shall be a separate statement of actual progress made towards reaching the objective, determined by using the procedure specified above. These statements of actual progress shall be submitted to the department with the application for renewal of license.

c. Program shall submit information to the commissioner for evaluative purposes upon request.

d. Program shall provide documentation verifying integration of evaluation outcomes into the program operation.

8. Administration and management - every outpatient treatment program shall have written administrative and management policies governing the administration and supervision of the operations, the program and the duration of the program. Such documentation shall include:

a. A written plan describing the program's philosophy,

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organization and role of supervisory personnel.

b. Administration and service goals and objectives for the operation of the program.

c. Policies and criteria for admission and discharge, including a definition of when a client is considered active in the program. The admission procedure shall include:

(1) A description of the process by which a client is accepted or rejected by the program and disposition of client if not accepted.

(2) A procedure for determining the necessity of a medical evaluation, which is developed in conjunction with a physician, nurse practitioner, or registered nurse. Procedures for determining the necessity of the psychological evaluation shall be developed in conjunction with the consultant required under section G.5.b.

(3) Assessment that includes the chemical use history, a psycho-social history including utilization of relevant human services, cultural background, vocational and educational history, family relationships, socio-economic status and determination of current physical and emotional state.

d. A written description of program design and methodology.

e. A written delineation of the inter-relationship of the program and other appropriate public and private service providers.

f. The program must develop an annualized projection of individual and/or family counseling hours, group counseling hours, admission and discharge interviews and discharge and/or aftercare planning to be provided by the program. Program must also develop annualized projection of counseling hours available to provide these services based on number of staff positions and equivalent counselor time (see G.3.a.(1)). Annual projections of service hours and equivalent counselor time must be reviewed, updated and submitted to the commissioner with each application for renewal.

g. A written procedure for the provision of services required by individual clients which are unavailable in the program.

h. The program shall have a written referral policy and procedure for client referral between the program's components and/or between the program and other community service providers which includes:

(1) Conditions under which referrals are made.

(2) Means by which the program will assist in the

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referral of those individuals who are seeking services that the program does not provide.

(3) Documentation of at least one contact with the referral agency within a designated time period.

(4) Current and confidential log of all referrals that the program initiates and receives.

i. An individual record for each client of the program which includes:

(1) Demographic characteristics of the client, including age, sex, ethnic/cultural group, income, method of payment and source of referral into the program.

(2) Documentation of determination of the necessity of a physical and/or psychological assessment and the resulting referral when appropriate.

(3) Documentation of a psycho-social assessment, which shall include the nature and history of the client's chemical use, the nature and history of the problems associated with the client's chemical use, and the nature and history of the client's previous contacts with chemical dependency services, mental health services, the criminal justice system, or other social, vocational, educational or financial services.

(4) A written individual treatment plan which identifies client needs and problems, based on the psycho-social assessment, and if deemed necessary, the medical evaluation which:

(a) Specifies services planned for meeting the client's needs.

(b) Includes referrals for services not available within the program.

(c) Describes the client's participation in development of the treatment plan, and is signed by the client and a staff member.

(d) Documents progress and changes at least weekly.

(5) All entries must be legible, dated and signed.

(6) Written consent of the client or guardian for any release of information to persons not otherwise authorized to receive it pursuant with state and federal regulations.

(7) Documentation, signed by the client, that he/she has received a copy of the program rules and the client's rights and responsibilities while participating in the program.

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(8) A discharge summary which evaluates the client's progress toward goals and objectives set forth in the treatment plan and describes the joint program/client's plans for future activities to maintain effective functioning and the program's plans for followup of the aftercare plan.

(9) Each program shall provide a written individualized aftercare/discharge plan for each client which is designed to establish continuing contact, ensure utilization of other appropriate resources in the community, and record progress against pre-stated goals.

j. Follow-up data, obtained within three to six months after the client discontinues the program (those who are either discharged at completion of the program, and those who leave the program before completion), shall be collected from no less than 50 clients drawn randomly, or 100 percent of the discontinued clients, whichever number is less, served in the 12 months since issuance or last renewal of the license. Documentation of efforts to locate clients for follow-up shall be made on a client by client basis. Follow-up contacts should ascertain, for each client, (1) the client's present chemical use patterns; (2) whether problems originally associated with the client's chemical use are improved or have become worse; (3) whether the client is engaged in appropriate post-treatment activities or lifestyles which are consistent with the client's treatment and/or discharge plan; (4) whether the client needs or wants additional services. The follow-up collection procedure should permit quarterly summarization of data for all clients.

k. At the time of application for licensure renewal, the applicant shall submit a report to include a summary of data collected pursuant to section G.8.j.

l. Financial records including an annual budget, records of income and expenditures, fee policies, and record of an annual audit. New programs must document in writing assurances of funding sufficient to meet total projected program costs and start-up costs if any, for a period of at least one year.

m. Records shall be kept on a continuing basis that accurately reflect the number and dates of clients accepted and rejected, number and dates of clients discharged, length of service and what happens to clients upon leaving the program. Such records shall be furnished to the commissioner upon request. Such records shall be kept for a minimum period of five years for ongoing programs or for one year for defunct programs.

n. Written documentation of general liability insurance coverage in an amount sufficient to protect the interests of the clients and staff.

o. A description of the methods by which clients' legal, civil, and human rights will be protected. This shall

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include the procedures for handling complaints and grievances by clients, their relative, and/or guardians. A written copy of such rights and procedures shall be given to each client entering the program and posted in a prominent place.

(1) The program shall have a written statement of its policies and practices for handling cases of neglect and abuse of its clients.

(2) The risks associated with the use of any therapeutic procedures shall be fully explained to the client in terms he/she can understand.

9. Outpatient treatment programs serving adolescents must meet the above requirements and in addition each program must:

a. Provide a written rationale for its approach to the treatment of adolescents, demonstrating that within the context of its adult/adolescent population, the program can provide appropriate services to adolescent clients.

b. Provide counselor(s) with knowledge in adolescent chemical dependency behavior, adolescent behavior, and direct counseling experience with adolescents. Personnel files of these counselors must document that the qualifications and expertise of identified staff is sufficient to meet the needs of the clients.

c. Provide for each one hour of individual, group, or family unit counseling and each admission and discharge interview, a minimum of 1.5 hours of counselor time must be allocated. This section supersedes section G.3.(1) above.

d. Provide inservice training of direct counseling staff in areas specific to the treatment of chemically dependent adolescents, including training on incest, sexual and physical abuse, family dynamics, independent living skills, habilitation vs. rehabilitation, experimentation, and decision making.

e. Document attempts to obtain the active participation of the adolescent's family or family surrogate in the treatment process. If, despite reasonable effort, participation of a functioning family or family surrogate unit cannot be obtained or if the client chooses not to permit their involvement, it is then the obligation of the program to involve the anticipated provider of aftercare services in discharge planning.

f. Document appropriate educational opportunities. Treatment and discharge planning must occur in coordination with the client's ongoing educational setting. The program shall assist in identifying to responsible educational facilities the client's need for special learning and behavior problem teachers, tutors, class room teaching, vocational education, etc., as appropriate.

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g. Provide treatment, literature, lectures, etc. which are easily comprehendible to, and appropriate for the age level of adolescents served.

h. Provide a recreational rehabilitation program to clients. Activities should be planned to develop constructive leisure time activity skills and should be documented in each individualized treatment plan.

i. Develop a discharge plan which reflects consideration of aftercare provisions unique to adolescents to include leisure time, education, specialized adolescent services, role of family or family surrogate. The plan should be developed cooperatively by the client, program staff, referring agency, family (or surrogate) and the anticipated provider of aftercare services (when appropriate), and signed by the client.

H. Severability. If any provisions of the rule as adopted by the commissioner of public welfare are found to be unreasonable or not supported by the evidence, the remaining provisions shall remain valid.

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§ 2.044 Aid to families with dependent children.

A. Introduction.

1. This rule shall govern administration of the Aid to Families with Dependent Children (AFDC) program in Minnesota. The provisions of this rule are to be read in conjunction with Title IV-A of the federal Social Security Act, Title 45 of the Code of Federal Regulations, Minn. Stat. ch. 256, and other rules of the Department of Public Welfare pertaining to public assistance and the administration of Minnesota's state and local welfare departments. ["Local welfare department" or "agency" includes the county welfare department of those multi county welfare agencies established under Minn. Stat. § 393.01 (1974) or Minn. Stat. ch. 402]. The Commissioner of Public Welfare may issue instructions, bulletins, and manuals to the local welfare agencies to clarify the provisions of this rule (DPW 44 takes precedence over such documents) and may prescribe forms and procedures to be used in administration of this program. In order to assist others in interpretation of 12 MCAR § 2.044, the Department of Public Welfare has issued, informally, an AFDC Policy Manual. The material in the Manual is not an official rule and does not have the force and effect of law.

2. The commissioner shall cooperate with the federal government and its public welfare agencies in any reasonable matter that will be necessary to qualify for AFDC. Notwithstanding any provisions of this rule, administration of the AFDC program shall be subject to changes in federal or state law. The commissioner shall notify the local welfare agencies of such changes as they occur.

3. The AFDC program shall be administered to provide qualifying needy families with the resources necessary to sustain a reasonable subsistence compatible with decency and health, according to this rule. The AFDC program shall not be administered to deny applicants and recipients their individual and civil rights, nor to obtain or disclose information regarding them except as provided by DPW rules.

4. The commissioner shall supervise the AFDC program on a state wide basis in accordance with equitable standards for assistance and administration which shall be mandatory upon all political subdivisions.

B. Applications for assistance.

1. Any person may apply for AFDC to the local welfare agency in the county in which he/she resides, and the local agency shall promptly advise him/her of the program's eligibility requirements. The local agency shall provide an application form immediately upon receipt of a written or oral request for assistance. The local agency shall require a written application signed under a penalty of perjury, on a form prescribed by the state agency, by applicant himself/herself or his authorized representative, whom he/she has specified in writing, or, where the applicant is incompetent or incapacitated, by someone acting responsibly for him/her. If the application is for

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AFDC-Foster Care (FC), it shall be signed in accordance with this section, except that the agency, or its designee, may also sign in lieu of the applicant, his/her authorized representative or someone acting responsibly for him/her. (See H. 3. below.)

2. As soon as possible, but not later than 45 days from the date of request for assistance, the local agency shall determine the applicant's eligibility for assistance. All eligibility conditions must be met within this 45-day limit. Assistance may be issued before the eligibility process is completed, but if the applicant is found ineligible, no federal or state financial participation may be claimed for this assistance.

3. The applicant must be notified in writing that his/her application has been approved or denied, unless the applicant dies or cannot be located. If the application is denied, the recipient must be notified in writing of the reasons for denial and of his/her right to appeal.

4. Any person has the right to reapply for assistance. New applications must be taken whenever a previous application has been denied or withdrawn, or whenever a grant has been cancelled, or whenever the payee has been changed. An approved application shall be addended for the purpose of adding additional eligible persons or when the payee has changed his/her name.

a. An application for AFDC received by a county must be processed as such, formally acted upon, and written notification of the disposition of the application must be provided the applicant regardless of the length of time that the applicant intends to remain a resident of that county. Until the applicant is notified in writing of the disposition of his/her application, any additional AFDC applications signed by this applicant in the same or in a different county are null and void. An applicant may voluntarily withdraw his/her application at any time.

5. Eligibility shall be redetermined at least semi-annually. When the local income maintenance unit receives information about a change in case facts, eligibility shall be reviewed within 30 days. The recipient shall furnish such correct information and reports as required by the agency to assure eligibility and payments.

6. The local agency shall verify the information contained in the application from the applicant or other persons or agencies only with the applicant's signed permission; blanket consents may be used only for groups of related agencies (such as banks, insurance agencies, etc.). If the applicant refuses to cooperate with the county agency in verifying the needed information, the application must be denied.

7. The following information shall be verified:

a. Social Security numbers of caretakers applying for or receiving assistance;

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b. incapacity of a parent or unemployment of a father if such is the basis of eligibility; and

c. the applicant's income and acknowledged property.

Any other factor of eligibility may be verified depending on circumstances of the case.

8. The income maintenance unit shall make immediate referral to the social service unit when there is reason to suspect that the home in which the relative and child requesting/receiving aid reside is unsuitable because of neglect, or sexual or physical abuse as defined in state statute.

9. Because of the complexity of the welfare system in Minnesota applicants and recipients may have someone act as an advocate to ensure that their legal, civil, and human rights are upheld or have someone assist them in the application, redetermination, or fair hearing processes or in any other contacts with the agency. The applicant or recipient may be represented by an individual (who need not be a lawyer) of his/her choice whom he/she has specified in writing. Each local agency employee is to ensure the rights and benefits of all applicants and recipients.

10. The client shall be responsible for informing the agency within ten days of receipt or by the 5th of the following month, whichever is earlier, of changes in circumstances and/or income. Such reports shall include new sources or amounts of income. The local agency shall use this report to determine continued eligibility or the amount of assistance for the next subsequent month unless income averaging is used.

11. The local agency shall inform applicants and recipients of the availability of all programs, the benefits and limitations of each, the areas of client choice among and within programs and the results of such choices, the items concerning eligibility or payment which must be reported if they change, the time within which such reports must be made, and any other policies or actions which have a direct effect on recipients.

C. Financial responsibility and residence.

1. "Residence" or "abode" means where a person lives and intends to remain; the "county of financial responsibility" or "county of settlement" means the county which is liable for a person's public assistance.

2. Minnesota residence shall be an eligibility requirement for AFDC, but no length of residence is required. A person loses Minnesota residence when he/she leaves the state with the intent to establish a home elsewhere; evidence of intent under this rule is not simply the person's stated intentions, but includes consideration of objective criteria associated with the move (e.g., movement of possessions, rent payments, changes in voter or driver's license registrations).

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3. The county of financial responsibility for an AFDC grant shall be the county wherein the dependent child is residing as of the date the application is signed. The county of financial responsibility for an AFDC-Unborn (UB) grant shall be the county where the mother is residing at the time the application is signed. (See D. 1.) The county of residence if different from county of responsibility, shall be fiscally responsible for any erroneous payments, including payments to ineligible individuals and families which result from its decisions, failures to act, agency-caused errors or overdue eligibility redeterminations.

4. If more than one county is financially responsible for the children in one AFDC grant, the caretaker's needs shall be assigned to the county having the responsibility for the most children, or the county responsible for the oldest child if each county is responsible for the same number of children.

5. If a child moves from one county to another and continues to receive AFDC, the county of financial responsibility shall transfer to his/her county of residence when he/she has resided in that county for two calendar months, provided the child and/or his/her caretaker were not placed in such other county pursuant to a plan of treatment for health, rehabilitation, foster care, child care or training, nor as a result of a placement in any correctional plan. If the original county or court or related agencies developed a treatment plan requiring the child's and/or family's move to another county, and even if the original county did not take an application prior to the move, then the original county is still responsible for initiating and accepting applications and retains financial responsibility for the AFDC grants until the goals of the plan have been reached. If thereafter the family or child continues to reside in the second county, the latter shall not assume financial responsibility until two calendar months have elapsed subsequent to completion of the plan. Such delay in transfer of financial responsibility shall relate only to such treatment placement plans which are arranged by a local agency, court order or other governmental unit such as the Division of Vocational Rehabilitation or Probation and which became effective after July 31, 1977. The delay shall not apply to child care arrangements made by the family themselves and independent of local agency or court order. The delay will apply where the local agency, etc., arranged for plans of a parent to participate in a training plan for himself/herself only and he/she takes his/her children with him/her to reside near the training facility in another county. However, the county of the child's residence shall be the county which services his/her AFDC grant, whether or not it is the county of financial responsibility; moreover, whenever the county of financial responsibility and county of residence have policies which conflict, the latter shall take precedence. The county of residence must furnish the county of financial responsibility with reports of interviews and budgetary recommendations. The county of financial responsibility must establish grants in accordance with recommendations of the county of residence after review for conformity to the statutes and the rules of the state agency. If the county of financial responsibility's action is not the one recommended by the county of residence, the county of financial responsibility shall notify the county of residence of the action taken and the reason. Client eligibility shall not be affected by a change in county of residence of

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and by itself. Once the client has notified the current county of residence of a planned move, the current county shall immediately forward to the new county all current and permanent case record information. Within 30 calendar days the new county of residence shall interview the client and respond to any changed circumstances which affect eligibility for AFDC payment. The county shall not take a formal reapplication for the client or apply any eligibility criteria which governs only initial applications. This includes, but is not limited to, the quarters of work in unemployed fathers [see D. 10. a. (8) (a)] and the application of the $30 and 1/3 disregard [see D. 12. b. (8) (a) (i)]. In all situations in which a grant is being continued, as a result of a pending appeal or as an order resulting from an appeal, the county of financial responsibility shall be determined according to C. 5. supra.

6. If counties disagree as to which is the county of financial responsibility, the following procedures shall apply:

a. the county of residence shall grant AFDC to the applicant (if eligible) while it refers the case to the alleged county of financial responsibility;

b. the alleged county of financial responsibility shall promptly decide if the applicant is eligible for AFDC and if it is the county of financial responsibility;

c. if the alleged county of financial responsibility denies eligibility or financial responsibility for the applicant, the county of residence may accept financial responsibility or may refer the matter to the Commissioner of Welfare;

d. the Commissioner of Welfare shall review the matter and provide both counties with the opportunity to state their position (by formal hearing or otherwise) and decide which county is financially responsible; the commissioner's determination shall be binding on both counties unless it is appealed to and reversed by the courts according to law; and

e. the county determined to be financially responsible shall reimburse any other county for any costs the county previously paid on the grant; if eligibility is denied, the county of residence shall be responsible for costs previously paid.

D. Eligibility factors. Child status.

1. Age.

a. Children under the age of 18 are eligible for AFDC; children age 18-19 are eligible if they are full-time students attending a high school, college, university, vocational or technical training institute.

b. Unborn are eligible for AFDC during the last three months of the mother's pregnancy (as medically certified). AFDC grants for unborn are referred to as "AFDC-UB".

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2. Eligible relatives.

a. Parents (natural or adoptive), grandparents, brothers, sisters, uncles, aunts, great-grandparents, great-uncles, great-aunts, nephews, nieces, and first cousins, whether of whole or half-blood and stepparents, stepbrothers, and stepsisters, and spouses of these persons even after the marriage is terminated by death or divorce, are eligible to be the caretaker of a child receiving AFDC.

b. The caretaker must meet all eligibility requirements to be included in the child's AFDC grant.

3. Physical presence in the home.

a. A child must reside in the same home with an eligible caretaker to be eligible for AFDC unless he/she has special educational needs which cannot be met by local public school district which require that he/she reside away from home. "Educational needs" for this provision is defined as a curriculum directed toward achieving a special vocational or academic goal.

b. If an emergency exists that deprives the child of the care of the relative through whom he has been receiving aid, temporary absences of the caretaker or the child from the home shall not defeat AFDC eligibility for a temporary period necessary to make and carry out plans for the child's continuing care and support. No absence may exceed six months and all absences of more than three months shall be referred to the commissioner for a determination of continued eligibility. If the caretaker no longer, thereafter, can provide direct care for the child(ren), conditions for continued assistance do not exist. Alternative arrangements for care of the child(ren) shall be made.

4. Guardianship of a child shall not affect AFDC eligibility, but if the child does not reside with an eligible caretaker, he/she must meet the requirements of AFDC-FC (see H. 3.).

5. If a child dies (or if an unborn is stillborn), the AFDC grant shall be paid for the entire month in which death occurs.

6. Parental status. To be eligible for AFDC a child must be deprived of parental support or care due to the death, incapacity or continued absence of a parent from the home, or due to the unemployment of the father. This rule shall apply to natural and adoptive parents; the term "parental support or care" means financial maintenance, training, supervision, housekeeping and feeding normally given to children by their parents.

7. Death of a parent must be verified by official records (death certificates, military records, etc.).

8. Incapacitated parents.

a. A parent is incapacitated if he/she has a physical or mental defect,

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illness, or impairment which makes him/her unable to care for the child or substantially reduces or eliminates the ability to support the child. The incapacity must be expected to last at least 30 days from its onset. Budget deficiency alone shall not establish need in incapacity cases; the physical or mental handicap must cause the budget deficiency.

b. The incapacitated parent, and the caretaker relative, shall be included in the AFDC grant if need exists.

c. The incapacitated parent who is exempt from WIN registration (see H. 1.) must be referred to the Department of Vocational Rehabilitation.

9. Continued absence.

a. A parent is continually absent from the home if he/she is physically absent from the home and if this absence interrupts or makes uncertain his/her ongoing parental support or care; there is no minimum time period used to establish continued absence. The agency shall obtain, and the applicant shall provide, all available facts serving to establish a continued absence.

b. Upon an absent parent's return to the home, AFDC shall continue, if need exists, for one month following the month of his/her return.

c. Where continued absence exists:

(1) The applicant/recipient shall assign to the State his/her rights to any support from any other person. The assigned rights shall include support owed to the applicant/recipient on his/her own behalf and support owed on behalf of any other family member whose needs are included in the AFDC grant. The assignment shall not give to the State the right to agree to a reduction in the support being assigned or to a lump sum compromise or settlement of support due in the future. The maximum amount of the assigned support that shall be retained by the State shall be an amount equal to the total assistance expenditures.

(2) The applicant/recipient must be referred to the Child Support Unit.

(3) The applicant/recipient must cooperate in establishing paternity or obtaining support.

The Child Support Unit shall not attempt to establish paternity in cases involving incest or forcible rape, or in any case in which legal proceedings for adoption are pending if, in the opinion of the Income Maintenance Unit, it would not be in the best interest of the child.

(4) If an applicant or recipient fails to assign rights to support or to cooperate in establishing paternity or obtaining support, an AFDC grant shall be provided only for the child/children through protective or vendor payments. The needs of the caretaker shall not be deleted, nor protective or

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vendor payments instituted, if the caretaker demonstrates "good cause" that establishing paternity or obtaining support is not in the best interest of the child. The conditions of "good cause" as stated in federal regulations shall be applied.

10. Unemployed fathers (AFDC-UF).

a. An unemployed father is a father:

(1) whose family is in need;

(2) who is not unemployed due to a labor dispute;

(3) who works less than 100 hours per month;

(4) who has not been fully employed for 30 days prior to the receipt of AFDC-UF;

(5) who has not refused or quit employment except for good cause, within 30 days prior to the receipt of AFDC-UF;

(6) who has not been fired from his job within 30 days prior to the receipt of AFDC-UF;

(7) who is currently registered with the local Job Service Office of the Department of Economic Security and is available for training and/or employment;

(8) who has:

(a) worked at least six quarters during any 13 calendar quarters ending within one year prior to the date of application; at least $50 per quarter must have been earned during this period or the father must have been in an approved work-and-training program; or

(b) received or could have qualified for Unemployment Compensation during the year prior to application for AFDC-UF.

b. To refuse or quit employment or training except for good cause means that an individual refused or quit employment or training, or the offer of employment or training, which he was physically and technically able to perform, which was not excessively hazardous, for which transportation was available, and which paid the prevailing wage in the community for that type of work (but not less than the minimum wage).

c. An unemployed father and family shall be eligible to receive AFDC-UF and Unemployment Insurance concurrently, provided that the unemployed father applies for and accepts any Unemployment Insurance to which he is entitled. All Unemployment Insurance benefits received by the unemployed father must be subtracted from the amount of aid otherwise

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payable to the AFDC assistance unit. Ineligibility for AFDC for the whole family shall exist for any week for which the child's father qualifies for Unemployment Insurance, but refuses to apply for or accept these benefits.

d. To continue AFDC-UF eligibility in non-WIN counties, the father must re-register with the local Job Service Office of the Department of Economic Security every 30 days, and actively seek employment or enroll in a work training program or the entire family is ineligible. In WIN counties he must register for WIN (see H.1.).

e. If the father quits or refuses an offer of employment or training without good cause he shall no longer be considered registered in a non-WIN county and the entire family shall become ineligible to receive AFDC payments for so long as the father refuses a bona fide offer of employment or training. See H. 1. for sanctions in WIN counties.

11. Stepparent.

a. A stepparent is a potential resource for the support of his/her stepchildren, but cannot be required to support them. If a stepparent chooses to support a stepchild, that stepchild's needs must be removed from the grant.

b. A stepparent shall be legally responsible for the support of his/her spouse; if the stepparent is unable to support the spouse (and can document that fact), the spouses's needs may be included in his/her children's AFDC grant, assuming other eligibility conditions are met. To determine if the stepparent is unable to support his/her spouse, the amount of the stepparent's income (determined in the same way that an AFDC recipient's income is determined under D. 12. b.) shall be compared with the SSI payment level for one person; if the stepparent's income does not exceed this level, the spouse may be included in the AFDC grant, but any excess income shall be considered available for the support of the spouse.

12. Income and resources.

a. Property.

(1) Types of ownership. The owner of property in joint tenancy shall be considered as owning one-half of the value of such property, but the county or the joint tenant may establish legal interest of a greater or lesser amount. An owner of property as a tenant-in-common owns his/her pro rata share of the property's value. All other types of ownership shall be evaluated according to the law.

(2) Transfers of property. The transfer of real or personal property to establish or continue AFDC eligibility is contrary to public policy. Under this provision:

(a) Each AFDC applicant shall be required to disclose

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whether he/she has transferred any property within the last year worth more than $500 for which a reasonable consideration was not received; this disclosure requirement shall apply to all AFDC recipients upon a redetermination of their eligibility.

(b) Any property so transferred is a potential resource for the applicant or recipient, and the transferor must disclose the property's description and value, the names of the transferees, and the circumstances of the transfer.

(c) The applicant or recipient must cooperate with the local agency in reasonable efforts to reacquire the property or its value; failure to cooperate in reasonable efforts to do so shall constitute grounds for termination or denial of assistance.

(d) If the property cannot be reacquired, the matter must be referred to the county attorney for possible civil and criminal prosecution; the fact of transfer in itself shall not defeat AFDC eligibility.

(3) Real estate.

(a) No AFDC recipient may own net equity in real estate used as a home which exceeds $15,000, unless the local welfare board waives such excess equity. The amount of net equity is the difference between the recipient's share of the property's market value and encumbrances on the property.

(b) No AFDC recipient may own real property not used as a home (including properties being sold for contract for deed) unless the local welfare agency determines that the property produces net income applicable to the family's needs or which the family is making a continuous effort to sell at a fair and reasonable price. To determine net income from such property, taxes and maintenance expenses (but not principal payments of costs of improvement) shall be deducted from the gross income of the property.

(c) In deciding if the property limits of D. 12. a. (3) (a) of this section should be waived, the local board shall determine if such real estate is available for the support of the family or if the sale of such property would cause undue hardship. If so, then the excess shall be waived.

(d) The total real property (except for that used as a home and that which is income producing) plus all excluded and non-excluded personal property (except the earnings of a child being saved for educational needs) shall not exceed the limits established in federal regulations.

(4) Personal property.

(a) No AFDC recipient may own personal property the value of which is more than $300 if one child is included in the grant, or $500 if more than one child is included in the grant.

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(b) The provisions of D. 12. a. (4) (a) shall not apply to household goods, furniture, clothing, burial lots, mobile homes used as a home, or personal items; the limits of D. 12. a. (4) (a) may be exceeded where the excess is:

(i) derived from a child's earnings and is designated for specific educational needs of the child, and is in an amount reasonable for that need, and is held in a separate account, and/or

(ii) is designated for a specific purpose (such as real estate taxes or other large expenses), will be eliminated yearly, and does not exceed $500, and/or

(iii) is legislatively disregarded payment (such as some Indian tribal payments), and/or

(iv) is due to an income tax refund received within the preceding three months.

(c) A recipient may build his/her personal property to limits set forth in D. 12. a. (4) (a) as long as all his/her non-exempt income has been reported and counted in determining the amount of his/her grant.

(d) Income producing personal property shall be exempt from limits of D. 12. a. (4) (a). This includes tools, implements (trucks, tractors), and domestic animals.

(e) One automobile, the market trade-in value of which does not exceed $1650 shall be excluded in determining the personal property resources of all applicants/recipients. Market value shall be its current National Automobile Dealers Association (NADA) trade-in value. If client disagrees with NADA value, local agency evaluation shall be used. If the market trade-in value exceeds $1650 the automobile shall be excluded if client is employed, in training for employment, actively seeking employment, temporarily unemployed due to illness or injury and has a definite plan to work or the automobile is needed to obtain necessary medical care. Medical care shall mean the person or a member of such individual's immediate family has a medically diagnosed mental or physical condition which requires continued inevitable or unavoidable medical attention.

(i) If the market trade-in value exceeds $1650 and none of the exceptions are applicable, the automobile's equity (when added to the value of non-exempt personal property owned by the recipient) must be within the personal property limits for the family. Equity shall be NADA trade-in value minus encumbrances.

(5) Life insurance and trust funds.

(a) A recipient unit may retain life insurance policies with total cash surrender values of not more than $500 without defeating AFDC eligibility.

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(b) A trust fund whose beneficiary is a dependent child shall be subject to the property limits of this rule unless it can be demonstrated that the fund cannot be made available for the child's support.

(6) Prepaid burials. An AFDC recipient may have a prepaid burial contract which does not exceed $750 for each family member plus $200 in accrued interest. The funeral director must be the trustee of any such burial contract and a recipient must be the beneficiary, or a trust account specifically designated for funeral costs may be established by the funeral director and recipient jointly.

(7) Personal property which has increased in value beyond the limits of this rule must be reported to the agency. Such property will not defeat AFDC eligibility if the applicant/recipient within 15 days of notice by the county agency:

(a) converts the excess to an excluded type of property;

(b) uses the excess to repay the county for assistance already received;

(c) uses the excess to reduce his/her grant for one month; or

(d) uses the excess to meet all his/her needs for up to three months (thereby suspending his/her grant for those months).

(8) The resources of an SSI recipient shall be exempt in determining AFDC eligibility. In any family situation in which some members are eligible for AFDC and any other members are eligible for Minnesota Supplemental Aid (MSA) or General Assistance (GA), the property limitations in the program involved that has the least restrictive eligibility maxima will apply to the extent allowed by law.

b. Income.

(1) Generally, "income" is any benefit received by and available to an AFDC recipient as earnings or otherwise. Income may be earned or unearned. In family groups living together, the income of a spouse shall be considered available to his/her children under age 21. All income, except non cash items provided free of cost and other items specifically disregarded in this rule, must be evaluated in determining the need of AFDC recipients. Real or personal property which has been converted to cash shall be treated within the property standards stated in part D. 12. a. (4), not as newly received income.

(2) Exclusions. The following income is not considered a resource for AFDC purposes:

(a) inconsequential income (amounts up to $30 per month providing such amount is less than the grant);

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(b) reimbursement for the maintenance costs incurred in providing foster care;

(c) WIN work and training allowances;

(d) non-WIN training allowances received as a social service expense;

(e) Food Stamp bonuses;

(f) Comprehensive Employment and Training Act incentive payments;

(g) home-produced foods used in the home;

(h) reimbursement for out-of-pocket expense incurred for volunteer work;

(i) corrective payments from the local agency;

(j) assistance under the Uniform Relocation Act of 1970;

(k) Indian tribal payments specifically exempted by Congress;

(l) loans and grants, such as scholarships, obtained and used under conditions that preclude their use for current living costs;

(m) any grant or loan to any undergraduate student for educational purposes made or insured under any programs administered by the United States Commissioner of Education;

(n) Vietnam veteran's bonuses authorized by law;

(o) benefits under Titles VI or VII of the Older Americans Act of 1965;

(p) federal and state income tax refunds, (annual tax refunds shall not be considered available income; availability of income shall be determined at the time income is earned; determination of currently available income shall require assessment and disregard of the amount of tax obligation incurred at a given level of current monthly income; the amount withheld from wages, for various reasons, may exceed the amount of tax obligation; when the excessive amount withheld is returned in the form of a tax refund, the amount of the tax refund shall be disregarded; the availability of that income has been previously assessed);

(q) federal payments for presidentially declared disaster areas when specifically identified in federal law;

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(r) volunteer payments under Titles II and III of the Domestic Service Act of 1973;

(s) assistance through the National School Lunch and Child Nutrition Act amendments of 1973;

(t) allowances and expenses paid by Vocational Rehabilitation;

(u) other income disregards as mandated by federal or state law;

(v) earnings received by any youth under Title III, Part C, Youth Employment Demonstration Program of the Comprehensive Employment and Training Act of 1973 (Public Law 93-203) is to be disregarded;

(w) Minnesota property tax credits or refunds received by a recipient who does not receive a housing allowance pursuant to Section E. 3. following shall be excluded.

(3) Allocation of income.

(a) Before applying income to need, income may be allocated from spouse to spouse and from parents to children under age 21 if such person resides with the AFDC recipient and is in need.

(b) The income and resources of an SSI recipient shall not be counted in determining the AFDC recipient's income.

(c) Trust funds for a particular person or purpose shall not be allocated to the family until that person's needs or the particular purpose are met; only legally restricted trust funds shall be excluded.

(d) Retirement, Survivors, and Disability Insurance (RSDI) payments are considered family income unless they are paid on behalf of a child who is excluded from the grant.

(e) Income from jointly-held property shall be allocated according to the share of ownership and availability to AFDC recipients.

(4) Income cannot be allocated to meet past obligations. See DPW 53 (12 MCAR § 2.053).

(5) During the period of eligibility, the county may determine income and work expenses monthly or average them over a three-month period.

(6) All unexcluded unearned income and earned income minus allowable deductions must be applied against the AFDC Standard.

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(7) Income averaging shall involve use of three months of income to establish assistance for three months; actual income variations shall be ignored when income averaging is used unless a significant change requires a stop in the averaging cycle. Significant changes are: A decrease in total income (disregard, available income and grant) to less than the need standard; an increase in net income which would result in ineligibility; termination of employment; a change in net income totaling more than a $50 difference from the average in a given month, except when the difference is due to calendar fluctuations causing receipt of an extra paycheck, and except when the agency reconciles the budget at the end of the averaging period. When income is averaged or budgeted monthly, monthly equivalent income shall be established by one of the following methods: by multiplying weekly income by 4.3, bi-weekly income by 2.16, and semi-monthly income by 2, or by using any method resulting in an accurate reflection of total monthly income.

(8) Earned income.

(a) Generally, earned income shall include any compensation from employment or self-employment (wages, salary, tips, commissions, profits, etc.), plus training incentive payments and work allowances under the Equal Opportunity Act and Title I of the Elementary and Secondary Education Act.

(i) $30, plus one-third of the remainder of the family's total earned income shall be disregarded unless a family member has terminated or refused employment, or reduced earned income without good cause within the preceding 30 days (in which case the disregard shall not be applied for one month to the earnings of that individual); this disregard shall not apply to income from WIN public service employment.

(ii) The earned income of a child under age 14 shall be excluded.

(iii) The earned income of a child over age 14 who is a full or part time student (but not employed full time) in a high school, college, university, vocational or technical courses shall be excluded; the earnings of the student shall be considered in determining initial eligibility and afterward, excluded.

(iv) In new applications, the $30 and 1/3 earned income disregard shall not be applied to earned income unless the applicant's needs were met, in whole or in part, by AFDC in any of the four months preceding the month of application.

(b) The following employment expenses shall be deducted in determining net earned income:

(i) federal and state income tax obligation; (the expense of employment at a given level of income is the tax obligation incurred; in determining net income which is currently available, the amount of the tax

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obligation incurred at current monthly income is used; the amount of monthly tax obligation is displayed on tables developed and published by the Department of Public Welfare); (at client's request, a reconciliation shall be performed to determine whether client's tax obligation for a past tax year has been understated; any understatement discovered shall be corrected by a supplementary payment to the client);

(ii) FICA and SMI payments;

(iii) child care costs unless these are paid as a social service; or paid to a relative included in the AFDC grant; or paid to a relative who is financially responsible for the family and able to contribute to it; child care costs paid to a parent may not be deducted in determining net income;

(iv) business expenses (except depreciation);

(v) personal expenses in the manner described in paragraph D. 12. b. (8) (c);

(c) Personal expenses of employment shall be recognized by deducting 10% of gross income up to a maximum of $60. If the client requests that actual expenses be recognized in lieu of the standard deductions, the following expenses shall be deducted, if incurred, necessary and reasonable;

(i) mandatory retirement fund deductions;

(ii) transportation costs to and from work based on the actual cost of public transportation or car pool payments, or 13 cents per mile for the actual number of miles driven, not to exceed 100 miles per day of employment; no fault insurance is included in the 13 cents per mile;

(iii) cost of work uniforms;

(iv) union dues;

(v) professional association dues required for employment;

(vi) health insurance premiums;

(vii) cost of tools and equipment used on the job;

(viii) one dollar per day for the cost of meals eaten during employment;

(ix) public liability insurance required by the employer when an automobile is used in employment and the cost is not compensated for by the employer.

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(d) Income from small businesses is the difference between gross receipts and business costs. (Capital expenditures and depreciation are not a business cost.) Those expenses which are allowable as personal expenses of employment under D. 12. b. (8) (c) (i - ix) shall not be allowed as business expenses.

(e) Farm income is the difference between gross receipt (sales, rents, soil conservation payments) and operating expenses. Home-produced foods for sale are included. (Capital expenditures are not included as an operating expense.)

(f) Income from child care in the home shall be 40% of gross receipts. The client may rebut this presumption by documenting actual business expenses in conformance with IRS Schedule "C" and the limitations in D. 12. b. (8) (d), in which case income shall be gross receipts minus actual business expenses.

(g) Income from roomers and boarders is computed by allowing $58 per month (for each border), $48 per month (for each roomer), or $105 per month (for each roomer and boarder), as the expenses of producing this income.

(h) Unearned income is not the direct result of labor performed by the recipient as an employee. Receipt of SSI shall be a bar to receipt of AFDC. Serviceperson's income shall be counted after deducting the amount needed for the serviceperson's clothing, personal needs, and transportation, but cannot be greater than the amount actually received by the family.

(9) Special situations.

(a) Rental income is unearned income unless there is labor expended in obtaining the income from rental property. $69 shall be deducted per year or two percent of market value (whichever is less) for upkeep and repairs, and taxes, insurance, utilities and interest on principal payments shall be deducted. Where the recipient lives on the property, these expenses shall be allocated according to the number of rooms.

(b) Unless otherwise excepted, lump sum payments and windfalls shall be unearned income in the month received and shall be considered property thereafter.

(c) An AFDC recipient must be a U.S. citizen, an alien lawfully admitted for permanent residence, or a continuous U.S. resident since July 1948.

(d) Social Security numbers of all caretakers included in the grant must be provided to the county agency as a condition of eligibility (but assistance shall not be denied where a number has been requested from the Social Security Administration, but not received). Failure to cooperate shall result in deletion of the caretaker's needs and protective/vendor payments shall be issued for the children.

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E. AFDC family allowance.

1. Standards of need.

a. The need standards set forth in this section shall be used to determine the grant for every AFDC family in Minnesota (except AFDC-FC).

b. Definitions.

(1) An "eligible person" is one who is eligible for and receives AFDC; in most circumstances it means one caretaker relative and the dependent children he/she cares for. (More than one caretaker may be included when eligibility is based on parental incapacity or unemployment of the father.) All "eligible persons" receiving one AFDC grant constitute one "recipient unit".

(2) The "children" standard shall apply to all members of a recipient unit except the caretaker or other adult.

(3) The "first adult" standard shall apply to the caretaker relative.

(4) The "second adult" standard shall apply to an adult member of the recipient unit who is in addition to the caretaker.

(5) To determine the grant amount for an eligible family, the appropriate amount for the children from the standard shall be added to the amount for an adult(s) from the standard if applicable, to arrive at the grant amount.

(6) A family composed of individuals with varying bases of eligibility but living together as a unit shall constitute one recipient unit. This does not apply when two eligible adults share shelter without a marital bond.

(7) In family groups in which there is an adult caretaker(s), a minor, and a child of the minor, the minor shall have the choice as to which way the grant shall be determined:

(a) the minor and her child may be included in the adult caretaker's grant;

(b) the minor and her child may receive a separate grant; or

(c) the monor may continue in the adult caretaker's grant and the child of the minor shall receive a separate grant.

c. Family allowance.

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Eligible Persons	Children Standard	
1	171	
2	235	
3	295	
4	348	First Adult standard: 129
5	399	
6	451	
7	495	Second Adult standard: 51
8	540	
9	578	
10	614	
Each person above 10 add	37	

d. Amount of grant. The amount of the AFDC grant for a recipient unit is the difference between the standard of need as determined by the above table and the recipient's non-exempt, non-disregarded income (see D. 12. b.).

2. Special need items. The local agency shall provide funds for certain special needs of AFDC recipients as specified below. Allowances for these items shall receive prior authorization from the local agency. The payment shall be issued directly to the recipient, unless he/she elects to sign a request to have payment issued directly to the vendor.

a. Major home repairs. The local agency shall provide payment for costs of major home repairs if the home is owned and lived in by the recipient; if the need for repair is documented to the local agency's satisfaction; if such expenditures are within reasonable limits in relation to overall condition of dwelling and available alternative housing. Major home repairs allowed as special need items shall include repairs to the home's roof, foundation, wiring, heating system, chimney, and plumbing. The recipient shall provide the local agency with a vendor's written estimate for repairs and the agency may require up to two additional estimates when it deems the first estimate excessive. There shall be no maximum allowance established for major home repairs.

b. Replacement or repair of essential major appliances and household furnishings. Costs up to agency maximums for replacement or repair of essential major appliances and household furnishings shall be authorized if the need for such replacement or repair is established to the local agency's satisfaction and any existing rental agreement does not establish that such item, in good repair, is to be provided by landlord/lessor. The local agency shall inform the recipient of the maximum agency allowance for the item and the recipient's free choice to apply such allowance to either repair or replacement of the item. If the recipient elects to repair a major appliance, he/she shall provide the local agency with a vendor's written estimate for repairs. The local agency may require up to two additional estimates when it deems

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the first estimate excessive. The recipient may supplement the agency's maximum allowance if he/she so chooses.

(1) Major household appliances repair/replacement. Major household appliances covered and agency maximum allowances shall be as follows:

Item	Maximum
Cooking Stove or Range	$ 55.00
Refrigerator	$ 64.00
Washing Machine	$ 64.00
Dryer	$ 64.00
Water Heater	$128.00

(2) Household furnishings repair/replacement. Essential household furnishings covered and agency maximum allowances shall be as follows:

Item	Maximum
Kitchen Table	$ 17.00
Kitchen Chair	$ 7.00
Couch	$ 51.00
Living Room Chair	$ 17.00
Lamp	$ 9.00
Chest of Drawers	$ 18.00
Crib and Mattress	$ 34.00
High Chair	$ 11.00
Living Room Table	$ 7.00
Bed, Full Size (complete)	$ 81.00
Mattress or Box Spring (only)	$ 34.00
Frame (only)	$ 13.00
Bed, Twin Size (complete)	$ 51.00
Mattress or Box Spring (only)	$ 19.00
Frame (only)	$ 13.00
Bedding (includes blanket, pillow and case, sheets)	$ 14.00

c. Medically prescribed diets. Costs for medically prescribed diets shall be authorized if they are prescribed by a physician and add expense to a normal diet. The following diets shall not be authorized: diets which are paid for by the Medical Assistance Program, reducing or low caloric diets (1800 calories or less), sodium restricted diets (1000 mg. sodium), diabetic diets (1800 calories or less), fat controlled diets (55 mg. fat or less) and bladder, ulcer, low residue or low fiber diets which prescribe only soft food or prescribe special food preparation.

d. State appropriation. Each quarter the state appropriation for special needs shall be allocated among the local agencies on the basis of caseloads. Unused funds shall be reallocated at the end of the fiscal year.

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3. Housing Allowance. An AFDC allowance for a portion of housing costs attributable to the local property tax will be provided to individuals who have not received such payment under the Minnesota Property Tax Refund Act. The amount of the allowance shall be the same as that paid under the Property Tax Refund Act.

4. Funerals.

a. The local agency shall pay the funeral expenses of AFDC recipients (not exceeding $370) and actual cemetery charges, unless the deceased's estate or surviving spouse and children are able to pay. The local agency's payment shall not be limited by additional payments for or donation of a cemetery lot, interment, religious service, and transportation of the body to or from the community of the deceased's residence.

b. The state shall reimburse the county for 50 percent of the funeral expenses not exceeding $370, under this provision, and the county shall have a prior claim against the deceased's estate for the amount of the payments made hereunder.

F. Payment provisions.

1. Payment methods.

a. Money payments. In usual circumstances, AFDC payments shall be made by monthly check to the AFDC recipient. The initial grant shall be retroactive to the first day of the month of application when all eligibility factors were met in that month. The county shall impose no restrictions on the use of the grant. A money payment for one time only may be made to someone acting on behalf of the caretaker in an emergency situation. Recipients may elect to have their monthly Food Stamp purchase requirement withheld from the assistance check.

(1) Payment shall be made only to the address at which the recipient resides, unless another address has been approved in advance by the local agency. Box numbers shall not be sufficient as addresses unless:

(a) prior agency approval has been received for their use; or

(b) box numbers are used in the community as the usual means of mail delivery.

Failure to comply with this provision shall be a sufficient ground for termination of the grant.

(2) The issuance of duplicate checks shall be in accordance with the provisions of Minn. Stat. 471.415.

b. Protective and vendor payments.

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(1) A protective payment is one made to someone other than the recipient; a vendor payment is one made to a provider of goods and services.

(2) Protective and vendor payments shall be made only in the following cases:

(a) when a recipient fails to participate in WIN or during the 60-day counseling period (see H. 1.);

(b) when the caretaker fails to assign support, furnish or obtain Social Security numbers for himself/herself, or cooperate in establishing paternity or obtaining support;

(c) when the caretaker's continued mismanagement of funds causes hardship for the children; if this situation persists for more than two years, the agency shall take steps to establish a guardianship or other arrangements for the children.

(3) Protective and vendor payments because of money mismanagement shall not continue for more than two years and are subject to a fair hearing appeal by the recipient. Not more than ten percent of the total state AFDC recipients may be paid through protective and vendor payments under this provision.

(4) When protective and vendor payments because of money mismanagement are required, the local welfare board shall approve the payment method selected before it is implemented, and shall review it at least quarterly.

(5) Protective payments cannot be made to the local welfare director or welfare board members, or to landlords, grocers, or other vendors (who can receive vendor payments); a local agency staff member can be the protective payee for cases other than those in his/her own caseload if no other suitable payee can be found.

(6) As a WIN sanction, protective and vendor payments shall be made according to the above requirements for selection of payees. There shall be quarterly review of the payee's performance by the local agency; the recipient has the right to appeal the use of protective or vendor payments and the payee selected.

(7) For cases subject to protective or vendor payments because of failure to obtain support or cooperate in establishing paternity, the requirements for the selection of protective payees and vendors and quarterly reviews by the local agency of the way in which the protective payee's duties are carried out must be met. The entire amount of assistance must be made as a protective or vendor payment.

2. Grant termination, suspension, and reduction.

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a. AFDC applicants and recipients have the right to a fair hearing if they are aggrieved by action or inaction of the local agency. The following issues shall be appealable:

(1) denial of application for assistance;

(2) failure to act upon application within the prescribed time limits;

(3) suspension of assistance;

(4) reduction of assistance;

(5) termination of assistance;

(6) use of protective/vendor payments;

(7) referral by local agency to WIN for appraisal interview.

The foregoing items are meant to serve as examples only. An appeal shall also be authorized relative to any matter which is appealable based on state law or federal law and regulation as they currently exist or as they may exist based on subsequent amendment.

b. The local agency must give the recipient timely, advance notice of a grant suspension, termination, or reduction. This notice must be in writing, mailed to the recipient at least ten days before the effective date of the action, and must clearly state what action the agency intends to take, the reasons for the action, the right to appeal the action, the conditions under which assistance can be continued, and any collateral consequences of the action (e.g., loss of Food Stamp or Medical Assistance eligibility). Five days shall be sufficient for timely notice where the agency has verified and documented that the case facts require grant action and the action is based upon probable fraud by the recipient.

c. The local agency must give the recipient adequate written notice, no later than the effective date of the action, when there is:

(1) confirmation of the death of the recipient or payee;

(2) a written statement by the recipient that assistance is no longer desired;

(3) written information from the recipient that requires grant reduction or termination and the recipient understands that the change will occur; or when:

(4) the recipient has been admitted to an institution; placed in skilled nursing or intermediate care or long term hospitalization;

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(5) the recipient has been accepted for assistance by another county;

(6) the recipient has been placed in foster care; or

(7) the recipient's whereabouts are unknown.

d. If the recipient appeals the agency's action before it is effected, the action shall not be effected until the appeal is decided by the local or state hearings process.

3. *Incorrect payments.*

a. Underpayments shall be adjusted through an additional or a supplemental payment to the grant; the agency need not correct underpayments made more than 12 months prior to the date of discovery of error.

b. Overpayments caused by client or agency error shall be corrected through the process of recoupment or by the recipient's voluntary reimbursement. Voluntary reimbursements must be documented by the recipient's signed agreement and shall not be fulfilled through reduction of the grant. Overpayments caused by client error shall not be recouped unless the process is begun within a year after the agency learns of the overpayment. The process begins with the sending of the notice. Overpayments more than 12 months old when the agency learns of the error may not be recouped. Overpayment due solely to agency error shall be recoupable for the three months prior to the discovery if the client is notified in writing.

c. Recoupment shall be made by deducting an amount up to one-half of the recipient's disregarded earnings from the AFDC grant until the overpayment has been corrected. Recoupment shall be made only from recipients who have disregarded earnings. If recoupment has been interrupted by termination of employment or assistance, the recoupment shall be resumed when the individual resumes AFDC and employment.

d. The provisions of this section regarding incorrect payments shall be applicable to cases involving recipient fraud or abuse.

4. Wrongfully obtained assistance. The legal basis for prosecution of fraud in the AFDC program is Minn. Stat. 256.98.

a. The local agency director shall be responsible for securing appropriate action relative to any fraud allegation received. Appropriate action shall include:

(1) issuing timely notice and taking grant action where warranted;

(2) referring cases of suspected fraud to the agency investigative unit for necessary investigations; and

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(3) insuring the referral of substantiated fraud to the county attorney for necessary legal action.

b. If eligibility otherwise exists, a grant shall be continued at the established level when fraud is suspected or the case is under investigation for fraud.

c. Recovery in fraud cases may be based on client agreement, recoupment or court order. A client's basic grant shall not, however, be reduced to meet the recovery obligation. Recoupment shall be applicable only in cases involving disregarded earnings and shall follow the procedures outlined above dealing with incorrect payments.

d. The local agency director shall be responsible for securing and reporting such statistical data on agency fraud prevention activities as the commissioner may require.

G. Relative responsibility.

1. Procedures.

a. Parents, grandparents, brothers and sisters shall be responsible for the support of children on AFDC; spouses shall be responsible for the support of their spouses whose needs are included in an AFDC grant.

b. Failure of responsible relatives to furnish support shall not render an individual ineligible for AFDC; the local agency shall take the steps outlined in this rule to seek support from responsible relatives whom it believes are able to contribute toward the needs of AFDC recipients.

c. If the responsible relative fails to contribute support after the local agency notifies him/her of his/her obligation to do so, the agency shall notify the county attorney or the Commissioner of Welfare to take legal action against the relative.

d. The amount of support recoverable from a responsible relative, other than the parent of a child under 18, shall not exceed the amount of AFDC assistance granted after the relative is notified of his/her obligation to support. Recovery shall apply only to the period following issuance of notice to contribute. However, the court can order a continuing contribution while the recipient continues to receive public assistance.

2. Standards of support.

a. The amount of support due from the absent parent of a child or the parents of a child in AFDC-FC shall be established by the court or through voluntary agreement by the absent parent and the local child support unit.

b. Parental income shall be totally available for the needs of children

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under 18 and residing in the parental home. The ability of parent to support a minor, including one who is eligible for AFDC as a caretaker relative, shall be based upon a determination of parental income according to the procedures used in establishing AFDC eligibility for new applicants. All income in excess of the appropriate AFDC Standard is available for the support of the minor.

c. The financial contribution of other responsible relatives, and the parents of caretakers under 18 and residing outside the parental home, shall be computed according to the relative responsibility scale.

3. Relative responsibility scale.

Size of Family	Annual Cost of Living (ACL)	Monthly Cost of Living
1	$ 5,304	$ 442
2	8,196	683
3	11,784	982
4	14,088	1,174
5	16,200	1,350

Twenty percent of the ACL for a family of five shall be added for each additional family member.

a. The gross income of the responsible relative shall be assessed against the above scale; taxes or employment expenses shall not be deducted.

b. "Size of family" means all persons who are in fact supported by the responsible relative (whether or not he/she is legally responsible for their support).

c. Other justified expenses (such as medical and educational bills, or housing costs exceeding 30 percent of the family's gross income) shall be deducted from the gross income.

d. If a minus balance remains, no contribution shall be expected. If a plus balance remains, 1/3 of the amount shall be the expected contribution.

4. Child support and paternity.

a. Every AFDC applicant and recipient shall be required to furnish information (including court testimony) needed by the local agency to obtain child support payments, locate absent parents, establish paternity, and obtain support from responsible relatives.

b. If a caretaker relative fails to cooperate with the above requirements, his/her needs shall be deleted from the grant and the eligible children shall be furnished assistance through protective or vendor payments.

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c. If a court orders child support paid by an absent parent, the local agency shall petition the court for an order directing that all such payments be made to the local welfare board until AFDC assistance stops.

d. The regulations and procedures of Title IV-D of the federal Social Security Act shall be applied in the collection of support and establishment of paternity.

H. Other program requirements.

1. Work Incentive Program (WIN).

a. Registration requirements.

(1) All AFDC applicants and recipients residing in WIN counties (who are not exempted below) must register for WIN as a condition of eligibility.

(2) The following persons shall be exempted from WIN registration:

(a) children under age 16;

(b) children age 16 through 18 attending school full time;

(c) persons who are ill;

(d) persons who are incapacitated; if WIN exemption is based on incapacity a referral to the Division of Vocational Rehabilitation is mandatory (NOTE: the local agency may require a physical examination to confirm illness or incapacity.); or

(e) over age 65;

(f) persons who live so far away from a WIN project that more than a 10-hour day (employment plus commuting time) would be required to participate;

(g) persons whose presence in the home is needed because of the illness or incapacity of other persons;

(h) a caretaker of a child under age six (only one such exemption is allowed per family); (In AFDC-UF cases, either parent may elect to claim this exemption);

(i) the spouse of a WIN registrant.

b. Other WIN requirements.

(1) If a required WIN registrant refuses to register, his/her needs

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shall be deleted from the AFDC grant; if the only dependent child over age 16 and not in school in a family refuses to register, the entire AFDC grant for the family will be denied or terminated. If the father in an AFDC-UF case refuses to register, or if he refuses a bona fide offer of employment or training without good cause, the entire family is ineligible for AFDC-UF.

(2) An AFDC applicant or recipient may contest the requirement that he/she register for WIN through the fair hearing procedure.

c. "Failure to participate in WIN" means:

(1) failure to attend the WIN appraisal interview;

(2) failure to accept child care plans for the WIN program;

(3) failure to participate in Job Service Office of the Department of Economic Security activities;

(4) failure to accept employment or training;

(5) failure to remain in employment.

d. If a WIN registrant fails to participate in WIN, WIN Job Service Office of the Department of Economic Security shall provide him/her an opportunity to contest whether or not this failure was for good cause; the decision of this hearing shall not be appealable to the Commissioner of Welfare and the result shall be binding on the local welfare agency. If the hearing opportunity is not taken, or if the failure to participate is found to be without good cause, WIN will provide the individual with a 60-day counseling period to correct the situation.

e. If an individual is found to have failed to participate in WIN, the following sanctions shall apply:

(1) If the individual is the only dependent child in an AFDC family, assistance for the entire family shall be terminated; if the individual is one of several dependent children in an AFDC family, his/her needs shall be deleted from the AFDC grant. In AFDC-UF, if the father refuses to accept a bona fide offer of employment or training without good cause, he shall be considered deregistered and the entire family shall be ineligible unless the individual is undergoing the 60-day counseling period which is described in H. 1. e. (2).

(2) If the individual is the caretaker of AFDC children, his/her needs shall be excluded from the grant and assistance to other family members will be provided through protective or vendor payments. If the individual is undergoing the 60-day counseling period his/her needs will not be removed from the grant; however, assistance to the family shall be provided in the form of protective or vendor payments. These sanctions shall not apply to persons who are voluntary WIN registrants.

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An individual who has been found to have failed to participate in WIN without good cause must wait 90 days after his/her AFDC benefits are terminated to reregister for WIN; if an individual has twice failed to participate in WIN without good cause, he/she must wait six months to reregister. WIN may reaccept any such reregistrant whose prior failure to participate was the result of criminal or other activities which presented a hazard to WIN staff or other WIN participants.

f. A WIN participant's monthly $40 training allowance and $30 incentive payment shall be disregarded as income in computing the AFDC grant.

g. Public Service Employment (WIN/PSE) shall not be subject to the $30 plus 1/3 disregard.

h. On-the-job training (WIN/OJT) shall be subject to the $30 plus 1/3 disregard plus employment expenses. If the recipient is on AFDC-UF, the 100 hour rule shall apply.

2. Emergency Assistance for families with children under age 21 (AFDC-EA).

a. Eligibility qualifications.

(1) Emergency Assistance is immediate financial aid for AFDC families and other families in situations that place a child and any other member(s) of the family in jeopardy and cannot be resolved with the family's current resources. Examples of emergencies are natural and civil disorders, illness, accident, death, threat of eviction, etc.

(2) Emergency Assistance shall be granted only to a family which includes a child (under age 21) who is (or within six months prior to application has been) living with a relative eligible as an AFDC caretaker, and which is completely without resources to solve the emergency. It shall not be available to persons or on behalf of children over age 16 and not in school who have refused employment or training without good cause.

b. Allowable need items.

(1) Emergency Assistance shall cover payment for food, shelter, clothing, fuel and utilities, medical care and child care. It may also cover moving expense, major home repairs and major furniture and appliance replacement, replacement of furnace, roof, plumbing, or electrical systems, if authorized by the local agency before the expense is incurred.

(2) Emergency Assistance shall be available when the proceeds of cashed AFDC checks are lost or stolen; the theft must be reported to the police and the local welfare agency in the form of an affidavit. It shall not be available when uncashed AFDC checks are lost or stolen; in such cases, the lost or stolen AFDC funds shall be replaced in accordance with the provisions of F. 1. of this Rule.

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c. Emergency Assistance payments.

(1) The amount of Emergency Assistance shall be based on the AFDC Standard and the state standard for special need items; if this sum is insufficient to meet need, the AFDC-EA allowance shall be based on cost. Payments may be made as money, vendor payments, payments in kind, or in the form of interest free loans (up to $100) for employment expenses.

(2) AFDC-EA shall be granted only for one consecutive 30-day period in one consecutive 12-month period; needs which accrue prior to the 30-day period may be met only when necessary to resolve the current emergency situation (e.g., back rent or utility payments). Assistance may be extended for up to 30 days beyond the 30-day base period, if authorized during the base period.

(3) Each local agency shall designate at least one staff member to authorize immediate AFDC-EA grants.

3. AFDC-Foster Care (AFDC-FC).

a. Eligibility for AFDC-FC.

(1) AFDC-FC shall be available for children placed by judicial action in foster homes or private nonprofit child caring institutions. All such institutions, homes and agencies must be licensed for child caring. Payments for foster or institutional services may be made to cooperating public or private agencies for care given in foster homes or nonprofit private child care institutions.

(2) AFDC-FC shall not be available when the child lives with a relative who is legally liable for support. AFDC-FC shall be paid to non legally responsible relatives who are licensed or approved as foster care providers.

(3) AFDC-FC shall be available only for children eligible for ordinary AFDC during the month in which judicial proceedings are started, or who would have been eligible during the prior six months and if they had lived with an eligible relative.

b. AFDC-FC shall be available whether or not parental support is available; the local agency shall petition the juvenile court for an order requiring the parents to contribute to the child's support.

c. AFDC-FC will be paid to the foster home parent or institutional care representative, as the provider of care, not as the payee.

d. AFDC Foster Care Rates (AFDC-FC).

(1) The rates for AFDC-FC shall be applicable to foster and group homes and child care institutions. In no circumstances can rates paid to institutions include overhead costs.

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MANDATORY STATEWIDE RATES (BASIC)

Age	Basic Rate		Initial Clothing
	Monthly	Per Diem	
0-3	$123	$ 4.10	$ 56
4-8	156	5.20	83
9-11	172	5.73	110
12-14	206	6.87	193
15-18	225	7.50	221

The initial clothing allowance shall be available at the time of the initial application and each reapplication. The care rate includes food, clothing, shelter, physical attendance, and supervision, and transportation. Additional payments may be made for specific social services provided by the foster home or child care institutions. Additional payments shall not be made to supplement maintenance costs.

(2) In addition to the basic rate, monthly payments for additional maintenance needs (as determined by the local agency) may be made. The additional care rates shall be determined by adding the points assigned to each level and type of care required by the child. No more than 175 points may be designated for each child.

DIFFICULTY OF CARE SCHEDULE AND RATES

	A	B	C	D	E
Emotional	5	15	30	60	175
Physical	5	15	30	60	175
Auxiliary	5	10	15	60	
Points	Monthly	Daily	Points	Monthly	Daily
5	$ 34	$ 1.13	95	$242	$ 8.07
10	45	1.50	100	253	8.43
15	57	1.90	105	265	8.83
20	68	2.27	110	276	9.20
25	80	2.67	115	288	9.60
30	91	3.03	120	299	9.97
35	103	3.43	125	311	10.37
40	114	3.80	130	322	10.73
45	126	4.20	135	334	11.13
50	138	4.60	140	345	11.50
55	149	4.97	145	357	11.90
60	161	5.37	150	369	12.30
65	172	5.73	155	380	12.67
70	184	6.13	160	392	13.07
75	195	6.50	165	403	13.43
80	207	6.90	170	415	13.83
85	218	7.27	175	426	14.20
90	230	7.67			

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(a) Emotional.

(i) Level A. These are children who periodically exhibit excessive dependency, passivity, lack of responsiveness and the inability to relate.

(ii) Level B. Children at this level require abnormal amounts of attention and affection, and have need for a regimental program, such as behavior modification. Such children often have school problems, difficulty with peers, moodiness, and frequent enuresis. Foster parents often have to provide an abnormal amount of structure (e.g., constant repetition and follow through on instructions).

(iii) Level C. These children exhibit extreme attention-seeking behavior, stealing, drug use, encopresis, destructive behavior, extreme hyperactivity, sexual acting-out, running away, withdrawal, etc.

(iv) Level D. These children show extreme bizarre behavior, and may be self-destructive and require exceptional care.

(v) Level E. Children at this level show severely disturbed behavior, such as frequent running away, depression, attempted suicide, fantasizing, or inappropriate behavior. They may be dangerous to themselves or others, and cannot be maintained in a normal family setting.

(b) Physical.

(i) Level A. These children need some help with putting on braces or prosthetic devices, some help with buttons, laces, etc., but are basically self-caring.

(ii) Level B. These children need help with dressing, bathing, and general toilet needs, as well as some help in ambulation. They exhibit feeding problems such as excessive intake, or are extremely slow and/or messy requiring help and/or supervision due to retardation or emotional or physical handicap. They may need tube or gavage feeding. They may need physical therapy, under one hour per day.

(iii) Level C. These children need appliances for drainage or ileal conduit, or a colostomy. They may need aspiration, suctioning, mist tent, etc. They are non ambulatory, needing constant attendance, and/or prescribed physical therapy, 1-2 hours per day, by foster parent.

(iv) Level D. These children require custodial care, and physical therapy 2-3 hours per day. They may have uncontrollable seizures.

(v) Level E. Due to the severity of their physical handicap, these children are unable to tolerate a normal family setting and require ongoing care. Such children possibly need 24 hour supervision.

(c) Auxiliary.

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(i) Level A. These children require special diets or supplements that require extra expense and are not covered under any other program. Regular but infrequent (less than monthly) trips must be made to a physician, psychiatrist, therapist, etc.

(ii) Level B. These children require special equipment or a regular and consistent tutoring program at home. There is unusual wear and tear on the home, and need for occasional periods of relief by an adult. Therapeutic appointments must be met every two to four weeks.

(iii) Level C. There is extreme wear and tear on the home, frequent hospitalizations, and/or therapeutic visits every two weeks or oftener.

(iv) Level D. These children exhibit either emotional or physical problems of such severity that the foster parents must make extraordinary adjustments in their family life style to accommodate the foster child. Such adjustments may include, but not be limited to, ongoing regular attendance at supportive group meetings, physical changes in the home (such as building ramps, installing lifts, etc.), ongoing consultation with child care professionals. These children require foster parents who have shown skill in adapting family life to the needs of each child.

I. Relationship to other programs.

1. AFDC recipients are automatically eligible for:

a. Medical Assistance upon signing a benefit assignment Form 1933 for health care coverage in which he/she is a policyholder;

b. Food Stamps;

c. Social Services.

2. AFDC recipients may not be simultaneously eligible for:

a. General Assistance unless served by the Battered Women Program;

b. Poor Relief;

c. Supplemental Security Income.

3. The Income Maintenance Unit shall refer all cases involving minor caretakers to the Social Service Unit for evaluation of service needs. Such referrals shall not be a factor in determining eligibility, and shall be made after such eligibility is determined.

4. The following programs are not a bar to AFDC eligibility but may furnish the AFDC family with another source of support (which may remove the need for AFDC):

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a. Retirement, Survivors, and Disability Insurance;

b. School Lunch Program;

c. services and payments to veterans and armed forces personnel;

d. services and payments for immigrants and refugees;

e. Servicemen's Quarters Allowances.

The local agency shall help the AFDC recipient explore the resources offered by these programs.

J. Miscellaneous.

1. Former DPW Rule 44 is hereby amended.

2. The provisions of this rule shall be severable and if any phrase, clause, sentence or provision is declared illegal or of no effect, the validity of the remainder of this rule and the applicability, thereof, to any agency, person, or circumstances shall not be affected thereby.

3. The effective date of this Rule is the first day of the month following publication in the State Register, but not less than five working days after publication.

insert new:
12 MCAR § 2.2045
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§ 2.047 Medical Assistance.

A. Introduction.

1. This rule governs administration of the Medical Assistance (MA) program in Minnesota. The provisions of this rule are to be read in conjunction with Title XIX of the federal Social Security Act, Title 45 of the Code of Federal Regulations, Minn. Stat. ch. 256B, and other rules of the Minnesota Department of Public Welfare (hereinafter, DPW or the state agency) which is responsible for the administration of the Title XIX program in Minnesota.

2. The MA program shall be administered to provide eligible needy persons whose financial resources are not adequate to meet the cost of medical care and services with such care and services, according to the provisions of this rule.

3. The MA program shall not be administered to deny applicants and recipients their individual and civil rights, nor to disclose information regarding them except as provided under applicable state law and/or official departmental rules and regulations.

4. This rule is binding on all county welfare boards (hereinafter referred to as local welfare agencies) in the State of Minnesota administering the MA program (Title XIX), on all providers of service participating in the MA program, on all applicants/recipients under the MA program, and on the state agency.

5. The official State Plan is the submitted and approved federal document which indicates those options covered by Minnesota Statutes.

6. This rule specifically includes by reference any federal laws or regulations or state laws pertaining to the Minnesota Medical Assistance program, and any provision of this rule which is inconsistent with those laws and regulations is superseded thereby.

B. Application for medical assistance.

1. Definitions.

a. "Applicant." A person who has directly, or through his authorized representative (or where incompetent or incapacitated, through someone acting responsibly for him), made application for Medical Assistance with his local welfare agency.

b. "Application." The action by which an individual indicates in writing to the agency administering public assistance his desire to receive Medical Assistance. An application is distinguished from an "inquiry," which is simply a request for information about eligibility requirements for Medical Assistance.

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2. Any person has the right to apply for Medical Assistance to the local welfare agency in the county in which he resides and has established an abode, regardless of whether or not it appears he will be found eligible for participation in the MA program. In such cases, the local agency shall promptly advise the applicant of the MA program's eligibility requirements.

3. Each application form shall be signed by the applicant or the applicant's responsible relative, legal guardian or authorized representative (or where incompetent or incapacitated, by someone acting responsibly for him).

4. As soon as possible, but no later than 45 days from the date of application for Medical Assistance in the case of families, the aged and the blind, or no later than 60 days in the case of the disabled, the local welfare agency shall conduct a personal interview with the applicant and determine his eligibility for Medical Assistance. All eligibility conditions shall be met within these time limits. Where a delay is necessary because necessary information cannot be obtained within the time limits, the applicant shall be notified in writing of the delay and shall be advised of his right to appeal such delay.

5. Each applicant shall be notified in writing that his application has been approved or denied, unless the applicant dies or cannot be located. If the application is denied, the individual shall be notified in writing of the reasons for denial and of his right to appeal.

6. Any person has the right to re-apply for Medical Assistance. New applications must be taken whenever a previous application has been denied or withdrawn, or when the county of financial responsibility has been changed. An approved application shall be appended by an addendum thereto for the purpose of adding additional eligible persons or when the payee has changed his/her name.

7. Medical Assistance eligibility shall be redetermined in accordance with the provisions of applicable federal regulations. In those cases where the local welfare agency receives information about a change in case facts, eligibility shall be reviewed within 30 days of receipt of that information.

8. The local welfare agency shall verify information cited in this section and contained in the application received from the applicant or other persons or agencies only with the applicant's written permission. If the applicant refuses to cooperate with the local welfare agency in verifying the needed information, his application shall be automatically denied. The following information shall be verified:

a. Social Security numbers (as provided under (9) below) of all individuals applying for or receiving Medical Assistance and the parents of dependent children.

b. The applicant's income and property holdings.

c. Any other information affecting eligibility as deemed necessary under the circumstances of each particular case.

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9. For assistance under Title XIX of the Social Security Act, the local welfare agency shall request each applicant to supply the Social Security number (SSN) for each individual (including children) for whom assistance is requested. Furnishing or applying for a SSN is not an eligibility factor for Medical Assistance and benefits cannot be denied because an individual will not furnish or apply for a SSN or consent to use of a SSN.

a. The local, state and federal agencies are prohibited from using an individual's SSN without the written consent of the individual, unless required by law to use that number.

b. The local welfare agency shall request in writing and obtain written consent to use the individual's SSN to validate information contained in the application.

10. Local welfare agencies shall give a copy of the state agency's informational pamphlet on Medical Assistance to every person who inquires about, indicates a need for, and/or applies for any of the categorical aid programs. Local welfare agencies shall inform all applicants that their medical records may, only with their signed consent, be released to the state agency, the local welfare agency, the Minnesota Department of Health, the U.S. Department of Health, Education and Welfare, and the PSRO. No records will be released to any person or agency absent the specific consent of the recipient. No person shall be eligible for medical assistance unless he has authorized in writing the Commissioner of Public Welfare to examine all personal medical records developed while receiving medical assistance for the sole purpose of investigating whether or not a vendor has submitted a claim for reimbursement, cost report or rate application which the vendor knows to be false in whole or in part.

11. Individuals found eligible for Aid to Families with Dependent Children (AFDC) shall be eligible for Medical Assistance without a separate application. Aged, blind or disabled individuals found eligible for Minnesota Supplemental Aid (MSA) shall be eligible for Medical Assistance without a separate application. Aged, blind or disabled Supplemental Security Income (SSI) recipients are required to file a separate application for Medical Assistance. Cases converted from state administered payments under OAA, AB and AD programs which are terminated by SSI require a separate application and determination of eligibility. All other individuals not specified herein shall file a separate Medical Assistance application.

12. Medical Assistance eligibility for a recipient of categorical assistance ends when there is no longer eligibility for that assistance. At that point, the individual shall file a separate Medical Assistance application and the MA program eligibility criteria must be applied.

13. The county in which the applicant resides at the time of application for Medical Assistance is the county of financial responsibility. Continuous receipt of assistance will continue financial responsibility in that county.

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C. Eligibility factors under the medical assistance program.

1. Age.

a. Individuals eligible for Medical Assistance by reason of receiving a categorical form of public assistance, or who would be eligible under a category except for residence or amounts of income or resources, must meet the specific age requirements of the appropriate category.

b. Medical Assistance is available on behalf of otherwise eligible individuals who were, for any portion of the month in which they received medical care or services, under 21 years of age (or under 22 years of age and receiving inpatient psychiatric hospital services), or 65 years of age or older.

c. The unborn are eligible for Medical Assistance during the last three months of the mother's pregnancy (as medically certified), so long as other factors of AFDC eligibility exist.

2. Residence.

a. "Residence" or "abode." Where a person lives and intends to remain.

b. Minnesota residence is an eligibility requirement for Medical Assistance but no specific length of residence is required. A person loses Minnesota residence when he leaves the state with the intent to establish a home elsewhere. Evidence of intent under this rule is not simply the person's stated intentions but includes consideration of objective criteria associated with the move (e.g., movement of possessions, rent payments, changes in voter or driver's license registrations).

c. A "resident" of Minnesota is a person who is living in the state voluntarily with the intention of making Minnesota his permanent home. A child is a resident of Minnesota if he is living in the state on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether he is there voluntarily or for a temporary purpose. An agricultural migrant who meets all other eligibility requirements and who has an abode in another state shall be eligible for Medical Assistance. Residence is deemed retained until abandoned. Temporary absence from Minnesota, with subsequent return to the state or intent to return when the purpose of the absence has been accomplished, does not interrupt continuity of residence.

d. Under the following circumstances, Medical Assistance will be furnished to eligible individuals who are residents of Minnesota but who are absent from the state, to the same extent that such assistance is furnished under the MA program to meet the cost of medical care and services rendered to eligible individuals within the state:

(1) Where an emergency arises from accident or illness;

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(2) Where the health of the individual would be endangered if the care and services are postponed until he returns to Minnesota;

(3) Where his health would be endangered if he attempted to return to Minnesota in order to receive medical care.

e. Medical care and services will be provided outside Minnesota to eligible residents of this state in the following situations:

(1) When it is general practice for residents of Minnesota to use medical resources beyond the borders of this state; or

(2) When the availability of necessary medical care, services or supplementary resources make it desirable for the individual to use medical facilities outside the state, for short or long periods of time and in accordance with plans developed jointly by the local welfare agency and the individual, based upon sound medical advice.

f. The state agency shall assist in meeting the medical needs of residents of other states who are eligible for Medical Assistance in that state while they are within Minnesota.

3. Citizenship and alienage.

a. Medical Assistance payments may be made on behalf of any otherwise eligible individual who is a resident of the United States, but only if he is either:

(1) A citizen of the United States; or

(2) An alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

4. Income and resources.

a. Income.

(1) Medical Assistance may be paid for any person who anticipates receiving annual net income up to the amounts specified under state law. Individuals or families with income in excess of these maxima and who in the month of application or during the three preceding months incur expenses for medical care that total more than one-half of the annual excess income, may also be eligible for participation in the MA program.

(2) In the determination of eligibility for MA-only (over 65 years of age), and MA-categorically related, "income" is the total net income the applicant and relatives responsible under statutes expect to receive from all sources during the year.

(3) In determining eligibility for Medical Assistance for children

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under 18 years of age, the local welfare agency must consider all income of the applicants, and their relatives responsible under Minn. Stat. § § 256B.06 and 256B.14. Eligibility of individuals between 18 and 21 years of age shall be determined separately.

(4) *Definitions.*

(a) "Income." Any benefit received by or available to a Medical Assistance applicant/recipient as earnings or otherwise. Income may be earned or unearned. In family groups living together, the income of a spouse is considered available to his/her spouse and the income of a parent is considered available to his/her children under 18 years of age. All income, including non-cash items provided free of cost, is considered a resource to be evaluated in determining the need of Medical Assistance applicants/recipients.

(b) "Net income." The amount left after deducting allowable expenses and income disregards.

(c) "Earned income." Income received in the form of wages, salary, commissions or profits from activities in which the applicant/recipient is engaged as an employee or as a self-employed person.

(d) "Unearned income." Income which is not the direct result of labor or services performed by the individual as an employee or as a self-employed person.

(5) The following employment expenses are to be deducted in determining net earned income:

(a) Mandatory retirement fund deductions.

(b) Transportation costs to and from work based on the actual cost of public transportation or car-pool payments, or 13c per mile for the actual number of miles driven, not to exceed 100 miles per day of employment (unless the recipient can establish actual higher transportation costs).

(c) Cost of work uniforms.

(d) FICA and SMI payments.

(e) Federal and state income taxes withheld.

(f) Union dues.

(g) Professional association dues required for employment.

(h) Health insurance premiums.

(i) Cost of tools and equipment used on the job.

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(j) One dollar per day for the cost of meals eaten during employment hours (unless the recipient can establish actual higher work-related meal expenses that are necessary and reasonable).

(k) Public liability insurance required by the employer when an automobile is used in employment and the cost is not compensated by the employer.

(6) Rental income is considered unearned income.

(7) Lump sum payments and windfalls (e.g., Social Security retroactive benefits, inheritances, income tax refunds, gifts) are considered a resource which will necessitate a redetermination of Medical Assistance eligibility, except when specifically exempted by federal law.

(8) Income of a Medical Assistance recipient, as in any other public assistance program, shall first be applied to the maintenance needs of the recipient or his legal dependents up to the statutory standards.

(9) Income that is within the legal maxima of the MA program is not to be considered in determining the amount of payments made for medical services, except in long term care facility, convalescent care unit, state veterans' facility and state hospital cases. In such cases, if the applicant/recipient has legal dependents (spouse and/or minor dependent children), the family's total net income, within the Medical Assistance legal maxima, is to be applied to the maintenance needs of the patient and those legal dependents. In such a situation the only income to be considered allocable to the maintenance needs of the long term care facility patient is the allowance for personal needs and clothing. Retarded or handicapped persons living in skilled nursing facilities, intermediate care facilities, or intermediate care facilities/mentally retarded who are employed under a plan of rehabilitation are eligible for a special personal allowance from earned income as specified in state statutes. The remainder of the income within the legal maxima for the family is to be attributed to the maintenance needs of the legal dependents with any income over the Medical Assistance maxima to be applied to the institutional charges. If the patient has no legal dependents, any income in excess of the allowance for his personal needs and clothing is to be applied to the costs of long term care facility services.

(10) Income from an SSI grant is to be disregarded in determining the Medical Assistance eligibility of an SSI recipient. However, to be eligible under the MA program, other sources of income must comply with MA program standards.

(11) Persons receiving a maintenance grant under the AFDC or MSA programs shall be automatically eligible for Medical Assistance.

(12) Persons who have income in excess of the Medical Assistance income maxima and who do not qualify for categorical assistance because their income is in excess of the limits of those programs, may qualify for

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Medical Assistance through the spend-down provision of the MA program:

(a) "Spend-down" means to reduce available or anticipated income which exceeds the amount protected by state law for maintenance needs. Such reduction must be for current medical obligations.

(i) "Current" means medical obligations during the period of time the applicant is requesting assistance and which are allowable under state and federal law, or federal regulations.

(ii) "Medical obligations" are amounts owed any eligible provider for medical care, services or supplies which are covered under the MA program.

(b) Spend-down applies only to income.

(c) Spend-down is computed by the local welfare agency and is a condition of eligibility.

(i) Spend-down is computed by first determining the current and anticipated annual income of the applicant and his responsible relatives under state law.

(ii) The amount protected under state law is subtracted to determine the amount of anticipated annual income available to meet medical obligations.

(iii) This amount is reduced by one-half to indicate the anticipated income available during the next six (6) months.

(d) The spend-down requirement cannot be assumed by any third-party; such third-party resource shall be applied against medical obligations prior to determining the applicant/recipient's unmet medical obligation.

(i) For the purpose of spend-down only, "third-party" means anyone other than the applicant/recipient or his responsible relatives.

(e) The amount of spend-down shall be paid or incurred prior to establishing eligibility for Medical Assistance, except in those instances where a continuing spend-down exists.

(i) "Continuing spend-down" means the spend-down requirement is met on a monthly basis rather than on a six-month basis.

(aa) Continuing spend-down is limited to institutionalized individuals and those special situations individually approved by the state agency.

(f) When Medical Assistance eligibility is established through the spend-down provision, eligibility shall be limited to a period of

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six months beginning with the first of the month in which medical obligations are first incurred. This six month period may include retroactive coverage of up to three months prior to the first of the month in which the application was made.

b. Resources.

(1) Real property. Medical Assistance may be available to any individual who, either alone or together with his/her spouse, does not have equity in real property exceeding that permitted under state law. "Equity" shall be the assessed tax value minus any encumbrance against the property.

(a) In situations where the appropriate local welfare board determines that an applicant/recipient's excess equity in real estate cannot be converted into cash to meet his current maintenance needs, or that liquidation of the property would result in an undue hardship, the board may waive the equity limitation.

(i) It is not intended that this waiver provision be applied universally to achieve Medical Assistance eligibility for applicants or recipients. Instead, the following considerations shall act to restrict waiver of the real property equity limitation:

(aa) No maximum limit on the value of equity in real property to be waived shall be adopted by a local welfare board or local welfare agency as a matter of practice or general policy.

(bb) The circumstances and conditions under which the excess equity in real property was waived shall be examined periodically (at least annually) for changes in current market value, opportunity for sale or mortgage, or other pertinent factors.

(2) Personal property. Medical Assistance may be available to any individual whose cash or liquid assets do not exceed the limits established by state law.

(a) Under the MA program, the following items are exempted in determining the value of personal property owned by the applicant/recipient:

(i) Household goods and furniture presently used in the applicant's/recipient's residence.

(ii) Wearing apparel.

(iii) Life insurance policies with combined cash surrender values not exceeding $1,000 per insured person (individual applicant and each legal dependent or legally responsible member of his family).

(iv) Burial plots.

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(v) Prepaid burial contracts not exceeding $750 for the applicant/recipient and each legally dependent member of his family, plus $200 in accrued interest under each such contract. In order to be covered by this exemption, either the funeral director must be the "trustee" and the applicant/recipient (or a member of his family for whom he is legally responsible) the "beneficiary" under the terms of such burial contract, or a trust account must be created restricting use of its funds to payment of funeral and burial costs.

(b) Equity in personal property exceeding the applicable program maxima may be waived when the appropriate local welfare board determines that liquidation of the property would result in undue hardship.

(c) If personal property increases in value beyond the limits allowed under applicable state law, it will not defeat Medical Assistance eligibility if the applicant/recipient, within 15 calendar days from the date he received notice from the local welfare agency, either:

(i) Transfers the excess to an excluded type of property; or

(ii) Uses the excess to repay the local welfare agency and/or state agency for Medical Assistance already received.

(d) A trust fund is subject to the personal property limitations mandated under applicable state law unless it can be affirmatively demonstrated that such fund cannot be made available to meet the individual's medical needs.

(3) At the time of filing application for Medical Assistance, each applicant shall submit a complete and accurate list and description of all real and non-exempt personal property in which he has an equitable interest. Such list of property shall include not only the property currently owned, but all property in which he had an equitable interest during the three years prior to applying for Medical Assistance.

(4) Transfers of property. The establishment of initial or continuing eligibility for Medical Assistance by disposing of resources which otherwise would be available for the applicant/recipient's support is contrary to public policy. In some instances, such dispositions may constitute a criminal offense on the part of the donor and/or donee of the property. If a person tenders any amount of money as a deposit to a long term care facility within three years immediately preceding his application for Medical Assistance, or while receiving such assistance, all such deposits shall be considered a resource in determining such person's eligibility for Medical Assistance.

(a) The following provisions shall govern property transfers as they affect potential eligibility under the MA program:

(i) Each applicant for and recipient of Medical Assistance shall be required to reveal whether he has transferred within the pre-

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ceding three years real or personal property with a total fair market value in excess of $750 without receiving adequate consideration for such property. Any property so transferred shall be viewed as an available resource for the medical needs of the applicant/recipient.

(ii) The applicant or recipient who has transferred property as described in this section shall be required to provide to the local welfare agency a description, including value, of the property transferred; the name or names of all persons who received such property; and the specific circumstances under which the property was transferred.

(iii) The applicant or recipient who has transferred property as described herein shall be required to make a reasonable effort in cooperation with the local welfare agency to reacquire the property transferred.

(iv) The information required by (ii) and the efforts made to reacquire the property mandated by (iii), shall be entered in the applicant/recipient's case record with the appropriate eligibility determination.

(v) If return of the property or adequate consideration for the property cannot be arranged by the local welfare agency, the matter of the property transfer shall be reported with full documentation to the county attorney for possible criminal prosecution or civil action.

(vi) Transfer of property in violation of this rule shall not, in itself, constitute automatic ineligibility for Medical Assistance since such property may be deemed, in fact, to be unavailable to meet the applicant/recipient's medical needs.

(5) Types of property ownership. The owner of property in joint tenancy shall be considered as owning his pro-rata share of the value of such property, but the county or the joint tenant may establish ownership of a greater or lesser amount. An owner of property as a tenant-in-common owns his pro-rata share of the property's value. All other types of ownership shall be evaluated according to the law.

(6) Assignment of benefits. Each applicant or recipient shall as a condition of eligibility:

(a) Notify his county of service of any health care coverage available to him or his dependents and agree to apply all proceeds received or potentially receivable by him or his spouse from private health care coverage to the costs of medical care for himself, his spouse and children; and

(b) Assign any rights accruing under private health care coverage to the state agency, to be applied against the cost of medical care paid for by the MA program.

5. Relative responsibility. Within the limitations provided by state law

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and this rule, the spouse of an applicant and the parent of an applicant under 18 years of age shall be financially responsible for the cost of medical services.

a. In determining an applicant's eligibility for medical assistance, the income and resources of a responsible relative shall be considered in the following manner:

(1) Income and resources of spouses living together in the same household are to be considered available one to the other without proof of actual contribution. Income and resources of a parent are to be considered available to a child under 18 years of age.

(2) If an applicant for or recipient of medical assistance does not reside in the same household as a spouse, only the income and resources actually contributed by the spouse may be considered in determining medical assistance eligibility for the applicant or recipient.

b. In determining the liability of a financially responsible relative, the local welfare agency shall proceed in the following manner:

(1) When the local welfare agency determines that a responsible relative is able to contribute without undue hardship to himself or his immediate family but refuses to contribute, the local welfare agency shall exhaust all administrative procedures to obtain that relative's contribution. When such procedures fail, the local welfare agency shall consult its county attorney regarding possible legal action.

(2) In all cases when spouses are separated due to one spouse's need for care in a nursing home or state hospital, the following schedule of contribution shall be applied to determine the responsibility of the non-institutionalized spouse for support, out of his/her own income (earned or unearned). The local welfare agency may vary the contribution schedule for a specific case on a showing of undue hardship.

MONTHLY INCOME	CONTRIBUTION/MONTH
$400 to $449	$ 15
$450 to $499	$ 30
$500 to $549	$ 50
$550 to $599	$ 70
$600 to $649	$ 90
$650 to $699	$120
Over $700	$150plus 100% of the excess over $700

(3) If the responsible relative fails to contribute support, after the local welfare agency notifies him of his obligation to do so, the local welfare agency shall notify the county attorney in an effort to commence legal action against that relative.

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(4) The amount of support recoverable from a responsible relative (other than an absent parent) shall not exceed the amount of assistance paid on behalf of the recipient.

(5) The local welfare agency shall not withhold, delay or deny Medical Assistance because a responsible relative deemed able to contribute fails or refuses to accept financial responsibility.

6. Marriage or remarriage of parent. In the event that a parent with dependent children under 18 years of age marries or remarries and applies for Medical Assistance on behalf of those dependent minor children residing with him or her, the following provisions shall apply in determining available income with relation to eligibility for Medical Assistance:

a. All income and resources of natural or adoptive parents who reside in the home are to be considered available to meet the medical needs of the children.

b. All income and resources of the children themselves must be considered available to meet the medical needs of the children so long as such income and resources are under the control of the parents.

c. All other income and resources available to the MA applicants/recipients received in the form of gifts, income-in-kind, support payments, whether from responsible relatives or other family members, must be considered as a resource available to the children in determining their eligibility for Medical Assistance.

d. All income-in-kind received by the natural or adoptive parent must also be considered as an income or resource in determining Medical Assistance eligibility for the children.

e. Proof of actual contribution by relatives or other persons may be obtained by reference to previous income tax returns on which these children may have been declared as dependent by the parent or adult family member. Such proof of support or contribution may also be obtained by direct inquiry of the adult family members residing in the home.

7. Institutional status. An individual who is an inmate of a public institution, except as a patient in a medical institution or as a resident of an intermediate care facility, is not eligible for Medical Assistance. Individuals over age 65 and under age 21 who are patients in institutions for mental diseases or tuberculosis are eligible for Medical Assistance if all conditions of eligibility are satisfied.

a. Definitions.

(1) "Inmate." A person who is being involuntarily retained and who is living in the institution.

(2) "Public institution." A facility that is the responsibility of a

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governmental unit or over which a governmental unit exercises administrative control.

(3) "Patient." An individual who is in need of and receiving professional services directed by a licensed practitioner of the healing arts towards the maintenance, improvement or protection of health, or the alleviation of illness, disability or pain.

(4) "Resident." An individual receiving room, board and a planned program of care and supervision on a continuous 24-hour-a-day basis as determined necessary by a licensed physician or, if appropriate, a mental retardation team.

(5) "Institution." An establishment which furnishes (in single or multiple facilities) food and shelter to four or more individuals unrelated to the proprietor and, in addition, provides treatment services which meet some needs of the individuals beyond the basic provision of food and shelter.

8. Termination of medical assistance.

a. Medical Assistance applicants and recipients have the right to a fair hearing when aggrieved by action or inaction of the local and/or state welfare agencies. Such hearings shall be conducted in accordance with contested case and/or appeal procedures established by and consistent with applicable state law and federal regulations. The aggrieved applicant/recipient shall submit a written request for a hearing to the state or local welfare agency, whichever is appropriate. A local welfare referee shall conduct a hearing on the matter and shall issue a ruling affirming, reversing or modifying the action or decision of the local agency. The ruling of the local welfare referee shall be binding upon the local agency and the aggrieved party unless appeal is taken to the state agency. If appeal is taken directly to the state agency, a state welfare referee shall conduct a hearing on the matter and shall recommend an order to the Commissioner of Public Welfare. In appeals to the state agency from rulings of local welfare referees, the hearing may be limited, upon stipulation of the parties, to a review of the record of the local welfare referee. The Commissioner of Public Welfare shall issue an order on the matter to the local agency and the applicant/recipient. Any order so issued shall be conclusive upon the parties unless appeal is taken to District Court. Termination of Medical Assistance may be effected only at the end of the month, except in the case of the death of the recipient.

(1) An applicant/recipient for Medical Assistance is entitled to a hearing when the local welfare agency fails to act on his application within the time limits imposed by applicable federal regulations, or when his Medical Assistance coverage is to be denied or terminated (See, B.4., supra).

(2) The local welfare agency board shall give the applicant/recipient timely advance notice of its intention to deny or terminate Medical Assistance. This notice shall be in writing and mailed to the applicant/recipient at least 10 calendar days prior to the effective date of such proposed

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action and shall clearly state what action the local welfare agency intends to take, the reasons for such proposed action and the right to appeal such proposed action.

(3) If the applicant/recipient appeals the proposed action before it is effected, the action shall not be taken until the appeal is heard and decided in accordance with applicable state law and federal regulations.

D. General administration.

1. Free choice of provider. Subject to the following limitations, the MA program shall provide eligible recipients with free choice of participating local medical providers. The term "local" as used herein means that geographic area surrounding the recipient's residence which is viewed by the local welfare agency as reasonable for obtaining any given medical service.

a. Free choice is limited by the choice available to the local population.

b. Eligible recipients may exercise free choice by enrolling in participating Health Maintenance Organizations (HMO). While enrolled in an HMO, the recipient is limited to free choice within that HMO.

c. No long term care facility shall be eligible to receive medical assistance payments unless it agrees in writing that it will refrain from requiring any resident of the facility to utilize a vendor of health care services who is a licensed physician or pharmacist chosen by the facility.

2. County medical assistance plan. Counties shall administer the MA program according to the rules, procedural regulations and policies of the state agency, Minnesota Department of Public Welfare (DPW). Each local welfare agency shall develop methods and procedures for keeping adequate records to:

a. Verify current individual eligibility for the MA program.

b. Justify that payment for long term care facility services was correctly made.

c. Record individual eligibility for levels of care or other federal regulatory requirements as prescribed by the state agency.

3. The county of service (physical residence of eligible recipient) is responsible for submitting necessary information to DPW to insure compilation of an accurate recipient eligibility file. The county of service is solely and fully responsible for any payments made on behalf of ineligible recipients as a result of:

a. Late or inaccurate redeterminations of eligibility.

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b. Non-compliance with utilization review and control requirements (See, D.10, infra).

c. Inaccurate or incomplete record-keeping or failure to satisfy other written requirements (See, D.4.b, infra).

d. Failure to submit accurate information on recipient eligibility to DPW.

4. Records. The state and local welfare agencies and all medical providers shall maintain separate medical and/or fiscal records.

a. The state agency shall:

(1) Keep records necessary for a centralized disbursement system which maximizes federal financial participation (FFP);

(2) Maintain a recipient eligibility file based on information supplied by the county of service;

(3) Maintain records on all eligible providers; and

(4) Maintain an information retrieval system for necessary statistical reports and/or audits of payment.

b. Local welfare agencies shall:

(1) Maintain eligibility records to include at a minimum the recipient's application and redetermination forms, as necessary or advisable for efficient administration of the MA program; and

(2) Maintain records containing a physician's certification of the recipient's need for inpatient care to be used by DPW's utilization review and control system.

c. Medical providers participating in the MA program shall:

(1) Maintain for at least five (5) years, in the manner prescribed by DPW in accordance with applicable federal regulations, medical and financial records fully disclosing the extent of service provided, the medical necessity for such service and payment claimed under the MA program;

(2) On request, and upon being provided a copy of the recipient's written consent, make their records available to DPW, the state Legislative Auditor and the Department of Health, Education and Welfare (or representatives of those agencies) in order to justify all payments made to such provider and the propriety of all services rendered by such provider under the MA program;

(3) Not be subject to any civil or criminal liability for providing

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access to medical records to the commissioner of public welfare pursuant to Minn. Stat. ch. 256B.

5. Third-Party liability. The term "third-party" as used herein includes, but is not limited to, insurance companies, (including HMOs); other governmental programs such as Medicare; Worker's Compensation; and potential defendants in legal actions arising out of any type of accident or intentional tort. Insurance companies are liable for full payment of policy benefits on behalf of beneficiaries and any overage will be forwarded to the provider of service. Any recovery through court action shall be considered as a resource to the recipient in determining eligibility for Medical Assistance. A trust fund is a resource of first recourse.

a. The local welfare agency shall:

(1) Determine and identify any third-party which has a potential legal liability to pay for medical care provided eligible Medical Assistance recipients prior to establishing or continuing recipient eligibility; and

(2) As provided under state law, file its verified lien statements within one year from the date the last item of medical care was furnished.

b. The state agency shall:

(1) Seek recovery of all third-party liability benefits;

(2) Distinguish between third-party liability which is a current resource and one which is not current, based on the following considerations:

(a) Current liability consists of but is not limited to, known amounts of participation or coverage payable by liable third parties; the amount of actual claims, payments or settlements received.

(b) Liability which is not current includes potential resources such as legal actions or disputable claims whose results are speculative and uncertain. In such cases, the state agency shall either perfect a lien or refer the matter to the county attorney in the county of financial responsibility for the purpose of perfecting a lien.

(3) File its verified lien statement within one year from the date the last item of medical care was furnished; and

(4) Refrain from withholding payment on behalf of an otherwise eligible recipient when third party liability cannot be readily determined or collected.

6. Identification card. The state agency or the local welfare agency as directed by the state agency shall periodically issue Medical Assistance identification (ID) cards to eligible recipients, or if the recipient is legally incompetent to his guardian. Recipients shall show each provider a valid ID card

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establishing identity and current eligibility before obtaining medical care. Nothing in this rule shall be construed as requiring a provider to provide services to a recipient who fails to present a currently valid ID card. A provider may contact the local welfare agency for verification of current eligibility if the recipient fails to present a currently valid ID card. The state agency may restrict the use of ID cards to particular providers of specified services when necessary to prevent duplication or documented abuse of services, to prevent violation of prior-authorization requirements, or to assure continuity of care. Such restrictions on the use of ID cards shall be subject to the fair hearing requirements of applicable state law and federal regulations (See, C.8.a., supra). The state agency will periodically issue ID cards until instructed by the county of service that Medical Assistance eligibility no longer exists. The state agency shall automatically cease to issue cards when a spend-down period ends, when eligibility redeterminations are more than 90 days overdue, or when the special four month AFDC extended medical periods terminate in accordance with applicable federal regulations. Local welfare agencies shall notify the recipient during the first five days of the last month of eligibility prior to the automatic discontinuance to issue ID cards. The state agency shall be fully responsible for payments made on behalf of ineligible individuals due to state processing error.

7. Agreements with providers. An eligible provider is a vendor of medical care, services or supplies which meets federal and state standards for participation in the MA program, complies with all requirements of this rule, and executes a provider agreement. Providers shall complete and sign an appropriate provider agreement in the form stipulated by DPW. Failure by the provider to comply with federal and state statutes, rules and regulations pertinent to the MA program shall result in termination of the provider agreement, ineligibility to receive MA program reimbursement and, where appropriate, action to recover Medical Assistance funds. In order to be eligible for reimbursement under the Minnesota MA program, out-of-state providers must complete and sign an appropriate provider agreement and comply with all licensing and certification requirements of the state or Canadian province in which they are located.

8. Qualification of eligible providers. The state agency shall determine the eligibility of each provider of medical care, services and supplies. Any medical vendor who, on request, and upon being provided a copy of the recipient's written consent, refuses to allow a proper survey and/or reimbursement agency access to its records, shall become an ineligible provider upon written notification from DPW. The Commissioner may terminate payments under Chapter 256B to any person or facility providing medical assistance which under applicable federal law or regulation, has been determined to be ineligible for payments under Title XIX of the Social Security Act. Any vendor of medical care who submits to the state agency a claim for reimbursement, a cost report, or a rate application which he knows to be false in whole or in part shall be declared ineligible for further payments of medical assistance funds by the commissioner of public welfare. The commissioner shall determine the time period of ineligibility and any conditions for reinstatement of eligibility. No vendor of medical care shall be declared ineligible

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without prior notice and an opportunity for a hearing, pursuant to Minn. Stat. ch. 15, on the commissioner's proposed action.

9. Prior authorization. Services and items of care which must receive prior authorization are so indicated in Sections E.2.a. thru E.2.s, infra. The state agency shall provide vendors of medical care with designated forms to be used in making prior authorization requests. The vendor shall submit the contemplated charge and sufficient information to allow a reasonable evaluation of the request. The state agency shall send a form to the provider indicating whether the requested authorization has been approved or denied. The state agency shall use the following criteria in evaluating prior authorization requests in order to:

a. Safeguard against the unnecessary or inappropriate utilization of care and services;

b. Safeguard against excess payments;

c. Assess the quality and timeliness of such services;

d. Determine if less expensive alternative medical care, services or supplies are usable;

e. Promote the most effective and appropriate use of available services and facilities; and

f. Attempt to rectify misutilization practices of providers, recipients and institutions.

Emergency services may be covered under the MA program even if the required prior authorization was not obtained. In order to be covered, the provider shall attach to the invoice an explanation of the circumstances under which the services were provided and why such services should be classified as emergency care. The state agency shall reimburse only those services usually requiring prior authorization for which emergency status is established.

The state agency may delegate the responsibility for prior authorization of specific items and services to the local welfare agency which shall be responsible for implementing the methods and procedures prescribed.

10. Utilization control.

a. A statewide surveillance and utilization control program is established subject to applicable federal law and regulations. Such program shall include:

(1) An ongoing evaluation of the necessity for and the quality and timeliness of the services provided to eligible individuals under the MA

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program in order to promote the most effective and appropriate use of available services and facilities.

(2) A post-payment review process which allows for the development and review of recipient utilization profiles, provider service profiles, exception criteria, and one which identifies exceptions in order to rectify misutilization practices of recipients, providers and institutions.

b. Utilization control of inpatient hospital services and services provided in skilled and intermediate care facilities. Under this surveillance and utilization control program, all inpatient facilities shall:

(1) Have in effect a written utilization review plan which meets the requirements of applicable state law and federal regulations;

(2) Provide that the committee performing the utilization review activities will review each eligible individual's discharge plan to be developed in accordance with applicable state law and federal regulations;

(3) Obtain physician certification prior to or at the time of admission that such inpatient services are medically necessary or, in the case of an individual who applies for Medical Assistance while in an institution, obtain physician certification prior to authorization of payment;

(4) Obtain physician recertification at least every 60 days thereafter that such services continue to be medically necessary;

(5) Develop written plans of care in accordance with applicable state law and federal regulations; and

(6) Cooperate in a quality assurance and review program established by the Minnesota Department of Health in cooperation with DPW and in accordance with the provisions of applicable state law and federal regulations.

c. In accordance with the surveillance and utilization control program, all long term care facilities (i.e., skilled nursing facilities, intermediate care facilities, mental hospitals) shall provide for:

(1) A periodic review and evaluation of the necessity for admission and continued stay of each eligible individual receiving inpatient long-term care facility services. Such review and evaluation shall be performed by medical and other appropriate professional staff who are not themselves directly responsible for the care of eligible individuals, nor financially interested in any such institution nor (except in the case of mental hospitals) employed by such institution. Such reviews and evaluations shall be carried out in accordance with the requirements specified in applicable federal regulations.

(2) Review by the state agency (or its designee) of the recommendations for admission, in accordance with applicable federal regulations.

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d. Under the surveillance and utilization control program, the state agency shall:

(1) Establish and implement a program of medical review (including medical evaluation and on-site inspection) of the care provided patients in mental hospitals and skilled nursing facilities, and a program of independent professional review (including medical evaluation and on-site inspection) of the care provided residents in intermediate care facilities both of which shall satisfy the requirements of applicable federal regulations.

11. Transportation. The MA program shall pay for transportation through the centralized payment system only in accordance with section E.2.r.(1), infra. However, local welfare agencies may approve and pay for transportation when furnished by someone other than an enrolled medical provider. Such service must receive prior authorization and shall be reimbursable from the local welfare agency's medical assistance administrative account.

E. Services under the medical assistance program.

1. The following services are not covered under the MA program:

a. Medical services or supplies paid for directly by the recipient.

b. Medications dispensed by a physician that could reasonably be obtained from a licensed pharmacy (See, E.2.n., infra).

c. Medical services or supplies where the requisite prior authorization was not submitted or was denied.

d. Autopsies.

e. Missed appointments.

f. Telephone calls or other non face-to-face communication between the provider and the recipient.

g. Routine reports (e.g., Social Security, insurance) unless requested by the state agency.

h. Investigational surgery or procedures (e.g., research efforts not clearly essential to the patient's health).

i. Illegal operations and other procedures prohibited by law.

j. Artificial insemination.

k. Transsexual surgery.

l. Aversion therapy (including cash payments from recipients) unless provided in accordance with DPW 39 (12 MCAR § 2.039).

m. Cosmetic surgery aimed at beautification only.

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n. Weight reduction programs unless:

(1) The program treats a medical condition causing obesity; or

(2) Obesity interferes with the health, well-being or employability of the recipient.

o. Billing charges.

p. Mileage charged by eligible providers.

q. Reversal of voluntary sterilization procedures.

r. Medical care or services for an individual who is an inmate of a public institution, except as a patient in a medical institution or as a resident of an intermediate care facility (i.e., an individual who is under the care or control of a correctional authority).

s. Duplication of services by more than one provider without appropriate medical referrals.

t. Abortion services unless specifically provided in subsection E.2.t. of this rule.

2. The following services are covered under the MA program:

a. Inpatient hospital services. "Inpatient hospital services" are those items and services ordinarily furnished by a hospital for the care and treatment of inpatients; and which are provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases; and which is licensed or formally approved as a hospital by the Minnesota Department of Health; and which is qualified to participate under Title XVIII of the Social Security Act or is determined currently to meet the requirements for such participation; and which has in effect a utilization review plan applicable to all patients who receive Medical Assistance under Title XIX of the Social Security Act which meets applicable federal requirements, unless a waiver has been granted by the Secretary of the Department of Health, Education and Welfare. All inpatient hospitals certified for participation under Medicare (Title XVIII) are eligible to participate in the MA program upon completion of a provider agreement.

(1) The following inpatient hospitalization services must receive prior authorization:

(a) Medical care of marginal medical necessity.

(2) The following limitations apply to inpatient hospital services:

(a) Private room—must be certified by a licensed physician.

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as medically necessary, unless the private room rate does not exceed the semi-private room rate in that hospital.

(b) The hospital must comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply with these requirements will result in denial of payment by DPW.

(3) The following inpatient hospital services are not covered under the MA program:

(a) Leave days, leaves-of-absence and reserved beds as defined under federal regulations.

b. Long term care facility services. "Long term care facility services" are those services provided in facilities (or distinct parts thereof) licensed by the Minnesota Department of Health and certified as eligible providers of skilled nursing facility services, intermediate care facility services, tuberculosis or mental hospital services, or those facilities similarly licensed in another state or a Canadian province. The term "long term care facilities" (LTC) as used herein includes skilled nursing facilities (SNF), intermediate care facilities (ICF), and tuberculosis or mental hospitals.

(1) "Skilled nursing facility services" (other than services in an institution for tuberculosis or mental disease) are those services provided in a SNF. A SNF is a facility:

(a) Certified by MDH as meeting the requirements of Title XVIII of the Social Security Act, except that the exclusion contained therein with respect to institutions which are primarily for the care of tuberculosis or mental disease shall not apply; and

(b) Which meets the requirements of applicable federal regulations.

(2) "Intermediate care facility services" (other than services in an institution for tuberculosis or mental disease) are those services provided for individuals who are determined, in accordance with Title XIX of the Social Security Act, to be in need of the care provided in an ICF. An ICF is an institution which:

(a) Is licensed under state law to provide on a regular basis health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide but who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities;

(b) Satisfies the standards prescribed by the Secretary of Health, Education and Welfare as necessary for the proper provision of such

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care as enumerated in applicable federal regulations; and

(c) Meets such standards of safety and sanitation as mandated by federal regulations.

The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements described above. With respect to services furnished to individuals under age 65, the term intermediate care facility does not include any public institution for mental diseases or mental defects except it may include services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

"Intermediate care facility services/nursing home" means services provided in an ICF-NH. An "ICF-NH" is an institution licensed as a nursing home and which meets each of the conditions described above. "Intermediate care facility services/boarding care home" means services provided in an ICF-BCH or which could be provided in an ICF-BCH. An "ICF-BCH" is an institution licensed at least as a boarding-care home and which meets each of the conditions described above.

"Intermediate care facility services/mentally retarded" means services provided in an ICF/MR. An "ICF/MR" is an institution licensed by the Minnesota Department of Health, licensed in accordance with 12 MCAR § 2.034 and which meets each of the conditions described above.

"Intermediate care facility services/chemically dependent" means services provided in an ICF/CD. An "ICF/CD" is a facility licensed by the Minnesota Department of Health, licensed under 12 MCAR § 2.035 and which meets each of the conditions described above.

(3) "Inpatient psychiatric hospital services for individuals under age 21" are those services provided in an institution which is accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals. Such services include only inpatient services which, in the case of an individual:

(a) Involve active treatment which meets the standards prescribed by the Secretary of Health, Education and Welfare;

(b) Are provided by a team (consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and treatment thereof) and determined to be necessary on an inpatient basis and which can reasonably be expected to improve the condition giving rise to the need for such services, to the extent that eventually such services will no longer be necessary; and

(c) Are provided prior to the date such individual attains age 21, or if the individual was receiving such services during the period immediately preceding his twenty-first birthday, such services may be continued up to the date the individual no longer requires such services or the date the individual attains age 22, whichever date comes first.

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(4) Inpatient hospital, SNF and ICF services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases.

(a) "Inpatient hospital services in an institution for mental diseases" are those items and services which are provided under the direction of a licensed physician for the care and treatment of inpatients in a psychiatric hospital which meets the requirements of Title XVIII of the Social Security Act.

(b) "Inpatient hospital services in an institution for tuberculosis" are those items and services which are provided under the direction of a licensed physician for the care and treatment of inpatients in a tuberculosis hospital which meets the requirements of Title XVIII of the Social Security Act.

(c) "Skilled nursing facility services" are those items and services furnished by a skilled nursing facility as defined by applicable federal regulations.

(d) "Intermediate care facility services" are those items and services furnished by an intermediate care facility, as defined by applicable federal regulations, to residents who have been determined in accordance with such federal regulations to be in need of such care.

(e) An "institution for mental diseases" means an institution which is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases including medical attention, nursing care and related services.

(f) An "institution for tuberculosis" means an institution which is primarily engaged in providing diagnosis, treatment or care of persons with tuberculosis including medical attention, nursing care and related services.

(5) Levels of care. Reserved for future use.

(6) General limitations.

(a) Payment will be made only to facilities that have in effect an approved utilization review plan and which meet all other requirements of the surveillance and utilization control program prescribed by applicable federal regulations.

(b) Medical Assistance is not available on behalf of any individual who is an inmate of a public institution (except where a patient is in a medical institution (See, Minn. Stat. § 256B) or is a resident of an intermediate care facility) or any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases. An individual on provisional discharge or convalescent leave from an institution for

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mental diseases is not considered to be a patient in such institution. An institution for the mentally retarded or an institution for the chemically dependent is not considered an institution for mental diseases.

(c) Payments to institutions for the mentally retarded or persons with related conditions shall not include reimbursement for vocational and educational activities.

(d) Payment will be made to facilities only in accordance with applicable federal reimbursement formula regulations.

(7) Health care facility report. Every facility required by state law to be licensed by the Minnesota Department of Health shall provide such annual reports to the Commissioner of Public Welfare as may hereafter be required. Each health care facility participating under the MA program shall provide the Commissioner of Public Welfare with a full and complete financial report of the facility's operations, including:

(a) An annual statement of income and expenditures;

(b) A complete statement of fees and charges;

(c) The names of all individuals, partnerships and corporations (other than mortgage companies) owning any interest of ten percent (10%) or more of the facility; and

(d) The names of all owners of interest in the facility as defined in (c), or the children, parents or spouses of such owners who own an interest in any other health care facility or organization doing business with the MA program or who are otherwise enrolled as providers.

A DPW 49 (12 MCAR § 2.049) or DPW 52 (12 MCAR § 2.052) cost report shall satisfy this requirement. The financial records, reports and supporting data of each participating facility shall be accessible for inspection and audit by the Commissioner of Public Welfare or designees.

c. Physician services. Physician services are those services provided by or under the personal supervision of a licensed physician or osteopath within the scope of his profession as defined by state law. All physicians currently licensed to practice medicine under Minnesota law are eligible to participate in the MA program. Out-of-state physicians who are licensed in the state of service are also eligible for participation in Minnesota's MA program. The MA program shall pay for all emergency and medically-necessary health care.

(1) The following physician services must receive prior authorization:

(a) All medical, surgical or behavioral modification services aimed specifically at weight reduction.

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(b) Surgery and other procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to interfere with the individual's personal and social adjustment or employability.

(c) Removal of tattoo.

(d) Payment for physicians' services exceeding thirty (30) days of inpatient psychiatric treatment per calendar year.

(e) Individual hourly sessions with a psychiatrist licensed to practice medicine in the U.S. or Canada in excess of ten (10) per calendar year.

(2) The following are limitations to physicians' services:

(a) The MA program will pay for up to 10 hourly sessions with a psychiatrist licensed to practice medicine in the U.S. or Canada per calendar year for any eligible recipient.

(b) The MA program will pay for up to 26 additional hourly sessions with a psychiatrist licensed to practice medicine in the U.S. or Canada per calendar year when all of the following conditions exist:

(i) Three or more members of one family unit are all seen together at every session; and

(ii) The 26 hourly sessions extend over a period of time greater than six consecutive months; and

(iii) At least one of the family members is under age 18.

(c) The MA program will pay for ongoing chemotherapy management on a once-a-week average basis, provided that both of the following conditions apply:

(i) The medication required is an anti-psychotic or anti-depressant; and

(ii) No more than 52 sessions take place within a twelve month period.

(d) The MA program will pay for family psychotherapy of two family members (conjoint psychotherapy with continuing medical diagnostic evaluation and drug management) as needed for up to two hours per week for a twenty week period. (When more than two family members are involved, See, E.2.c.(2)(b), supra.)

(e) The MA program will pay for multiple family group-

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psychotherapy or group-psychotherapy for up to two hours per week for a ten week period.

d. Health maintenance organization (HMO). Health Maintenance Organizations are organizations licensed by the state which provide comprehensive health care to a voluntarily enrolled population in a specified geographic area. The MA program shall reimburse participating HMOs through a pre-negotiated and fixed per capita payment determined in accordance with applicable federal regulations made on behalf of enrolled recipients. HMOs shall provide, either directly or through arrangements with other medical providers, for all medical services and supplies covered under the official Medical Assistance State Plan. HMO services shall be provided in accordance with the HMO contract and shall not be subject to service limitations, prior authorization requirements and billing and recovery procedures under this rule.

e. Other licensed practitioners. The MA program shall pay for medical and remedial care or services, other than physicians' services, provided by a practitioner currently licensed under Minnesota law and performed within the scope of his practice as defined by state law. Out-of-state practitioners who are licensed in the state of service are also eligible to participate in Minnesota's MA program. This category is limited to services provided by licensed chiropractors, podiatrists, vision care providers, psychologists, nurse-midwives, osteopaths not licensed to practice medicine and surgery and by public health nurses. Limitations on the number of treatments pertain to each eligible recipient per calendar year.

(1) Chiropractors. Chiropractors must be licensed and conform to the uniform minimum standards promulgated by the Secretary of Health, Education and Welfare under Title XVIII of the Social Security Act, as amended. The MA program limits payment for services provided by chiropractors as follows:

(a) The request for chiropractic services must originate with the recipient, his family or caseworker and may proceed only with the recipient's full knowledge and consent.

(b) Payment is limited to manual manipulation of the spine for a diagnosis of subluxation of the spine. No other chiropractic service is covered under the MA program.

(c) Payment is limited to 6 treatments per month and 24 treatments per calendar year for each eligible recipient. Treatment in excess of these maxima must receive prior authorization.

(d) The MA program shall not cover x-rays nor any other diagnostic or laboratory procedure provided by a chiropractor.

(2) Podiatrists. The MA program limits payment for podiatry services as follows:

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(a) The request for podiatry services must originate with the recipient, his family, his caseworker or, where applicable, the staff of the long term care facility wherein he resides, and may proceed only with the patient's full knowledge and consent.

(b) A limit of 3 visits per month and 12 visits per year is placed on the following:

(i) Total office and outpatient visits.

(ii) Total home or long term care facility visits.

(iii) Hospital visits.

(c) Treatment in excess of these maxima must receive prior authorization.

(d) The following podiatry services are not covered under the MA program for long term care facility patients:

(i) Ordinary foot hygiene.

(ii) Use of skin creams to maintain skin tone.

(iii) Normal trimming of nails and other services that can reasonably and safely be performed by LTC facility personnel.

(3) Vision care. "Optometric services" are those services provided by or under the personal supervision of a licensed optometrist within the scope of his profession as defined by state law. "Eyeglasses" are lenses (including frames when necessary) and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the patient may select, to aid or improve vision. Eligible providers include optometrists currently licensed by the State Board of Optometry, ophthalmologists currently licensed by the state, opticians who are normally associated with the fabrication and/or dispensing of materials, and out-of-state providers in one of the above classifications licensed by the state of service.

(a) The following vision care services must receive prior authorization:

(i) Contact lenses.

(aa) Supplemental contact lens evaluation.

(bb) Contact lens check-up.

(cc) Spherical lens fitting (single vision).

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(dd) Cylindrical, lenticular, aphakic or prism ballast lenses.

(ee) Keratoconus lenses.

(ff) Cosmetic lenses (disfigurement only).

(gg) Fitting previous contact lens wearer.

(hh) Soft contact lens fitting.

(ii) Fitting monocular patient.

(ii) Custom-fit prosthetic eye.

(iii) Amblyopia therapy.

(aa) "Amblyopia" includes all test procedures necessary for classification and determination of expecteds.

(iv) Strabismus therapy.

(aa) "Strabismus" includes all test procedures necessary for classification, degree of squint and determination of expecteds.

(v) Vision therapy-supplemental evaluation and report.

(vi) More than one (1) pair of eyeglasses in any single 12 month period.

(vii) Photochromatic lenses: Must be accompanied by a statement of medical necessity.

(viii) Sunglasses: Must be accompanied by statement of medical necessity.

(ix) Lens coating-surface or edge.

(b) The following vision care services are not covered under the MA program:

(i) Services provided principally for cosmetic reasons, including:

(aa) Contact lenses prescribed for reasons other than aphakia, keratoconus, aniseikonia or marked acuity improvement over spectacle correction.

(bb) Replacement of lenses or frames due to a

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recipient's personal preference for a change of style or color.

(ii) Technical services related to the provision of non-covered services.

(4) Psychologists. Eligible providers are individuals currently licensed by the Minnesota Board of Examiners of Psychologists to practice as licensed psychologists or licensed consulting psychologists in the appropriate service areas.

(a) The following psychological services must receive prior authorization:

(i) Services in excess of the limitation on the number of visits (See, below).

(b) The MA program limits payment for services provided by psychologists as follows:

(i) The MA program will pay for up to 10 hourly sessions with a licensed psychologist per calendar year for any eligible recipient.

(ii) The MA program will pay for up to 26 additional hourly sessions with a licensed psychologist per calendar year when all of the following conditions exist:

(aa) Three or more members of one family unit are all seen together at every session; and

(bb) The 26 hourly sessions extend over a period of time greater than six consecutive months; and

(cc) At least one of the family members is under age 18.

(iii) The MA program will pay for family psychotherapy of two family members as needed for up to two hours per week for a twenty week period. (When more than two family members are involved, See, E.2.e.(4)(b), supra.)

(iv) The MA program will pay for multiple family group-psychotherapy or group-psychotherapy for up to two hours per week for a ten week period.

(c) The following psychological services are not covered under the MA program:

(i) Medical supplies and equipment.

(5) Public health nurses. A "public health nurse" is a registered

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nurse who is licensed as a professional nurse and certified by the State Board of Health as a public health nurse. The MA program limits payment for public health nurses to the following services:

(a) Health assessment and screening.

(b) Health promotion and preventive counseling.

(c) EPSDT screening if approved by the Minnesota Department of Health.

(d) Health care services provided at the residence of the patient if the services are performed by a public health nurse and the nurse indicates in a statement submitted under oath that the services were actually provided.

f. Outpatient hospital services. "Outpatient hospital services" are preventive, diagnostic, therapeutic, rehabilitative or palliative items or services furnished by or under the direction of a licensed physician or dentist to an outpatient in an outpatient facility which is licensed as a hospital by the state and which is qualified to participate under Title XVIII of the Social Security Act, or is currently determined to meet the requirements for such participation. All outpatient hospitals certified to participate under Medicare (Title XVIII) are eligible to participate in the MA program upon completion of a provider agreement.

(1) The following outpatient hospital services must receive prior authorization:

(a) Kidney dialysis not covered by Medicare.

(b) Oral surgery (except in emergencies).

(c) Hemodialysis back-up service.

(d) Supplemental and tube feedings for patients who have special nutritional needs.

(e) All physician services which must receive prior authorization (See, E.2.c.(1), supra).

(2) The following are limitations to services provided by outpatient hospitals:

(a) Each hospital shall comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply will result in denial of payment under the MA program.

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(3) The following outpatient hospital services are not covered under the MA program:

(a) Hypoallergenic foods; baby foods.

(b) Diapers.

(c) Charges for services of house staff, interns, residents, administrative or supervisory staff (including physician-owners) who are paid by the hospital or by other sources.

g. Clinic services. "Clinic services" are preventive, diagnostic, therapeutic, rehabilitative or palliative items or services furnished to an outpatient by or under the direction of a licensed physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to outpatients. Family planning agencies or centers are considered "clinics" under this definition.

(1) "Family planning agencies" are agencies or clinics which primarily offer family planning related services and have executed either a contract or provider agreement with the state agency. Family planning agencies provide services concerned with the voluntary planning of the conception and bearing of children. Such services include both fertility and infertility programs.

(a) The following are limitations to services provided by family planning agencies:

(i) The request for such services must originate with the recipient and proceed with his full knowledge and consent.

(ii) The agency or clinic must comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply with these requirements will result in denial of payment under the MA program.

h. Home health care services.

(1) "Home health care services" are any of the following items and services when they are prescribed by a licensed physician to a patient in his place of residence, but excluding residence in a hospital, SNF or ICF:

(a) Intermittent or part-time nursing services furnished by a home health agency.

(b) Intermittent or part-time nursing services of a professional registered nurse or licensed practical nurse under the direction of the patient's physician, when no home health agency services are available.

(c) Medical supplies, equipment and appliances prescribed

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by a physician as necessary for the care of the patient and suitable for use in the home.

(d) Services of a home health aide under the supervision of a professional nurse assigned by a home health agency.

(2) A "home health agency" is a public or private agency or organization, or a subdivision of such an agency or organization, which is qualified to participate as a home health agency under Title XVIII of the Social Security Act or is determined by the Department of Health to currently meet the requirements of applicable federal regulations. The following home health care services are not covered under the MA program:

(a) Homemaker services.

(b) Social services provided by a home health agency.

i. Medical supplies. The term "medical supplies" as used herein includes the most cost effective non-durable medical supplies, durable medical equipment, prostheses, orthoses and oxygen. Medical supplies must be prescribed by a physician or other licensed medical practitioner within the scope of his profession as defined by state law. Medical supplies must be necessary and reasonable for the treatment or diagnosis of an illness or injury or to improve the functioning of a malformed body member.

(1) "Non-durable medical supplies." Those items which have a limited life expectancy (e.g., atomizers, nebulizers, fountain syringes and incontinence pads).

(2) "Durable medical equipment." Equipment which can withstand repeated use, is primarily used for medical purposes, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home (e.g., wheel chairs, hospital beds and side rails).

(3) "Prostheses" and "orthoses." Replacement, corrective or supportive devices for the purpose of artificially replacing a missing portion of the body or to prevent or correct physical deformity or malfunction or to support a weak or deformed portion of the body.

(4) The MA program pays for oxygen and any equipment necessary for administration of oxygen (or other than nasal catheters and positive pressure breathing apparatus) when prescribed by a licensed physician so long as prior authorization is obtained.

Payment for equipment repair will be allowed only when that equipment is medically necessary. Routine periodic servicing such as testing, cleaning, regulating and checking of a recipient's equipment will not be covered. Extensive, complex maintenance may be covered as a necessary repair. Payment on equipment will not continue after the recipient's need for that equipment ceases to exist. The MA program will pay for supplies essential to the effec-

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tive use of medically necessary durable equipment.

Eligible providers include those individuals or agencies who supply and/or service medical supplies. Medical supply and hearing aid dealers must complete a "Performance Agreement" to be eligible to participate in the MA program. Performance agreement as used herein means a written agreement between a provider of service and the state agency, as required by federal regulations.

(5) The following medical supplies must receive prior authorization:

(a) Non-durable medical supplies, when:

(i) The cost exceeds the performance agreement limitations;

(b) Durable medical equipment, when:

(i) The purchase, projected cumulative rental, repair or maintenance cost exceeds the performance agreement limitation;

(c) Prostheses and orthoses, when:

(i) The purchase, projected cumulative rental, or repair cost exceeds the performance agreement limitations;

(ii) The order is for an indwelling catheter (which requires a diagnosis of permanent urinary incontinence) or

(iii) The order is for a hearing aid, repairs to hearing aids when the costs of parts and labor exceeds the performance agreement limitations, repairs under the limitations, if performed by a hearing aid dealer more than once a year, or visits by a hearing aid dealer/servicer to the recipient's home in excess of one visit per year.

(d) Oxygen and any equipment necessary for the administration of oxygen, except in documented emergencies.

(e) Medical supplies for recipients who are residents of long term care facilities may be authorized under the following conditions:

(i) The cost of a specific item cannot be covered in the per diem rate; and

(ii) The item is necessary for the continuous care and exclusive use of this recipient to meet an unusual medical need; and

(iii) The need is identified and documented in the recipient's plan of care.

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(6) The following items are not covered under the MA program:

(a) Equipment primarily and customarily used for non-medical purposes, i.e.:

(i) Air conditioners.

(ii) Food blenders.

(iii) Exercycles.

(iv) Orthopedic mattresses.

(v) Dehumidifiers.

(vi) Humidifiers.

(vii) Air filters.

(viii) Auto modifications.

(ix) Books.

(x) TV sets.

(xi) Bicycles.

(xii) Household items.

(xiii) Safety bars.

(xiv) Training equipment.

(b) Comfort or convenience items (i.e., electric beds, elevators, waterbeds, cushion lift chairs).

(c) Stock orthopedic shoes unless attached to a leg brace.

(d) Medical equipment and supplies for recipients who are residents of long term care facilities, except as provided in E.2.i.(4)(e), supra.

(e) The three follow-up visits per year at the hearing aid dealer's office or service center specified in the Hearing Aid Performance Agreement.

(f) Reimbursement to long term care facilities for any medical equipment or supplies other than allowed under DPW 49 (12 MCAR § 2.049) and DPW 52 (12 MCAR § 2.052).

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j. Private duty nursing services. "Private duty nursing services" are nursing services provided by a professional registered nurse or a licensed practical nurse under the general direction of the patient's physician to the patient in his own home or in a hospital or SNF, when the patient requires individual and continual care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital or SNF. Eligible providers include registered nurses and licensed practical nurses in independent practice who provide services separate and apart from any employment or contract with any agency, organization or facility.

(1) The MA program pays for private duty nursing services only:

(a) When ordered in writing by the patient's primary physician or consulting physician;

(b) In hospitals having no intensive care unit capable of meeting the patient's needs;

(c) In the family residence when there is no available home health care agency to provide the required level of nursing care which meets the requirements for participation under Title XVIII of the Social Security Act.

(d) If the private duty nurse is not a member of the patient's family.

k. Rehabilitative and therapeutic services. "Rehabilitative and therapeutic services" are provided for the purpose of increasing or maintaining the maximum level of functional independence of patients. These services are defined as follows and include the use of such supplies and equipment as necessary, when pursuant to physician orders and when purchased by a facility, agency or independent practitioner.

(1) Rehabilitative and therapeutic services in long term care facilities. Such services must be provided in accordance with applicable federal regulations, state law and DPW rules.

(a) "Physical therapy." Those services prescribed by a physician and provided to a patient by a qualified physical therapist. In addition, other qualified rehabilitative personnel, including physical therapy assistants, physical therapy aides, and physical therapy orderlies may assist the physical therapist in performing physical therapy services and in the performance of duties that do not require a qualified physical therapist's knowledge and skill. The full responsibility for the patient's instruction or treatment remains with the qualified physical therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct, on-site observation and supervision by the qualified physical therapist. A "qualified physical therapist" is a graduate of a school of physical therapy approved by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association, and who has a valid Minnesota

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certificate of registration (as soon as such certificate is available from the Minnesota Department of Health).

(b) "Occupational therapy." Those services prescribed by a physician and provided to a patient by a qualified occupational therapist. In addition, other qualified rehabilitative personnel, including occupational therapy assistants, occupational therapy aides, and occupational therapy orderlies may assist the occupational therapist in performing occupational therapy services and in the performance of duties that do not require a qualified occupational therapist's knowledge and skill. The full responsibility for the patient's instruction or treatment remains with the qualified occupational therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct, on-site observation and supervision by the qualified occupational therapist. A "qualified occupational therapist" is a graduate of a school of occupational therapy approved by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, and/or who is registered by the American Occupational Therapy Association.

(c) "Services for individuals with speech, hearing and language disorders." Those diagnostic, screening, preventive or corrective services prescribed by a physician and provided by a qualified speech pathologist or a qualified audiologist in the practice of his profession. A "qualified speech pathologist" or "qualified audiologist" shall have a Certificate of Clinical Competence from the American Speech and Hearing Association, or shall have completed the equivalent educational requirements and work experience necessary for obtaining such a certificate, or shall have completed the academic program and be in the process of accumulating the necessary supervised work experience required to qualify for such a certificate.

(d) Specialized rehabilitative service requirements—inpatient and outpatient.

(i) Restorative therapy. There must be a medically appropriate expectation that the patient's condition will improve significantly in a reasonably and generally predictable period of time. This expectation shall be based on an assessment made by the attending physician of the patient's restorative potential after consultation with qualified rehabilitative personnel.

(ii) Specialized maintenance therapy. Physician orders must relate the necessity for specialized maintenance therapy to the patient's particular disabilities. Such therapy must be necessary for maintaining the patient's current level of functioning or for preventing deterioration of the patient's condition. Specialized maintenance therapy shall be provided only by qualified rehabilitative personnel and only to those patients who cannot be adequately and appropriately treated solely within the facility's nursing program.

(e) Billing and reimbursement.

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(i) The long term care facility in which the recipient resides shall bill on behalf of the rehabilitative personnel, agency or hospital for services provided. In cases where a patient residing in a facility is provided specialized rehabilitative services in a setting other than his residential facility, the residential facility shall bill for services provided pursuant to agreement with the agency, hospital or other institution where the service is provided.

(ii) Reimbursement to qualified rehabilitative personnel (including rehabilitative assistants and aides) under contract with a facility: Each facility shall bill the MA program on behalf of qualified rehabilitative personnel providing services under contract to it.

(iii) Reimbursement to qualified rehabilitative personnel (including supervised rehabilitative assistants and aides) salaried by the facility. Each facility shall bill on behalf of salaried, qualified rehabilitative personnel for the services provided. At the end of each fiscal year, the facility shall:

(aa) Determine the total number of treatment sessions provided by each salaried, qualified rehabilitative employee during the fiscal year. A "treatment session" is defined as one or more treatment procedures and/or modalities provided to one patient during one session.

(bb) Determine, for each qualified rehabilitative employee, the total number of treatment sessions (as defined herein) provided to eligible recipients and indicate this number as a percentage of the total number of treatment sessions provided by that employee.

(cc) Multiply the resulting percentage by the salary of the employee. "Salary" means all direct costs related to employment. If Medical Assistance reimbursement exceeds the percentage of salary related to treatment sessions provided to Medical Assistance recipients, the excess amount shall be applied to and, therefore, reduce the "General and Administration" expenses on the health facility cost report submitted by the respective facility.

(f) The following rehabilitative and therapeutic services are not reimbursable as a separate charge under the MA program when furnished in a long term care facility;

(i) Services authorized by a physician but not documented in the patient's medical record.

(ii) Services provided by unsupervised assistants, aides and/or other supportive personnel. Salaries and costs related to these personnel are to be included as part of the facility's rate determination in accordance with the health facility cost report.

(iii) Rehabilitative services provided by nursing personnel.

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(iv) Services for personal comfort.

(v) Services of qualified rehabilitative personnel related to training or consultation of facility staff.

(vi) Activities programs.

(vii) Services of a rehabilitative nature provided by living unit personnel, qualified mental retardation professionals, direct care staff, and training or habilitational personnel.

(viii) Screening procedures not ordered by a physician.

(ix) Services not reasonable and necessary to the treatment of the patient's condition.

(x) Services provided without written orders of the patient's attending physician.

(xi) Services provided without physician review of the patient's progress and plan of care at least once every 30 days, with written certification and recertification by the physician.

(xii) Services of a preventive or maintenance nature when physician orders do not relate such services to the patient's disabilities.

(xiii) Physical therapy services not authorized after the initial 90-day service period by an independent medical consultant or the facility's utilization review committee, or through the local welfare agency's approved review plan only if authorization by an independent medical consultant or the utilization committee is not possible.

(xiv) Outpatient services provided by a facility not certified as an outpatient provider.

(xv) Outpatient services provided off the facility's premises.

(xvi) Services billed for by any source other than the skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.

(2) Speech pathology, audiology and physical therapy provided by independent practitioners. Such services are of a diagnostic, screening, preventive or corrective nature and provided to individuals with speech, hearing and language disorders or physical impairments. Such services must be provided in accordance with the applicable federal regulations, state law and DPW rules.

(a) "Speech pathology." Those services prescribed by a licensed physician and provided to a patient by a qualified speech pathologist in independent practice. A "qualified speech pathologist in independent

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practice" shall have received a Certificate of Clinical Competence from the American Speech and Hearing Association (ASHA) or shall have submitted to the MA program an equivalency statement from ASHA indicating that ASHA certification standards have been met.

(b) "Audiology." Those services prescribed by a licensed physician and provided to a patient by a qualified audiologist in independent practice. A "qualified audiologist in independent practice" shall have received the Certificate of Clinical Competence from ASHA or shall have submitted to the MA program an equivalency statement from ASHA indicating that ASHA certification standards have been met.

(c) "Physical therapy." Those services prescribed by a licensed physician and provided to a patient by a qualified physical therapist in independent practice. A "qualified physical therapist in independent practice" is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, has a valid Minnesota Certificate of Registration (as soon as such certificate is available from the Minnesota Department of Health), and has been certified as an independent practitioner by the Minnesota Department of Health.

(d) The following services are not covered as independent practitioner services under the MA program:

(i) Services provided by an independent practitioner speech pathologist, audiologist or physical therapist not maintaining at his own expense an office or office space and the necessary equipment to provide an adequate treatment program.

(ii) Services which are not physician prescribed.

(iii) Any service authorized by a physician but not documented in the clinical record of the patient.

(iv) Training or consultation provided by a speech pathologist, audiologist or physical therapist to an agency, facility or other institution.

(v) Screening procedures not physician authorized.

(vi) Services provided under a written treatment plan which is not reviewed at least once every 30 days with certification and recertification by the ordering physician.

(e) The following services of independent practitioners must be billed through the contracting or employing facility, agency, or person and will not be reimbursed directly to the practitioner:

(i) Services provided in settings other than the inde-

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pendent practitioner speech pathologist's, audiologist's or physical therapist's own office or the recipient's place of residence. "Place of residence" excludes skilled nursing facilities, intermediate care facilities, hospitals, rehabilitation agencies, home health agencies, public health agencies, clinics and day activity centers.

(ii) Services of a speech pathologist, audiologist or physical therapist employed and salaried by physicians.

(3) Rehabilitation agencies: An agency which provides an integrated multidisciplinary program designed to upgrade the physical function of handicapped, disabled individuals by bringing together as a team specialized rehabilitation personnel. At a minimum, a rehabilitation agency must provide physical therapy or speech pathology services, and a rehabilitation program which in addition to physical therapy or speech pathology services, includes social or vocational adjustment services. Eligible providers include all rehabilitation agencies participating in the Medicare program (Title XVIII) who have signed and returned to the state agency a provider agreement within sixty (60) days after receipt thereof. "Rehabilitation agency services" are those services provided by certified rehabilitation agencies in accordance with applicable federal regulations, state law and DPW rules and defined as follows:

(a) "Medical services." Those services provided to a patient within the scope and practice of medicine as defined by Minnesota law and performed by a currently licensed physician.

(b) "Psychological services." Those services provided to a patient by a psychologist licensed to practice in the appropriate service areas, when medically necessary.

(c) "Psychosocial services." Those services provided to a patient by a social worker for whom a licensed physician assumes total professional and administrative responsibility as if the services were provided by the physician himself. To receive reimbursement under the MA program all psychosocial services shall be ordered by a licensed physician.

(d) "Physical therapy." Those services prescribed by a licensed physician and provided to a patient by a qualified physical therapist. Other personnel may assist physical therapists in performing physical therapy services and in the performance of duties that do not require professional therapy knowledge and skill. The full responsibility for patient instruction or treatment remains with the qualified physical therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct on-site observation and supervision by the qualified physical therapist.

(e) "Occupational therapy." Those services prescribed by a licensed physician and provided to a patient by a qualified occupational therapist. Other personnel may assist occupational therapists in performing occupational therapy services and in the performance of duties that do not

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require professional therapy knowledge and skill. The full responsibility for patient instruction or treatment remains with the qualified occupational therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct on-site observation and supervision by the qualified occupational therapist.

(f) "Speech pathology or audiology services for individuals with speech, hearing and language disorders." Those diagnostic, screening, preventive or corrective services provided by a qualified speech pathologist or audiologist in the practice of his profession for which a patient is referred by a licensed physician.

(g) "Special services." Physician-ordered and monitored evaluations, classes, clinics or programs provided to patients generally by a rehabilitation team.

(h) The MA program will reimburse for services provided only by the following qualified personnel:

(i) Physicians. A qualified physician who is currently licensed in the State of Minnesota to practice medicine or, if an out-of-state physician, who is licensed in the state of service.

(ii) Psychologists. A qualified psychologist who is currently licensed by the Minnesota State Board of Examiners of Psychologists as a licensed consulting psychologist or a licensed psychologist.

(iii) Social workers. A qualified social worker is an individual with a master's degree from a school of social work accredited by the Council on Social Work Education.

(iv) Physical therapists. A qualified physical therapist is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, and, has a valid Minnesota Certificate of Registration.

(v) Occupational therapists. A qualified occupational therapist is a graduate of a school of occupational therapy approved by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, and/or who is registered by the American Occupational Therapy Association.

(vi) Speech pathologists and audiologists. A qualified speech pathologist or audiologist is an individual with a Certificate of Clinical Competence from the American Speech and Hearing Association or an individual who has completed the equivalent educational requirements and work experience necessary for obtaining such a certificate, or, who has completed the academic program and is in the process of accumulating the necessary supervised work experience required to qualify for such a certificate.

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(i) Rehabilitation agencies—non-covered services include:

(i) Services provided without physician orders (excluding psychological services).

(ii) Psychosocial services provided by a social worker when a licensed physician does not assume professional and administrative responsibility for such services.

(iii) Services authorized by a physician but not documented in the patient's clinical record.

(iv) Services provided in day activity centers which are subsidiaries of rehabilitation agencies.

l. Dental services. "Dental services" are diagnostic, preventive or corrective procedures administered by or under the supervision of a licensed dentist. The MA program pays for all emergency care and basic medically necessary oral health needs. "Dentures" are artificial structures prescribed by a dentist to replace a full or partial set of teeth and made by or according to the directions of a licensed dentist. Eligible providers are dentists licensed to practice dentistry in Minnesota, another state or a Canadian province.

(1) The following dental services and procedures must receive prior authorization:

(a) Pedodontics (only when the secondary tooth has completed two-thirds of its development).

(b) Hospitalization for dental treatment.

(c) Periodontics.

(d) Root canal therapy (molars only and only if more than one needs treatment).

(e) Gold restorations and/or inlays (including cast non-precious and semi-precious metals).

(f) Fixed prosthodontics.

(g) Orthodontics.

(h) Surgical services except emergencies and alveolectomies.

(i) Removal of impacted teeth.

(2) The following are limitations on the MA dental program:

(a) Oral hygiene instruction—1 time only.

(b) Dentures (any type)—1 per 5 year period, except under

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special circumstances and only then if prior authorization is received. Dentures that are lost and/or destroyed by recipient negligence will not be replaced during such 5 year period.

(c) Relines or rebase—1 every 3 years, except under special circumstances and only then if prior authorization is received.

(d) Patients in hospitals or long term care facilities—3 visits by the dentist to the hospital or LTC facility per diagnosis. (As used here, "diagnosis" means evaluation, determination of medical condition and plan of treatment. This limitation applies to inpatient hospital facilities only if the recipient has been hospitalized in order to treat a dental condition. This does not limit the number of visits a recipient can make to the dentist's office.)

(3) The following services are not covered under the MA dental program:

(a) Additional clasps for partial dentures.

(b) Bases.

(c) Sealants.

(d) Local anesthetics when billed as a separate procedure.

(e) Toothbrushes and/or other hygiene aids.

(f) Services provided to a recipient in his home.

m. Other laboratory and x-ray services. "Other laboratory and x-ray services" include professional and technical laboratory and radiological service ordered by a licensed physician, dentist or other licensed practitioner within the scope of his practice as defined by state law and who is not employed by that laboratory. The MA program shall pay for such services only when provided by or under the direction of a physician or licensed practitioner in an office or similar facility other than a hospital outpatient department or clinic. Such laboratory must be qualified to participate under Title XVIII of the Social Security Act, or be currently determined to meet the requirements for such participation. Eligible providers are facilities that render professional and technical laboratory services as described herein.

n. Pharmacy services. A "pharmacy" is a facility licensed by the State Board of Pharmacy in which prescriptions, drugs, medicines, chemicals and poisons are compounded, dispensed, vended or sold on a retail basis. "Prescribed drugs" are any simple or compounded substance or mixture of substances prescribed for the care, mitigation or prevention of disease or for health maintenance, by a physician, dentist or other licensed medical practitioner within the scope of his professional practice as defined by state law. The MA program covers prescribed drugs obtained from a licensed pharmacy or from a hospital in which drug dispensing is under the supervision of a li-

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censed pharmacist. All licensed pharmacies are eligible to participate in the MA program when the pharmacist in charge has enrolled as a provider in accordance with state agency requirements. The MA program shall pay for pharmaceuticals prescribed and dispensed by a physician or dentist in his office when there is no licensed pharmacy within the recipient's local trade area, as defined in D.1., supra.

(1) The following are service limitations of the MA pharmacy program:

(a) Pharmaceuticals must be prescribed by a licensed physician, dentist or other authorized licensed practitioner of the healing arts. The drug dispenser must keep the signed prescription on file for 5 years, subject to audit at any reasonable time (See, D.4.c., supra).

(b) Telephone orders, where legal, must be reduced to writing with the name of the prescribing physician shown and must be signed by the pharmacist.

(c) Prescription refills:

(i) The prescriber must indicate, either verbally or by specification on the original prescription, approval for refilling the prescription.

(ii) As many as five (5) refills may be authorized by the prescriber, but in such cases the total amount authorized must be dispensed within six (6) months of the original prescription date, except when the patient is in a long term care facility where no such limit shall exist.

(iii) In the absence of specific refill instructions, the prescription will be interpreted to be not refillable. Refills are covered only when refilled by the pharmacy where the original prescription was filled.

(d) The quantity supplied will depend on the usual and customary prescribing practice of the physician provided that the quantity does not exceed 30 days for acute illness and 100 days for maintenance therapy.

(2) The following services must receive prior authorization:

(a) Supplemental and tube feedings for patients who have special nutritional needs. The patient's dietary requirements must be identified on a physician's prescription and the product(s) must be available from an eligible supplier.

(3) The following items are not covered under the MA pharmacy program:

(a) Non-legend drugs, stocked by a long term care facility and administered to a patient in such facility for short term (up to 36 hours) therapy.

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(b) Cosmetic products (including hypoallergenic cosmetics).

(c) Toiletries (non-medicated soaps, body lotions, powders) used for personal cleaning and grooming.

(d) Oral antiseptics.

(e) Dentifrices and other dental hygiene equipment and supplies.

(f) Throat lozenges.

(g) Contact lens wetting solutions and cleaners.

(h) Investigational drugs.

(i) Biologicals (i.e., vaccines, serums, toxoids) generally considered inappropriate for self-administration.

(j) Amphetamines, amphetamine derivates and any other Drug Enforcement Agency Schedule II anorexient agents for weight control purposes, except as provided in E.1.n., supra.

(k) Nutritional services:

(i) Modified diets consisting of conventional foods.

(ii) Salt and sugar substitutes; salt or sugar-free specialty food and beverage products.

(iii) Baby foods.

(iv) Hypoallergenic foods (See, E.2.n.(2), supra).

(v) Alcoholic beverages.

(l) Any medication not prescribed by a licensed physician, dentist or other licensed practitioner authorized by the state to prescribe drugs within the scope of practice.

o. Other diagnostic, screening, preventive and rehabilitative services. The MA program provices for these services as described herein.

(1) "Diagnostic services," other than those for which provision is made elsewhere in this rule, include any medical procedure or supplies recommended for a patient by his physician or other licensed medical practitioner within the scope of his practice as defined by state law, as necessary to enable him to identify the existence, nature or extent of illness, injury or other health deviation of the patient.

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(2) "Screening services" consist of the use of standardized tests performed under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations, or to identify suspects for more definitive studies.

(3) "Preventive services" are those services provided by a licensed physician or other licensed medical practitioner within the scope of his practice as defined by state law, to prevent illness, disease, disability and other health deviations or their progression, and to prolong life and promote physical and mental health efficiency.

(4) "Rehabilitative services" include any medical remedial items or services, except those expressly excluded under this rule, which are prescribed by a licensed physician or other licensed medical practitioner within the scope of his practice as defined by state law, for the purpose of reducing physical or mental disability and restoring the patient to his best possible functional level. Prior authorization must be obtained on any services for which payment is claimed under this section.

p. Early periodic screening, diagnosis and treatment (EPSDT). The MA program provides for early and periodic screening and diagnosis of individuals under the age of 21 to ascertain physical or mental defects and for health care, treatment and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Services rendered by providers other than licensed physicians are reimbursable only if the Minnesota Department of Health has previously approved the screening activities.

(1) In order to comply with federal and state EPSDT requirements, local welfare agencies shall:

(a) Notify in writing on an annual basis all recipients eligible for EPSDT services about the existence of such services;

(b) Provide or arrange for provision of screening services when they are requested;

(c) Arrange for needed corrective treatment; and

(d) Maintain adequate EPSDT records and report activities as required by federal and state agencies.

(2) In order to comply with federal and state EPSDT requirements, providers shall:

(a) Follow required EPSDT billing/reporting procedures;

(b) Adhere to free choice of provider policy when making referrals for recipients.

q. Health care insurance premiums. The MA program shall pay health insurance premiums determined by the state agency to be cost-effective, for:

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(1) Eligible recipients not covered under Title XVIII of the Social Security Act, when coverage under the insurance policy justifies the premium charged and the policy provides coverage only for health care.

(2) Supplemental medical insurance (SMI) on a buy-in basis for eligible recipients covered under Title XVIII of the Social Security Act.

(3) Such other insurance programs as the state agency may approve for eligible recipients.

r. Other medical care. The MA program shall pay for other necessary medical and/or remedial care as follows:

(1) Transportation only when furnished by an enrolled medical provider licensed by the Minnesota Department of Health (See, D.7., supra).

(a) The following services rendered by medical transportation providers are not covered under the MA program:

(i) Any routine service determined by the local welfare agency not to be medically necessary.

(ii) Ambulance service in cases where another means of transportation would have sufficed.

(2) Emergency hospital services which are necessary to prevent the death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital equipped to furnish such services even though the hospital does not currently meet the conditions for participation under Title XVIII of the Social Security Act or the definitions of inpatient or outpatient services.

(3) Personal care services in a recipient's home rendered by an individual, other than a member of the patient's family, who is qualified to provide such services, when the services are prescribed by a physician and supervised by a registered nurse in accordance with a plan of treatment.

(4) Whole blood, including items and services required in the collection, storage and administration thereof, when it has been ordered by a licensed physician and is not available to the patient from other sources.

(5) Crippled children services program (CCS). Pursuant to a cooperative agreement between the Minnesota Department of Public Welfare and the Minnesota Department of Health, DPW will reimburse the state's CCS program (Title V) for diagnosis, evaluation and ongoing medical follow-up services in CCS field clinics for Medical Assistance eligible children up to 21 years of age. DPW will also reimburse CCS for evaluation, diagnosis and/or

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consultation provided Medical Assistance eligible children who are residents of the Minnesota School for the Deaf, the Minnesota School for the Blind and Visually Handicapped and certain other state institutions.

s. Mental health centers. "Mental health centers" are centers currently receiving grant-in-aid who are operating in accordance with DPW 28 (12 MCAR § 2.028). Services provided by mental health centers must be provided under the auspices and direction of a physiciatrist licensed to practice medicine in the U.S. or Canada or a licensed consulting psychologist, currently enrolled as an eligible provider under the MA program. The MA program will pay for mental health center services provided to residents of long term care facilities only if the attending physician helped develop the plan of treatment and periodically reviews that plan.

(1) Mental health centers are subject to the same service limitations and prior authorization requirements as is the practitioner under whose auspices or direction the services are rendered (See, E.2.c.(1) and (2) and E.2.e.(4), supra).

(2) The following mental health center services are not covered under the MA program:

(a) Community planning.

(b) Community consultation; program consultation.

(c) Program and service monitoring and evaluation.

(d) Public information and education.

(e) Resource development.

(f) Training and education.

t. The cost of abortion services shall be paid only when the conditions under (1), (2), or (3) are met:

(1) The abortion is necessary to prevent the death of the mother. The cost of the abortion shall be covered only if the following documentation accompanies the provider's invoice to the state agency:

(a) The signed written statement of two physicians that it was their professional judgment that the abortion was necessary to prevent the death of the mother; and

(b) The signed written statement of the recipient that she voluntarily consented to the abortion. In the event that the recipient is physically or legally incapable of providing informed consent, consent may be obtained as is otherwise provided by law.

(2) The abortion is to terminate a pregnancy which is the result

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of a sexual assault. The cost of the abortion shall be covered only if a report of the assault was made to a valid law enforcement agency within 48 hours of the time the assault occurred and a signed statement from the law enforcement agency accompanies the provider's invoice to the state agency. In the event the recipient was physically unable to make the report within 48 hours of the assault, the report must have been made within 48 hours after the recipient became physically able to make the report.

The statement of the law enforcement agency shall include the following information:

(a) The name of the victim; and

(b) The date of the alleged incident; and

(c) The date the report was made to the law enforcement agency; and

(d) The name and address of the person who signed the report to the law enforcement agency; and

(e) A statement by the law enforcement agency that the report alleges at least one of the following:

(i) Circumstances existing at the time of the assault caused the recipient to have a reasonable fear of imminent great bodily harm to herself or to another.

(ii) The assailant was armed with a dangerous weapon or an article used or fashioned in a manner which led the recipient to reasonably believe it to be a dangerous weapon, and used or threatened to use the weapon or article to cause the complainant to submit.

(iii) The assailant caused personal injury to the complainant and used force or coercion to accomplish sexual penetration.

(iv) The assailant was aided or abetted by one or more accomplices and either:

(aa) An accomplice used force or coercion to cause the recipient to submit; or

(bb) An accomplice was armed with a dangerous weapon or an article used or fashioned in a manner to lead the complainant reasonably to believe it to be a dangerous weapon and used or threatened to use the weapon or article to cause the recipient to submit.

The provider's invoice shall also be accompanied by a statement, signed by the recipient, that her pregnancy resulted from the sexual assault reported, and a statement, signed by the recipient's physician, that in his/her profes-

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sional opinion the length of the pregnancy at the time of the abortion was not inconsistent with the recipient's statement.

(3) The abortion is to terminate a pregnancy which is the result of incest. The cost of the abortion shall be covered only if a report of incest was made to a valid law enforcement agency prior to the time of the abortion and a signed statement from the law enforcement agency accompanies the provider's invoice to the state agency. The statement shall include the following information:

(a) The name of the victim; and

(b) The date of the alleged incident; and

(c) The date the report was made to the law enforcement agency; and

(d) The name and address of the person who signed the report to the law enforcement agency; and

(e) A statement by the law enforcement agency that the name of the relative who allegedly committed incest with the victim appears in its report.

The provider's invoice shall also be accompanied by a statement, signed by the recipient, that her pregnancy resulted from the incest reported, and a statement, signed by the recipient's physician, that in his/her professional opinion the length of the pregnancy at the time of the abortion was not inconsistent with the recipient's statement.

(4) For the purposes of this subsection E.2.t. only, the following definitions apply:

(a) "Abortion services": medical service performed for the purpose of terminating a pregnancy. This shall not be construed to include:

(i) drugs or devices which prevent implantation of the fertilized ovum; or

(ii) medical procedures necessary for the termination of an ectopic pregnancy.

(b) "Assailant": person who allegedly committed the sexual assault reported to the law enforcement agency.

(c) "Incest": sexual intercourse with another nearer in kin than first cousin, of the whole or half-blood.

(d) "Valid law enforcement agency": an agency charged under applicable law with enforcement of the general penal statutes of the United States, or of any state or local jurisdiction.

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F. Reimbursement.

1. Payments to eligible providers. Participation in the MA program is limited to those providers of medical care, service and supplies who accept as payment in full amounts paid in accordance with DPW's maximum allowable charges. Providers are prohibited from requesting or receiving additional payment from the recipient, his relatives or guardian, except to meet the spend-down provision of state law. Providers will be directly paid for providing medical care and services rendered within the scope of practice recognized under federal and state law and regulations. The state agency or, where appropriate, the local welfare agency, may pay an agency, institution or group pursuant to a contract with an approved provider only if required under a written contract between the provider and the agency, institution or group. The state agency shall have access to all such contracts at its request.

2. Billing procedures. Providers of medical care and services shall bill the state agency up to their usual and customary fee and only after the medical care or services have been provided. Providers proven to consistently bill in excess of their usual and customary fee shall be referred to the SURS pro-

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gram for investigation and, if appropriate, shall be determined ineligible to participate in the MA program. Medical bills should be presented for payment at the conclusion of each month's service. Providers shall bill within twelve (12) months of the date of service or, in unusual circumstances, in accordance with applicable federally-imposed time restrictions. The state agency shall deny payment until the following criteria have been met:

a. Providers submit all necessary forms and reports to the appropriate state or local welfare agency.

b. All prior authorization requirements are fulfilled.

c. Providers bill for care or services rendered on prescribed forms according to state agency instructions.

(1) The state agency shall require providers to submit diagnosis and procedure codes on all billings when deemed necessary for proper administration of the MA program, to comply with applicable federal regulations and to maximize federal financial participation.

d. Providers shall bill the state agency directly, except as follows:

(1) Where a written contract or other formal arrangement exists between the provider of the service and any agency, institution or group, in which case such agency, institution or group shall bill the state agency.

(2) If a provider of service who is eligible to accept Medicare assignments wishes to be paid by the MA program, such provider shall accept assignments on Medicare billings and shall bill Medicare prior to billing the MA program.

3. Authority to recover from medical providers. The state agency is authorized to recover any Medical Assistance funds paid to providers when it determines that such payment was obtained fraudulently or erroneously. Such recovery may be accomplished through withholding current obligations due the provider or by demanding that the provider refund amounts so received. Recovery under the MA program is permitted for intentional as well as unintentional error on the part of the provider or state or local welfare agency; for failure to comply fully with all utilization control requirements, prior authorization procedures or billing procedures; for failure to properly report third-party payments; and for fraudulent actions on the part of the provider.

G. Miscellaneous.

1. Former DPW 47 (12 MCAR § 2.047) is hereby repealed except section S which becomes section F.4.

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006334

12 MCAR S 2.049 Rules for determining welfare per-diem rates for nursing-home providers under the Title XIX Medical Assistance Program.

A. Applicability and purpose.

1. Authority. This regulation is enacted pursuant to the statutory authority vested in the commissioner of public welfare pursuant to Minnesota Statutes, section 256B.27 to require reports, information and audits, and pursuant to Minnesota Statutes, section 256B.04, subdivision 2, to promulgate rules and regulations for carrying out and enforcing the provisions of Minnesota Statutes, chapter 256B. This regulation is further promulgated pursuant to the procedures set out in Minnesota Statutes, section 15.0412, of the Minnesota Administrative Procedures Act.

2. Objectives. The procedures embodied herein define a system for the determination of per-diem welfare rate for all nursing homes participating in the medical assistance program and board and care licensed facilities participating in the Minnesota supplemental aid program that promotes efficiency and economy and treats all providers of nursing home care on a uniform basis. Facilities that provide care to other than nursing patients must comply with these regulations if nursing-home patients account for 50 percent or more of the facility population.

Procedures have been defined to satisfy the state plan for medical assistance and HEW Medical Services Administration Program Regulation Guide 19, which prescribe reasonable charges/cost-related rate-setting methods. The rate-setting procedures have also been defined to comply with the state statute that requires that cost differences between individual providers be recognized (Minnesota Statutes, section 256B.04, subdivision 2) while at the same time establishing cost limitations to satisfy federal requirements that the welfare rates be consistent with efficiency, economy, and quality or care.

The welfare rate-setting procedures include herein also recognize required level and quality of care as defined by all governmental entities (including, but not limited to federal, state and local entities), establish effective accountability over the disbursement of medical assistance appropriations, and provide for a regular review mechanism for rate changes.

While the rate-setting procedures are intended to compensate the provider for the reasonable cost incurred by prudent management, including a return of capital through depreciation, they are not intended to provide funds for financing working capital needs or purchase of facilities. It is not intended that the regulations provide for reimbursement of actual cost through retroactive settlement.

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B. Rate determination.

1. Method of calculating per diem rate.

a. Historical rate. The method of calculating the nursing-home provider per-diem rate for skilled, ICF I, and ICF II facilities will be to determine reasonable costs for the most current fiscal year and divide by adjusted patient days according to reasonable cost provisions of D. and cost-reporting regulations contained in C.

b. Incentive factors.

(1) In no case will the historical rate so determined under B.1.a. be less than the historical rate calculated for the previous year minus one-half of the difference. This provision shall not apply for rates for newly established providers under B.3.a. rates set by applying exceptions provided by D.8.d. and flat rates established under B.3.e. For multi-level providers this provision will be applied to the facilities average historical rates.

(2) Per-diem rates for non-proprietary facilities may include an efficiency allowance. If the facility's allowable historical cost per patient per day for the most recently completed fiscal year is less than the allowable welfare rate exclusive of B.4.a. and b. and as adjusted for the lack of implementation of known cost changes, an efficiency allowance will be granted equal to the difference between the allowable historical cost and the allowable welfare rate subject to a maximum efficiency allowance of 60 cents per patient per day. For each year after the year in which the non-proprietary facility was originally purchased and there is no transfer of ownership of the facility, the efficiency allowance maximum will be increased one cent per patient per day subject to a maximum of an additional 25 cent per patient per day after 25 years. If a non-proprietary facility is operated on a lease basis, there shall not be recognized as an allowable cost for the operator any rental fees in excess of the total amount allowed for depreciation, interest, and pursuant to B.1.b.(2), provided however that such a rental fee may be recognized in entirety for the period that it was incurred under a lease entered into before April 13, 1976 and prior to the subsequent renewal of said lease. This provision of the rule will be effective for rates paid non-proprietary facilities on January 1, 1978 and subsequent until such time as it is disapproved by HEW.

c. Allowance for known cost changes.

(1) Future cost increases or decreases that are in accordance with the reasonable cost principles of D.1. known as of the report filing date, must be added to or deducted from the historical rate determined according to B.1.a. and b. Such adjustment will be restricted to the elements defined in B.1.c.(1)(a) through (h) and shall be the annualized cost effect of such cost changes exclusive of any portion of the cost change

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included in the historical rate.

(a) Salary and wage changes to occur during the effective period of the welfare rate:

(i) Future changes according to labor contracts, board resolutions, written policies, or minimum wage laws.

(ii) Changes that are in effect as of the end of the fiscal period covered by the historical cost portion of the welfare per-diem rate.

(b) Changes in facilities or equipment.

(c) The annualized cost effect of complying with federal, state, or local laws and regulations and Department of Public Welfare announced policies on care or facilities.

(d) All taxes except for income taxes.

(e) Interest.

(f) Depreciation.

(g) Utilities and insurance.

(h) Rental payments pursuant to a written lease.

(i) Raw food cost increase computed annually by multiplying the average food cost per day by the percentage change in the consumer price index for raw food costs in Minneapolis-St. Paul as published by the Bureau of Labor and Statistics for the period October through September. The initial average food cost is $1.82 per day and the initial increase is $.22 per day. Subsequent annual cost changes will be made on a calendar basis.

(j) Unidentified cost increases equal to changes in the annual percentage increase in the consumer price index in Minneapolis-St. Paul as published by the Bureau of Labor and Statistics, using the October indices (new series index 1975 equals 100) as applied to the historical cost portion of the facilities previous year's cost less those costs relating to areas where the facility is seeking specific allowances for known cost changes. In no case may the increase be applied against the historical cost of salaries, changes in facilities or equipment, property taxes, interest, depreciation, rental payments or food costs.

(2) Cost changes determined under this provision must be based upon facts and commitments in existence as of the original filing date of the report C.1.c.1. If the provider cannot substantiate that such facts and commitments did exist as of the filing date, the welfare rate will be subject to adjustment according to B.2.c. If known cost changes calculated

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under (a) through (h) above do not in fact occur, the welfare rate will similarly be subject to adjustment under B.2.c. If actual cost increases exceed the known cost changes determined under (a) through (i) above, no adjustment in welfare rate will be made.

2. Effective date, notifications and adjustments.

a. Effective date. A new per-diem rate determined by the department will be effective the first day of the month following the provider's normal fiscal year-end except in instances in which penalty provisions of C.1.f. are applicable. If the new rate results in a lower rate than the previous rate, the provider has 120 days from the original filing date in which to pay back any difference received during the period the new rate was to be effective. If the new rate results in a higher rate than the previous rate, payment shall be made to the provider within 45 days after receiving notification of the rate adjustment.

b. Rate notifications. A temporary rate notification consisting of the previous year's allowed historical cost per patient day plus 80 percent of the indicated allowed known cost changes per patient day will be issued and paid on receipt of the report. The temporary rate shall be limited by all maximums contained in 12 MCAR S 2.049. Individual as well as overall maximums apply. The commissioner will notify the provider in writing and the respective county welfare boards of the final rate determined under these regulations and the effective date of such rate. Included in the notification will be a detailed statement of the reason for any difference between the rate requested by the provider and the rate determined.

c. Adjustments for errors or omissions. All rates determined according to 12 MCAR S 2.049 may be subject to adjustment as a result of errors or omissions determined through audit of the provider's accounting and statistical records or by amended reports as provided by C.1.i. Such adjustments are limited to the three complete fiscal years preceding the date an audit commences. If the adjustment results in a payment from the provider to the county welfare board(s), the provider will have up to 120 days from the date the provider receives written notification of the adjustment. If the adjustment results in a payment to the provider, payment shall be made within 45 days after the date of receiving written notice of the adjustment.

3. Special rate setting procedures.

a. Newly constructed facilities.

(1) Required reports. Providers with newly constructed facilities may request an interim welfare rate. Providers who increase the facility's capacity by at least 50 percent may at their option be considered in this classification. The provider must submit reports as required in C.1.a. for the immediate future fiscal year forecast results.

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(2) Report compliance. Reports will comply with all applicable sections of these regulations governing cost finding, reporting, and allowable costs to the extent feasible in the individual circumstances. Noncompliance with any provision of these regulations must be so stated together with the reason why the provider cannot comply.

(3) Interim rate establishment. The commissioner will establish an interim rate in accordance with B.1. retroactive to the first day a medical assistance recipient is placed in the home. Such rate shall be subject to retroactive upward or downward adjustment in accordance with all provisions of 12 MCAR S 2.049 except B.1.b. on the basis of first cost report covering actual results for the period to which the rate has been applied. Adjustments to the interim rate will be in accordance with B.2.a. and C.1.i.

b. Rates for lesser care levels in facilities without certification classification. Providers who provide care to welfare recipients requiring less care than the care level to which the provider is certified will receive a per-diem rate as follows:

(1) ICF I care per-diem rate in a skilled nursing-care facility will not exceed 85 percent of the established skilled nursing-care rate for that facility except that facilities whose skilled rates are affected by B.4.c.(2) shall receive up to 85 percent of what their skilled rate would have been without application of B.4.c.(2).

(2) ICF II care per-diem rate in an ICF I facility will not exceed 60 per cent of the established ICF I rate for that facility.

(3) ICF II care per-diem rate in a skilled nursing-care facility will not exceed 50 per cent of the established skilled nursing-care rate for that facility.

This provision shall be applied in conjuction with C.3.c.(2).

c. Private room rate. A private room rate of 115 per cent of the established welfare per-diem rate for the applicable care level in an individual home shall be allowed for a medical assistance recipient when deemed a medical or other necessity for the individual patient or as the patient's condition affects others; such condition must be determined by the attending physician and approved by the county welfare board. This provision, together with the provisions of D.8.d. shall apply only to facilities applying for a certificate of need after August 15, 1972.

d. Care classification additions. Providers who add certified care classifications may file an amended report under C.1. that includes known cost changes associated with care classification additions to obtain a welfare per-diem rate for

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care not previously provided. At the provider's option he may accept the lesser care rates under B.3.b. in lieu of filing reports according to this provision.

e. Election of flat rate for small providers. Providers with a capacity of less than 30 licensed beds may annually elect to receive a flat per-diem rate for providing required care of welfare patients by filing a flat rate report in lieu of receiving a rate complying with reporting requirements of C.1. and otherwise being subject to provisions of 12 MCAR S 2.049. The flat rate for skilled, ICF I, and ICF II for each region or group of regions as defined in B.4.b. shall be the regional average rates as determined from filed reports before the maximum rate limitation and exluding rates for providers electing the flat rate. These rates will be adjusted annually through policy bulletins. Such an election must be filed within reporting deadline provided by C.1.e. or be subject to penalty provisions of C.1.f. Such rates elected by providers will be in effect for one year.

f. Incidental welfare rate. Providers may elect to receive a flat rate under B.3.e. for care of welfare recipients if welfare recipients account for less than 20 percent of the certified capacity of the home.

4. Rate limitations.

a. Limitation based on private pay rates or relevant federal or state laws and regulations. Notwithstanding any other provisions of these regulations, the established provider rates for nursing-home care will not exceed the normal provider's rate charged private patients for comparable nursing-care services. This rate limitation shall be applied when the welfare rate is anticipated to exceed the private pay rate for a comparable time period. Welfare rates may further be limited by federal and state laws or regulations that affect the medical assistance program.

b. Maximum rate. Individual welfare rates will be subject to a maximum of 125 percent of regional average costs plus known cost changes exclusive of this limitation and flat rates under B.3.e. Regions will be those areas designated by the governor for regional planning and economic-development purposes. Regions may be combined when deemed appropriate by the commissioner as announced through policy bulletins. The regional averages will be calculated separately for proprietary, non-proprietary and hospital-attached facilities except the regional average costs for hospital-attached facilities shall be included in the regional average calculation for non-proprietary free-standing facilities. The maximum-rate limitations will be adjusted annually through policy bulletins. The regional averages will be determined by the commissioner, using all available information from reports that indicate a fiscal-year end during a calendar year and will be applied to rates that become effective during the second succeeding calendar year. Facilities that have a non-calendar-year end and have been

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previously subject to the maximum rates may adjust the rates to the new maximum rates if previously justified by the reports.

c. Maximum rate exceptions.

(1) Welfare per-diem rates in excess of the maximum rate limitation will be allowed in the initial year to the extent that the welfare rate requested includes cost increases required to increase wages to the minimum standards of federal or state wage laws.

(2) Provision B.4.b. will not apply to homes that qualify for exception under D.8.d.(3) or facilities licensed under 12 MCAR S 2.080.

(3) Provision B.4.b. will not apply to providers with newly constructed facilities or providers who increase the facility's capacity by 50 percent for the first two immediate fiscal years.

(4) A welfare per-diem rate component in excess of either of the maximum rate limitations contained in B.4.b. will be allowed to the extent of 85 percent of the first $2 per patient day over the maximum welfare rate when total allowable costs are divided by actual patient days or 93 percent of total capacity patient days, whichever is greater provided that in no event shall this section affect a per-diem rate by more than $1.70.

(5) Provision B.4.b. will not apply to those salary cost changes which exceed 6 percent of the historical salaries if the salary cost changes are reasonable and are required to bring facility salaries to the salary range of comparable facilities. The salary cost changes for top management compensation are excluded from this exception.

d. Minimum rate. The minimum welfare per-diem rates will be 75 percent of the regional average as defined in B.4.b.

5. Appeal procedures.

a. Scope of appeals procedures. These procedures describe the manner by which unresolved individual provider or county welfare board disputes that may arise concerning application of these regulations excluding regulation B.5. will be settled. Unresolved disputes are defined as those disagreements which cannot be resolved informally between the provider and the department staff normally assigned responsibility for administration, or the provider and a county welfare board.

b. Time limit. The provider, or the county, has 30 days to appeal from the date of the department's notification of the new per-diem rate. Appeals will be heard by a hearing examiner of the Office of Hearing Examiners and will be according to rules of that office in addition to the provision

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of this rule.

c. Effective date of resolved disputes. If the dispute is related to a change in the provider's rate, the new per-diem rate will prevail until final determination according to these appeal procedures is made. The total dollar amount due the provider or the department resulting from the resolved disputes will be subject to payment provision of B.2.c.

C. Reports.

1. General reporting requirements and submittal procedures.

a. Required reports. Except as provided by B.3.e. and f. to receive a per-diem rate for providing care to welfare recipients, the provider must submit reports covering the provider's normal fiscal year conforming to the uniform accounting system defined in forms supplied by the department. Reports, supporting documentation, and worksheets will consist of the following:

(1) General provider information and statistical data.

(2) Financial statement consisting of a comparative balance sheet, statement of changes in equity, and comparative statement of earnings or operations.

(3) Reports of historical costs and known cost changes together with supporting calculations and worksheets.

(4) Rate-determination worksheets.

(5) Other relevant data may be required by the commissioner to support a welfare rate request. If such data are not provided within 30 days, the commissioner must calculate a rate, making whatever assumptions deemed appropriate to arrive at the rate in the absence of the requested data.

(6) A complete statement of fees and charges.

(7) The names of all persons other than mortgage companies owning any interest in the facility including stockholders with an ownership interest of ten percent or more of the facility.

Specific report formats and preparation instructions will be contained in a provider manual prepared and revised periodically by department personnel. Copies of said manual will be made available to all interested parties through the Documents Section of the Department of Administration. Newly established providers or providers who change their fiscal year must file short-period reports if the period covered is more than five months.

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b. Method of accounting. The accrual basis of accounting in accordance with generally accepted accounting principles shall be the only method acceptable for purposes of satisfying reporting requirements. In a unique situation, such as the use of government providers, the use of the accrual basis of accounting may not be applicable. In such an instance, the commissioner may permit the provider to use a cash or modified cash basis of accounting if the provider can establish that no difference in rate would result.

c. Records. The provider will maintain statistical and accounting records to support information in no less detail than that required by C.1.a. required reports for at least three years following submission of a cost report. The provider shall also make available federal and state income tax returns upon request of department personnel.

d. Report certification.

(1) Reports required in C.1.a. will be accompanied by a certification of (1) the majority owner defined as the person having over 50 percent effective ownership, or the chief financial officer if there is no majority owner, and (2) the administrator or the chief operating executive. If reports have been prepared by someone other than the above individual, a separate statement signed by the preparer shall be included stating the terms of the preparer's employment.

(2) If the provider has either audited or unaudited financial statements prepared by an independent public accountant, such statements must be submitted as a part of reports required by C.1.a.

e. Reporting deadlines and extensions.

(1) Deadlines. Required reports shall be submitted directly to the department within three calendar months after the close of the provider's normal fiscal year. A final rate will be established within 30 days of receipt by the department of complete and accurate reports and required documentary information.

(2) Inadequate reports. The department may reject any report that is incomplete or inaccurate within 30 days of receipt. In such case, the department will establish a temporary rate in accordance with B.2.b. to be paid until the information is completely and accurately filed.

(3) Report deadlines exceptions. The commissioner may grant exceptions to the reporting deadline for just cause. A routine extension of 60 days will be granted when a written request is received by the department prior to the reporting deadline.

f. Penalties.

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(1) Report preparation and submittal. The penalty for non-compliance with C.1.a. and C.1.e. will be to reduce the reimbursement rate to 80 percent of the rate then in effect on the first day of the fourth calendar month after the close of the provider's normal fiscal year. This penalty is not to apply for minor errors and omissions on reports. If the required reports are subsequently submitted, retroactivity of the established rate will be limited to the first day of the month following the month in which acceptable reports are received, unless retroactivity to a prior date is otherwise designated by the commissioner.

(2) False reports. Incorrect or false information supplied by the provider on required reports resulting in over-payments to the provider will result in one or more of the following:

(a) Immediate adjustment of the welfare rate, along with retroactive recovery by the county welfare board of funds incorrectly paid to the provider.

(b) Termination of the provider contractual agreement.

(c) Prosecution under applicable federal and Minnesota statutes.

g. Audits. All reports will be subjected to desk audit and at least every three years will be subjected to field examination of supporting records and compliance with regulations by state and federal auditors or auditing firms under contract to the state. If such audits reveal inadequacies in provider record keeping and accounting practices, the commissioner may require that the provider engage competent professional assistance to properly prepare required reports. Penalties of C.1.f.(1) or (2) may be applied to ensure compliance with this provision.

h. Application of reasonable cost principles. Reports required by C.1.a. must be prepared in accordance with reasonable cost principles in D.

i. Amended reports. Except as provided in B.1.c.(2) providers may file amendments to previously filed reports when errors or omissions are uncovered or when federal or state minimum wage laws changes occur unexpectedly or when long term labor contracts expire and are renegotiated subsequent to the reporting deadline in C.1.e.(1). The cost change omissions to comply with minimum wage law changes or labor contracts will be limited to the wage increases required to meet the minimum standards of federal or state wage laws or reasonable labor agreements. Such changes in the welfare per-diem rate must result in at least a five cent per patient day or $2,000 adjustment, whichever is less, for each annual period. The payment and period covered by this provision are governed by B.2.c.

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2. Special provisions for multi-home providers and providers involved in other business activities.

a. Reporting exceptions. Providers who operate several homes or who are engaged in activities other than nursing care may not be able to comply with the required reports referred to in C.1.a. In that case, the provider must indicate reasons for noncompliance.

b. Charges from related organizations. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. If the related organization in the normal course of business sells services, facilities or supplies to the outsiders, the cost to the provider shall be the outsider's price; however, sales to outsiders must constitute at least 25 percent of its sales.

c. Cost allocation of top-management salaries and management fees. The allocated portion of compensation for the chairman of the board, directors, presidents, or other similarly titled individuals allocated to an individual nursing home shall be subject to the limitation provided in D.3.a. Other corporate charges or costs allocated to a nursing home must represent the cost of services actually rendered and be identified as to the type of service provided.

3. Definitions.

a. Care definitions. The following care classifications are used in cost reporting required by these rules. The definitions of these terms included in 12 MCAR S 2.047 and appropriate federal regulations governing Title XIX are hereby adopted.

(1) Skilled Nursing Home (Skilled)

(2) Intermediate-Care Facility I (ICF I)

(3) Intermediate-Care Facility II (ICF II)

b. Cost categories. Costs used for rate-setting purposes and related to patient care are to be grouped according to major cost categories used in required reports. Such categories are defined as follows:

(1) Nursing - All directly identifiable costs associated with nursing care defined in C.3.a. In general, these include bedside care; administration of medications, irrigations, and catheterizations; application of medications, dressings, or bandages; rehabilitative nursing techniques; and definition of modified diets, as well as other treatments prescribed by a physician that require professional or technical knowledge, skills, and judgment as possessed by a professional nurse. Included are comfort medications, medical supplies,

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devices, and other routine supplies not separately reimbursed as listed in C.3.b.(8). Personnel costs to be included in nursing are the salaries of the director of nursing, supervising nurses, registered professional nurses, licensed practical nurses, nurses aides, orderlies, and attendants (ICF II care only). The salaries or fees of physicians performing consulting services not reimbursed by separate fee schedule are also to be included in this cost category.

(2) Dietary - All directly identifiable costs of normal and special diet food including food preparation and serving. Personnel costs to be included in dietary are the salaries of dieticians, chefs, cooks, dishwashers, and all other employees assigned to the kitchen and dining room.

(3) Laundry and linen - All directly identifiable costs of linen and bedding, laundering and laundry supplies. Personnel costs to be included in laundry are the salaries of laundry employees, seamstresses, laundrymen, and ironers.

(4) Housekeeping - All directly identifiable costs of housekeeping, including cleaning and lavatory supplies. Personnel costs to be included are the salaries of housekeepers, maids, and other cleaning personnel.

(5) Plant operation and maintenance - All directly identifiable costs for maintenance and operation of the buildings and grounds, including fuel, electricity, water, supplies and parts to repair and maintain equipment and facilities, and tools. Personnel costs to be included are the salaries of engineers, painters, heating-plant employees, plumbers, electricians, carpenters, and watchmen.

(6) Other care-related services - All directly identifiable costs of other services, such as recreational activities, religion, rehabilitation, arts and crafts, and social services.

(7) General and administration - All directly identifiable costs for administering over-all activities of the facility, including business-office functions, travel expense, motor vehicle operating expense, telephone charges, office supplies, advertising, licensing fees, and professional services. Personnel costs are the salaries of administrators, assistant administrators, accounting personnel, and all clerical personnel. Also included in administration are fringe benefit costs of all employees, such as employment taxes, health insurance, pensions, and life insurance; also included are other costs not otherwise classified under definitions in C.3.b.

(8) Miscellaneous nonreimbursable services and expenses.

(a) All directly identifiable costs of functions normally reimbursed by charges to patients, employees, or outsiders, such as the operating costs of a pharmacy, beauty

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shop, or coffee and gift shop are included here.

(b) Also included are specific costs that may be incurred by the provider and reimbursed spearately according to a fee schedule. These include but are not limited to the following:

(i) Services provided by licensed medical, therapeutic, or rehabilitative practitioners.

(ii) Oxygen at prevailing prices.

(iii) Wheel-chair alterations for specific medical assistance recipients.

(c) Also included in this section will be costs associated with operating activities financed by gifts or grants from private or public funds.

(d) All costs classified in C.3.b.(8)h. are not allowable for purposes of determining a per-diem rate under these regulations.

c. Patient days.

(1) General definition. For purposes of determining a per diem rate, a patient day is defined as a day for which full and normal billings were rendered.

(2) Special care rates. Facilities that provide care to a patient requiring less care than the care level to which the facility is certified may adjust lesser-care patient days for rate-calculation purposes as follows:

Level of Care Provided	Certification	
	Skilled	ICF I
Skilled	1.00	N/A
ICF I	.85	1.00
ICF II	.50	.60

The lesser care patient day adjustment cannot exceed 15 percent of actual patient days. This limitation may be waived temporarily to accommodate a transition period during which the provider obtains the proper facility certification.

4. Cost allocation procedures.

a. General provisions for all providers.

(1) Costs will be classified in accordance with categories defined in C.3.b. and, if applicable, by care level defined in C.3.a.

(2) Classification of costs to cost categories C.3.b. will involve one or more of the following steps:

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(a) Direct identification, without allocation, which will be accomplished in the routine classification of transactions when costs are recorded in the books and records of the provider.

(b) In instances in which individuals have multiple duties, the person's salary cost will be allocated to categories C.3.b. on the basis of management's estimate of time spent on various activities. This procedure will not be applied to administrators or other chief executives' salaries in facilities with 60 or more licensed beds.

(c) Other costs that cannot be classified to cost categories through use of procedure C.4.a.(2)(a) and C.4.a.(2)(b) will be classified in the administrative category.

(3) Adjustments for costs otherwise reimbursed. Recorded costs will be reduced for costs related to other activities not subject to rate determination as defined in C.3.b.(8).

(4) Non-allowable cost adjustments. Recorded costs will be adjusted when such costs exceed reasonable cost principles defined in D. of these rules. All adjustments will be footnoted with the applicable rule number. Costs previously excluded by C.3.b.(8) will not require further adjustment.

b. Specific care level allocation procedures for multi-level providers. Cost allocation procedures are necessary to determine costs among different care level facilities. Allocation procedures are defined in the following sections and will be applied in the order stated except where noted otherwise. Regardless of method selected, a reasonable identification of costs to care level must result.

(1) Nursing care - Any combination of allocation procedures (a), (b), and (c) below can be used as long as the result is a reasonable approximation of actual costs incurred by care level.

(a) Direct identification (without allocation) in the routine classification of transactions when costs are recorded in the books and records of the provider (e.g. invoice and time record account classification).

(b) Cost allocation on the basis of regularly validated time or cost studies.

(c) Remaining costs (e.g. nursing supervisor, supplies, etc.) not classified under methods (a) or (b) above will be allocated on the ratio of costs identified to care levels (using (a) and/or (b) above), one care level to another.

(d) If methods (a), (b), or (c) above cannot be used, costs will be allocated on the basis of actual patient days weighted by the ratio of maximum allowable nursing care and

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attendant hours as defined in D.2.

(2) Dietary.

(a) Cost allocation on the basis of regularly validated time or cost studies.

(b) Cost allocation based on the number of meals served.

(c) Cost allocation based on the actual patient days.

(3) Laundry and linen, housekeeping, and plant operation and maintenance. The following allocation procedures can be applied to individual department costs or the combination of these three departments at the option of the provider.

(a) Same as C.4.b.(1)(b) time or cost studies.

(b) Allocation on the ratio of square feet of floor space devoted directly to each care level.

(c) Same as C.4.b.(1)(c) - patient days.

(4) Other care related services.

(a) Same as C.4.b.(1)(b) time or cost study.

(b) Same as C.4.b.(1)(c) - patient days.

(5) General and administration - Cost allocation on the ratio of the combined cost by care level determined for categories C.4.b.(1) through (4) and (6).

(6) Depreciation, interest and real estate and personal property taxes.

(a) Location of equipment when determinable.

(b) Same as C.4.b.(3)(b) square feet.

(c) Same as C.4.b.(2)(c) patient days. This allocation procedure must be used if actual patient days in any care level exceeds certified capacity patient days.

(7) Earnings allowance - Cost allocation on the ratio of the combined cost by care level determined for categories C.4.b.(1) through (4) and (6).

c. Hospital attached facilities. Hospital attached facilities will include those facilities which are under common ownership and operation with a licensed hospital and are required to adhere to uniform cost reporting for governmental reimbursement programs. Common operation shall be defined as the sharing of services, such as, nursing services, dietary,

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housekeeping, laundry, plant operations, and/or administrative. The nursing care limitation under D.2.a. and the investment per bed limitation under D.4.b.(1) will be waived when the Medicare cost allocation factors result in these limitations being exceeded. Costs between hospitals and attached facilities must be allocated by the "Medicare Worksheet B" using Medicare allocation factors for the following three cost groups:

(1) All expense classifications without depreciation, administration and general.

(2) Depreciation.

(3) Administration and general.

D. Reasonable cost principles.

1. General provisions.

a. Reasonable costs. Costs to be allowable for rate setting purposes must satisfy the following over-all criteria:

(1) They must be necessary and ordinary costs related to patient care.

(2) They must be costs that prudent and cost-conscious management would pay for a given item or service.

b. Costs not allowable. Costs that relate to management inefficiency, unnecessary care or facilities, and activities not common and accepted in the nursing care field are not allowable.

c. Reasonable compensation. Reasonable compensation of individuals employed in the facility is an allowable cost, provided the services are actually performed in a necessary function and the costs reported are actually incurred. To be reasonable the compensation allowance must be such an amount as would ordinarily be paid for comparable services by comparable facilities. To be necessary the function must be such that had the individual not rendered the services, the facility would have had to employ another person to perform the services. The function must also be pertinent to the operation and conduct of the facility. Where the services are rendered on less than a full-time basis, the allowable compensation should reflect an amount proportionate to a full-time basis. Compensation shall include payment to individuals as well as to organizations of non-paid workers that have arrangements with the provider for the performance of services by non-paid workers.

d. Substance over form. The cost effect of transactions that are conceived for the purpose of circumventing the regulations contained in 12 MCAR S 2.049 will be disallowed under the principle that the substance of the transaction shall prevail over form.

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e. Costs due to changes in federal or state requirements. Costs incurred to comply with the changes in federal or state laws and regulations on increased care and improved facilities are allowable costs for purposes of determining a historical per-diem rate under B.1.a.

f. Reduction in costs. Purchase discounts, allowances, and refunds are a reduction of the cost of whatever was purchased.

g. Annual review of cost limitations. The commissioner shall review annually the dollar limitations for top management compensation limitation D.3.a. and depreciation basis limitation D.4.b. and adjust the limitations accordingly if justified by current data. The data used as a basis for this determination shall be made available to all providers.

h. Application of principles and specific limits. The reasonable cost principles defined in D.1. apply to all reported costs and have been specifically defined for certain cost elements in D.2. through D.8.

2. Nursing care and attendant limitations.

a. Nursing care. Nursing-care costs will be limited by a maximum number of nursing hours per patient day as follows:

Skilled - 2.9 hours

IFC I - 2.3 hours

If the actual average nursing hours per patient day exceed the above limit, the reasonable cost limitation will be calculated by multiplying the ratio of the above stated limit to the average actual nursing hours per patient day for the year times the actual cost per patient day. This limitation will not apply to facilities that qualify for exception under D.8.d.(3) or facilities licensed under 12 MCAR S 2.080, or facilities mandated by a correction order from the Department of Health to provide additional nursing care.

b. Attendants (ICF II facilities only). Reasonable costs for attendants in ICF II facilities will be limited to one hour per patient day. If the actual average attendant hours per patient day exceeds this limit, the reasonable cost limitation will be calculated by multiplying the ratio of the stated limit to the average actual attendant hours per patient day for the year times the actual cost per patient day.

c. Limitation exception. The nursing and attendant care limits established in D.2.a. and b. may be exceeded as described below:

(1) The Department of Public Welfare shall establish the 1980 per diem in accordance with section D.2.

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(2) Increased nursing and attendant care hour costs may only be funded through expenditure reductions in the following cost categories as defined in section C.3. and as subject to the limitations prescribed elsewhere in this rule:

Dietary

Laundry & linen

Housekeeping

Plant operation & maintenance

Other care related services

General & Administration

Amounts for which a known cost increase has been granted shall not be included in these calculations. Reductions from historical costs in these categories will be recognized.

(3) Subsequent years rates will be determined based on actual nursing and attendant care limits to the extent that they equal reported actual cost reductions in the categories identified in section D.2.c.(2).

3. General and administrative expenses. Reasonable cost criteria for general and administrative expenses are as follows:

a. Top-management compensation limitation. Top-management compensation includes that of owners, administrators, president, chairman of the board, board members, or other individuals receiving compensation as executives but not performing duties of a department head. Compensation includes the costs of non-cash compensation such as residences, salaries, and deferred compensation except IRS qualified pension or profit sharing plans. The average annual cost limitation for rate-setting purposes on compensation is determined according to the average number of combined licensed nursing-home and boarding-care beds according to the following schedule:

Number of Beds	Cumulative Annual Compensation Per Bed Limitation
First 50	$264
Next 51-100	132
Over 100	66

The minimum annual compensation limitation is $10,000 or actual compensation, whichever is less, and the maximum shall be $35,000. For each full percentage point increase in the consumers price index in Minneapolis-St. Paul as published by the Bureau of Labor and Statistics for the months October, 1973 and October, 1974, new series index (1967=100), the accumulation annual compensation per paid limitation listed above shall be increased by one percent. The increase, if any, generated by

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this formula shall be affected in January 1, 1975. Similar calculations shall be made for each successive year using the October indices for two successive years with the increases beginning effective the following January.

b. Assistant administrator. Reasonable compensation of assistant administrators is not subject to the limitation in D.3.a.

c. Other management services. The costs of other directors' fees, unidentified management fees, and physician compensation for performing administrative functions are allowable to the extent that such costs together with compensation of top management do not exceed the limitations defined in D.3.a.

d. Other general and administrative costs.

(1) Owners life insurance. The costs of premiums are not allowable.

(2) Personal expenses. Personal expenses of owners or employees, such as homes, boats, airplanes, vacation expenses, etc., are not allowable costs. The costs of residences for administrators and key staff are allowable costs if such costs together with other compensation do not exceed the limitations of D.1.c. and D.3.a.

(3) Professional, technical or business-related organizations. These costs are allowable if their function and purposes can be reasonably related to the development and operation of nursing facilities, patient-care facilities, and programs for the rendering of patient-care services.

(4) Social, fraternal, and other organizations. Costs incurred in connection with memberships in all organizations not included in D.3.d.(3) are not allowable.

(5) Travel and automobile. These expenses are not an allowable expense unless they are related to activities of managing the nursing home.

(6) Entertainment. These expenses are not allowable costs.

(7) Pension and profit-sharing plans. Contributions to either an Internal Revenue Service approved pension or profit-sharing plan, but not both, are allowable costs.

(8) Employee education costs, orientation, and on-the-job training. Costs relating to providing improved patient care or, where required by state law, are allowable costs. If part or all of these costs are reimbursed by private or public funds, only the excess of cost over reimbursed funds are allowable costs. All such costs should be included in respective cost categories, C.3.b. unless not identifiable.

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(9) Training programs for non-employees. Costs of training programs conducted for non-employees other than for volunteers are not allowable.

(10) Telephone, television, and radio service. These are allowable costs where furnished to the general patient population in areas of provider day rooms, recreation rooms, lounges, etc. The cost of these services when located in a patient accommodation is not allowable.

(11) Noncompetitive agreement. Costs of these agreements are not allowable.

(12) Pre-opening costs. One time pre-opening costs of new facilities incurred prior to admittance of patients must be capitalized as a deferred charge. Costs in the form of amortization will be recognized as allowable costs over a period no less than 120 consecutive months beginning with the month in which the first patient is admitted for care. Examples of these costs are wages paid prior to the opening of the facility. Construction financing, feasibility studies, and other costs related to construction must be depreciated over the life of the building.

(13) Bad debts. Amounts considered to be uncollectible patient accounts are not allowable costs.

(14) Fund-raising costs. Costs incurred for such purpose including advertising, promotional, or publicity costs are not allowable in the year in which they are incurred except in the form of amortization as allowed by D.6.a.

(15) Charitable contributions. These are not allowable costs.

(16) Other general and administrative costs. As provided in Minnesota Statutes, section 256B.47, subdivision 2, the following shall not be recognized as allowable costs unless otherwise noted:

(a) Political contributions. Political contributions made by a health care facility or institution shall not be recognized as allowable.

(b) Salary of a lobbyist. The salary of an individual in the employ of a facility shall be allowed for lobbying activities as defined in Minnesota Statutes, section 10A.01, subdivision 11 only if the lobbying activity is incidental to the individual's job functions and if such lobbying directly relates to the licensed and certified functions of the facility.

(c) Advertising. Reasonable yellow pages listings, brochures, flyers, newsletters and other similar items which are primarily designed to describe the services, licensure, accreditation, staffing, and other similar matters

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concerning the facility are allowable costs.

(d) Assessments levied by the Health Department for uncorrected violations. Assessments levied and collected by the Minnesota Health Department shall not be recognized as allowable costs.

(e) Legal fees for unsuccessful challenges to decisions by state agencies.

(f) Association dues. Association dues are allowable only if they directly relate to patient care. For purposes of this section, directly related to patient care means activity which the nursing home clearly demonstrates is a necessary part of the licensed or certified function of the nursing home or directly leads to improved quality of care or improved administrative operations.

Each association for which dues are claimed as an allowable cost must file annually with the department a statement summarizing its activities, its revenues generated by dues and its expenditures of funds received from dues payments. The percentage (up to 100 percent) of dues revenue which the association expends for direct care purposes as defined above will be allowed during the next year. The statement must be filed within 30 days of the end of the association's fiscal year except that in order for dues to be allowable effective September 1, 1977 each association must file such a statement by October 1, 1977 covering its most recently completed fiscal year. This provision of the rule is effective for rates paid on September 1, 1977.

4. Depreciation.

a. Basis for depreciation calculation.

(1) Cost. Historical cost of nursing facilities shall be the basis for calculating depreciation as an allowable cost, except as provided by D.4.a.(2).

(2) Change in ownership of facilities. In a case in which a change in ownership of a nursing-home facility occurs, and the new owner's investment is greater than the old owner's investment, if a bona fide sale is established by the new owner, the basis for depreciation will be adjusted as follows:

(a) In the case of a complete change in ownership, the basis for calculating depreciation will be the lower of:

(i) The portion of the purchase price properly allocable to depreciable nursing home facilities; or

(ii) The appraised value of the depreciable nursing home facilities calculated under the replacement cost, depreciated method.

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(b) In the case of a partial change in ownership, as defined below, the basis for calculating depreciation shall be determined according to provision of D.4.a.(2)(a) the case of a complete change in ownership except that all relevant figures will be placed on a scale proportionate to the percentage of ownership change. For purposes of this provision, a partial change in ownership occurs only in the case of an organization with ten or fewer owners, after the change in ownership, and when the ownership change exceeds 20 percent. Any increase allowed by this section will then be adjusted according to D.4.a.(6).

(3) Redemption of ownership interests. In a case in which the remaining owners establish the fact that a bona fide redemption of an ownership interest has occurred, the basis for calculating depreciation will be increased by the excess, if any, of the redemption price over the former owner's investment. The adjusted basis shall be determined by applying the provision of D.4.a.(2)(b).

(4) Donated assets. The basis of donated assets, except for donations between providers or related parties, shall be fair market value defined as the price that an able buyer would pay a willing seller in an arms-length sale or appraised value defined in D.4.a.(2)(a)(ii) whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. In the instance of the exception stated, the net book value to the donor shall be the basis for the donee.

(5) Subsequent acquisitions. The basis for calculating depreciation may be increased for the actual cost of equipment additions or facility modification or renovation.

(6) Recapture of depreciation resulting from sale of facility. The sale of depreciable nursing-home property, or substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation calculated in accordance with D.4. indicates the fact that depreciation used for purposes of computing allowable costs was greater than the actual economic depreciation.

(a) The amount of the recapture will be determined as follows:

(i) The gross recapture amount will be the lesser of the actual gain on the sale or the depreciation after the effective date of 12 MCAR S 2.049 (November 1, 1972).

(ii) The gross recapture amount as determined in (i) above shall be allocated to fiscal periods from November 1, 1972, through the date of sale. The gross recapture amount shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed under 12 MCAR S 2.049. The amount allocated to each period shall be divided by the total actual patient days in that period, thereby determining a patient-day

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cost for the period. The total net recapture shall then be determined by multiplying the actual welfare days times the patient-day cost for each fiscal period.

(iii) The total net recapture amount determined according to (ii) above will be reduced by one percent for each month of ownership since the date of acquisition of the facility. The net recapture paid to the state of Minnesota is includable in the new owner's basis for depreciation subject to the provisions of D.4.a.(2).

(b) The net recapture amount so determined in (iii) above will be paid by the new owner to the state of Minnesota within a time period agreed to by the commissioner and the new owner. The time period should effectuate an orderly payment schedule and must not exceed two years after the date of sale.

(7) Gains and losses on disposition of equipment. Gains and losses on the sale or abandonment of equipment are includable in computing allowable costs. A gain shall be an offset to depreciation expense to the extent that such gain resulted from depreciation reimbursed under these regulations. Gains or losses on trade-ins should be reflected in the asset basis of the acquired asset. Losses will be limited to five cents per patient day annually; however, any excess over this limitation can be carried forward to future years.

b. Limitations.

(1) The total basis of depreciable nursing-facility assets shall not exceed an average of $13,000 per bed for licensed beds in two or more beds per room and $19,500 per bed for licensed private rooms built or purchased after January 1, 1974. This limitation will be adjusted annually beginning January 1, 1975 according to a construction index as determined by the commissioner. The depreciable basis for licensed beds built or purchased prior to January 1, 1974 shall not exceed an average of $11,000 per bed for licensed beds in two or more beds per room and $16,500 per bed for licensed private room which satisfy the certificate of need provision of B.3.c. However, the depreciable basis for licensed private rooms built prior to August 15, 1972 shall not exceed an average of $16,500 per bed for a maximum of five percent of licensed beds.

(2) In no instance can accumulated depreciation calculated in accordance with D.4. exceed the basis defined in D.4.a.

(3) Accumulated depreciation as of the beginning of the first fiscal year covered by this regulation shall be calculated retroactively using the useful life concept defined in D.4.c. and D.4.d.

(4) Regardless of the applicability of the limitation stated in D.4.b.(1) above, depreciation on

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investments in facility modifications and new equipment will be allowed if they were required by governmental requirements.

c. Depreciation rates for new facilities and equipment. Depreciation shall be calculated using the basis determined under D.4.a. applying one of the "useful life" schedules defined in D.4.c.(1) or D.4.c.(2).

(1) Building - 35 years.

Major building improvements (depreciated over the remaining life of the principal asset or useful life, but not less than 15 years).

Land improvements - 20 years.

Equipment - 10 years.

Vehicle - 4 years.

(2) American Hospital Association depreciation guidelines.

d. Other useful lives.

(1) Depreciation rates for used facilities and equipment. The useful life shall be assigned by the provider considering the individual circumstances; however, the useful life will not be shorter than one-half of the useful life provided by D.4.c(1) or D.4.c.(2).

(2) Leasehold improvements. The useful life of the improvement or the remaining term of the lease, including renewal periods, shall be used, whichever is shorter.

e. Depreciation method. The straight-line method of depreciation should be used except, at the option of the provider when the principal payments on capital indebtedness (as defined in D.6.a.(1)) exceed the total depreciation allowance calculated in accordance with D.4. In such instances, depreciation may be increased to equal principal payments on capital indebtedness amortized over actual amortization periods; however, the amortization period cannot be less than 20 years for building and six years for equipment. Accumulated depreciation cannot exceed the basis defined in D.4.a. Depreciation on any new construction or expansion of facilities commenced on or after January 1, 1977, other than governmentally owned facilities, shall be on a basis of not less than 30 years. For facilities constructed or expanded prior to January 1, 1977, and for facilities purchased after January 1, 1977, presently existing depreciation rules will apply.

f. Facilities financed by public funds. Depreciation will not be allowed on the portion of facilities financed by federal, state or local appropriations or grants unless the intent of such appropriation or grant was that to be repaid

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through operating revenue of the facility. This limitation will not apply to governmentally owned nursing homes.

g. Non-depreciable assets. Nursing-facility assets that are not depreciable include but are not restricted to:

(1) Land. Includes the land owned and used in provider operations included in the cost of land and the costs of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the provider, and other land expenditures of a non-depreciable nature.

(2) Goodwill. Includes amounts that result from purchase of property or stock in excess of determinable value as determined in D.4.a.(2).

h. Capitalization vs. expense. Expenditures for equipment that has a useful life of more than one year shall be capitalized except that the provider may show as expenses small equipment purchases normally capitalized if such items do not exceed two cents per patient-day annually.

5. Leased facilities or equipment.

a. Rental charges. Reasonable rental charges incurred by a provider through a lease entered into an arms length transaction are includable in allowable costs. Unless:

(1) Rental charges result from a sale, lease-back arrangement, or lease with option to buy at a price less than anticipated value.

(2) Rental charges are paid to a related or controlled organization. If either D.5.a.(1) or (2) exists, the provisions of D.5.b. will be applied.

b. If rental charges are not allowed, the rate of the provider will be determined as for any other provider as though the lease did not exist. In this case allowable costs would include both costs of the lessor and the lessee.

c. Limitation. Allowable rental charges are subject to the investment per bed limitations of D.4.b.(1) determined by calculating the present value of lease payments exclusive of real and personal property taxes and other costs assumed by the lessor. Interest rates used in capitalizing lease payments shall be the mortgage rate of the lessor or, if the mortgage rate is not available, 2.15 percentage points above the interest rate of Federal Hospital.

Insurance fund obligations as of the effective date of the lease. The formula for determination of this provision is as follows:

Present value of lease = Lease payment per period x present

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value factor per period

Investment per bed = Present value of lease -- Licensed Beds

The present value factor can be determined from annuity tables according to the present worth of $1 per period for the term of the lease.

6. Cost of capital.

a. Interest.

(1) Except as provided in D.6.a.(6) interest is an allowable cost for non-proprietary facilities only and will be classified as follows:

(a) Interest on capital indebtedness includes amortization of bond premium and discount and related financing costs. Capital indebtedness is defined as any loan that is applied to purchase fixed assets related to providing nursing care as defined in D.6.b.(1). The form of indebtedness will include mortgages, bonds, notes, and debentures, when the principal is repaid over a period in excess of one year.

(b) Other interest for working capital and operating needs that directly relate to providing nursing care is an allowable cost. The form of indebtedness will include, but not limited to, notes, advances, and various types of receivable financing the principal of which will be generally repaid within one year.

(2) Interest income will be a deduction from interest allowable under provision D.6.a.(1)(a) or D.6.a.(1)(b). Interest income on restricted funds will not be deducted from interest expense. Restricted funds are defined as all unexpected donated funds carried by the institution that are restricted for other than operating costs. The operating or building funds cannot be included as part of restricted funds for this purpose.

(3) Interest rate. The interest rate incurred must not be in excess of what a borrower would have had to pay in an arms-length transaction in the money market when the loan was made. When a non-proprietary provider borrows from its own restricted fund, interest paid by the general fund to the restricted fund is allowable at a rate not to exceed the interest rate the fund is currently earning. Interest on liens between operating and building funds is not allowable.

(4) Construction interest. Interest cost incurred during and related to construction must be capitalized as a part of the cost of the facility. The period of construction is considered to extend to the date the facility is put into use for patient care.

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(5) After the first three years that a non-proprietary or governmentally owned nursing home has been owned by its current owners, the state agency shall not recognize as an allowable cost the expense of interest on net debt for any indebtedness and loans which exceed 100 percent of the net asset value of the facility. Effective July 1, 1977, interest expense on indebtedness incurred prior to April 13, 1976, is exempted from this provision if the expense is allowable according to D.6.a.(1).

(6) Interest expense for a proprietary nursing home will be allowable on capital indebtedness to the extent that the rate of interest exceeds nine percent, but no more than twelve percent, if the indebtedness relates directly to the purchase of the nursing home or to working capital for the operation of the nursing home and if the rate of interest does not exceed a rate which a prudent and cost-conscious borrower would incur in an arms-length transaction.

b. Investment allowance.

(1) Determination of allowance. Effective July 1, 1980 proprietary homes shall receive an investment allowance of 11.1 percent of the original value of the facility for depreciation purposes. For each year after the year in which the nursing home was originally purchased in which there is no transfer of ownership of a nursing home, the investment allowance shall be increased by one percent of the original investment allowance, but the increases shall be limited to a maximum of 25 percent of the original investment allowance effective for rates paid on August 1, 1977.

(2) For purposes of this section the following terms shall have the meaning given to them.

(a) Facility means the building in which a nursing home is located and all permanent fixtures attached to it. Facility does not include the land or any supplies and equipment which are not fixtures.

(b) Original value means the lesser of purchase price or appraised value at the time of purchase. Appraisals at the time of purchase shall be on the depreciated replacement cost basis. If a nursing home expands its facility or makes any other capital expenditure which increases the value of the facility, the cost of the expansion or capital expenditure shall be added to the original value. If the department disputes the cost of the expansion or capital expenditure, it may request an appraisal and use the appraised value as the allowed cost.

(3) Allowance for leased facilities. Leased facilities shall receive an investment allowance not to exceed the greater of $ .35 per the facility's 93 percent capacity patient days or the investment allowance of D.6.b.(1) for those fixed assets owned by the lessee facility.

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7. Welfare. All directly identifiable costs associated exclusively with the welfare program and benefiting welfare patients exclusively will be calculated in a manner that results in an assignment of the incremental costs stated above wholly to welfare patients. Such costs may include reasonable expenditures for utilization review, preparation and processing of a cost statement under these regulations.

8. Facility utilization incentives.

a. Capacity limitation. The allowable cost amount per patient day depreciation, interest, property taxes, administration and earnings allowance will be calculated by dividing such allowable costs by 93 percent of total capacity patient days for licensed beds. Facilities qualifying for the special care rate of C.3.c.(2) may adjust the capacity limitation by the same formula. The capacity limitation cannot be reduced below 90 percent of total capacity patient days for licensed beds.

b. Calculation of patient days. For purposes of calculating patient days at 93 percent of licensed capacity and to assign a greater proportion of costs to private rooms, a factor of 1.5 times the number of licensed private beds will be used in determining the number of patient days. This provision shall apply only to facilities applying for a Certificate of Need after August 15, 1972.

c. Licensed bed capacity. Usable or operable bed capacity may be used for purposes of the calculation required by D.8.a. and b. if the provider can justify in writing, to the satisfaction of the commissioner that licensed beds is an inappropriate measure of capacity.

d. Waiver of limitation. Providers may apply for a waiver of the provisions of D.8.a. and b. in the following instances:

(1) For new facilities or facilities with major changes in capacity, that are applying for a certificate of need after the effective date of these regulations, the commissioner may grant a waiver of this capacity calculation and allow a rate based on anticipated actual patient days for the period through the end of the first full fiscal year.

(2) In cases of extreme hardship, nursing homes not covered by D.8.d.(1) and having over 65 percent welfare patient days may be granted an annual waiver by the commissioner of this capacity calculation and be allowed a rate based on actual patient days. "Extreme hardship" will include a financial situation in which projected cash flow indicates the fact that debt and operating obligations cannot be met.

(3) Skilled care facilities which have a patient population with an annual average length of stay of 180 days or less may be granted an annual waiver by the commissioner of this

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capacity calculation and be allowed a rate based on actual patient days. The average length of stay is determined by dividing the actual patient days for the historical fiscal year by the total discharges for the historical fiscal year.

E. Implementation procedures.

1. Effective date of 12 MCAR S 2.049 revisions.

a. Unless noted otherwise, all changes are effective for rates paid January 8, 1978 and subsequent.

F. Severable provisions.

1. If any provisions of the rule as adopted by commissioner of public welfare are found to be unreasonable or not supported by the evidence, the remaining provisions shall remain valid.

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§ 2.051 Standards for foster homes for adults.

A. The county welfare departments shall maintain files on homes approved for the care of adults. These files shall be available for review by the Commissioner or his agents. Each file shall contain the following information to support and justify the county agency recommendation for approval of the home:

1. An application for approval signed by the operator.

2. A signed agreement between the county agency and the operator of the foster home on provisions and limitations of the approval.

3. Physician's statements (physical health of operator and family).

4. Fire inspection reports (annual statements about fire and safety conditions to be made by a representative of the county welfare department). This information is to be obtained from state, county, or local fire-prevention officers.

5. A recorded evaluation based on the standards listed below supporting the approval of the home (Form DPW-111, to be furnished by the Department of Public Welfare).

6. A record of guests in the home and an evaluation of the service and care given to each guest (form to be furnished by the Department of Public Welfare).

B. Definition of a foster-care home for adults. A foster home is a domicile provided for a disabled or infirm or aged person as a replacement of his own home wherein he can obtain household services in addition to a family-living situation. This living arrangement is intended for single persons or man and wife, with no more than four of such persons in a single-family home. The foster home should provide friendly understanding as well as regular household care. Such a home should be for persons who are alone and lonely who have difficulty with or are unable to do household tasks and yet are not considered to be in need of nursing-home care.

C. Standards.

1. The operator of the home must be emotionally and physically capable of providing proper care for aged or other adult persons without detriment to other members of the household.

2. The members of the operator's household must be in agreement on the plan to provide care for aged or other adult persons.

3. The operator of the home and members of his household must be in good health; or if any health difficulty exists, it must be under control.

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4. The county welfare department shall determine that the operator is able to provide adequate bedroom space for each single guest or a married couple. The county agency shall determine whether the size of the room will permit occupancy by two persons not a married couple.

5. The operator and members of the household must be willing to include guests in their family life as well as to provide privacy for guests when needed.

6. The living arrangements and conditions created by the operator and other members of the household must be stable and harmonious.

7. The operator of the home must agree to provide adequate heat, ventilation, and sanitation, as well as adequate preparation and serving of food.

8. The operator of the home must have an understanding of and an ability to meet the emotional and physical needs of aged or other adult persons.

9. The operator of the home must be willing to protect the religious interests of any person placed in the home.

10. The operator of the home must give indication of being able to work with a county welfare department.

D. Duration of county welfare board approval. The county welfare board shall issue approvals for foster homes for a period of one year. Approval of a foster home may be withdrawn on issuance of a 30-day notice to the operator by the county welfare agency.

E. Effective date is July 1, 1969.

Effective Date—December 6, 1971.

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12 MCAR S 2.052 Regulations for determining welfare per diem rates for providers of residential services for the mentally retarded.

A. Applicability and purpose.

1. Authority. This regulation is enacted pursuant to the statutory authority vested in the commissioner of public welfare pursuant to Minnesota Statutes, section 256B.27, to require reports, information, and audits, and, pursuant to Minnesota Statutes, section 256B.04, subdivision 2, to promulgate rules, and regulations for carrying out and enforcing the provisions of Minnesota Statutes, chapter 256B. This regulation is further promulgated pursuant to the procedures set out in Minnesota Statutes, section 15.0412, of the Minnesota Administrative Procedures Act.

2. Objectives. The procedures embodied herein define a system for the determination of a per diem welfare rate for all residential facilities for the mentally retarded with more than four beds participating in the medical assistance and cost-of-care program, except state institutions that are governed by other state laws, that promotes efficiency and economy and treats all providers on a uniform basis. Facilities for the mentally retarded are defined as facilities licensed under the provisions of Minnesota Statutes, section 252.28. Facilities which provide care to other than mentally retarded residents must comply with these regulations if mentally retarded persons account for more than 50 percent of the facility population. Procedures have been defined to satisfy the state plan for medical assistance and HEW Program Guide 19, which prescribe reasonable charge/cost related rate-setting methods. The rate-setting procedures have also been defined to comply with the state statute that requires that cost differences between individual providers be recognized (Minnesota Statutes, section 256B.04, subdivision 2) while at the same time establishing cost limitations to satisfy federal requirements requiring that the welfare rates be consistent with efficiency, economy, and quality of care.

The welfare rate-setting procedures included herein also recognize required residential classification and quality of care as defined by Department of Public Welfare licensing and federal certification standards, establish effective accountability over the disbursement of medical assistance appropriations, and provide for a regular review mechanism for rate changes.

While the rate-setting procedures are intended to compensate the provider for the reasonable costs incurred by prudent management including a return of capital through depreciation and earnings allowance, they are not intended to provide funds for financing working capital needs or purchase of facilities. It is not intended that the regulations provide for reimbursement of actual costs through retroactive settlement.

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B. Rate determination.

1. Method of calculating welfare per diem rate.

a. Historical rate. The method of calculating the per diem rate will be to determine reasonable costs for the most current fiscal year, except for the property and related costs, general and administrative costs, and the earnings allowance or minimum cost of capital allowance, and divide by actual resident days according to the reasonable cost provisions of D. and cost reporting regulations contained in C. Such rate shall be based on occupancy factor of no less than 80 percent. The 80 percent occupancy factor shall apply only to facilities of more than ten beds. The property and related costs, general and administrative costs, and the earnings allowance or minimum cost of capital allowance will be divided by 93 percent of total capacity resident days for licensed beds. For facilities of ten beds or less the facility may use actual resident days. This provision shall not be in conflict with section B.3.a.(3).

b. Incentive factor. In no case will the historical rate so determined under B.1.a. be less than a comparable amount calculated for the previous year minus one-half of the difference. This provision shall not apply for rates for newly established providers under B.3.a.

c. Allowance for known cost changes.

(1) Future cost increase or decreases known as of the report filing date must be added to or deducted from the historical rate determined according to B.1.a. and b. Such adjustment will be restricted to the elements defined in B.1.c.(1)(a) through (k) and shall be the annualized cost effect of such cost changes exclusive of any portion of cost change included in the historical rate.

(a) Salary and wage changes to occur during the effective period of the welfare rate:

(i) Future changes according to labor contracts, board resolutions, written policies, or minimum wage laws.

(ii) Changes that are in effect as of the end of the fiscal period covered by the historical cost portion of the welfare per diem rate.

(b) Changes in facilities or equipment.

(c) The annualized cost effect of complying with federal, state, or local laws and regulations on increased care or improved facilities.

(d) Taxes - payroll and property.

(e) Interest.

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(f) Depreciation.

(g) Utilities and insurance.

(h) The cost effect of reductions and expansions to program services approved by the Department of Public Welfare.

(i) Rental payments pursuant to a written lease.

(j) A food cost change computed initially by multiplying the average of food services costs per day for available 1979 cost reports less the lower and upper 10 percent times the percentage change in the consumer price index for raw food costs in Minneapolis-St. Paul as published by the Bureau of Labor and Statistics, for the period October through September. Subsequent annual cost changes will be made on a calendar year basis.

(k) The cost effect of changes in occupancy levels based on average occupancy for the last three months of the fiscal period covered by the historical cost portion of the welfare per diem rate. This provision is applicable only to the first two fiscal years of newly-constructed or newly established facilities. Welfare rates in subsequent fiscal periods will be based on the occupancy from the most recently completed fiscal year.

(l) An unidentified cost change computed by multiplying the allowable historical costs from the most recently completed fiscal year less those costs relating to line-item costs for which there has been a cost projection times the percentage change in the consumer price index in Minneapolis-St. Paul as published by the Bureau of Labor and Statistics for the period October through September. In no case may the cost change be applied against the historical cost of salaries, changes in facilities or equipment, payroll-related costs, property taxes, interest, depreciation expense, rental payments or raw food costs.

(2) Cost changes determined under this provision must be based upon facts and commitments in existence as of the filing date of the report. If the provider cannot substantiate the fact that such facts and written commitments did exist as of the filing date, the welfare rate will be subject to adjustment according to the provisions of B.2.c. and C.1.i. If the sum of known cost changes calculated under (a) through (i) above do not in fact occur, the welfare rate will similarly be subject to adjustment under B.2.c. If the sum of actual cost increases exceed the known cost changes determined under (a) through (l) above, no adjustment in welfare rate will be made.

d. Government grants for operations during the prospective rate period must be deducted from the welfare per diem rate either calculated in B.1.a.b., and c., or elected in B.3.b.

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2. Effective date, notifications, and adjustments.

a. Effective date. A new per diem rate determined by the department will be effective the first day of the month following the provider's normal fiscal year-end except in instances in which penalty provisions of regulations C.1. and E.2. are applicable. If the new rate results in a lower rate than the previous rate, the provider has 120 days after the original filing date in which to pay back any difference received during the period the new rate was to be effective. If the new rate results in a higher rate than the previous rate, payment shall be made to the provider within 45 days after receiving notification of the rate adjustment.

b. Notification of rate decision. A temporary rate notification consisting of the previous year's allowed historical cost per resident day plus 80 percent of the indicated allowed known cost changes per resident day will be issued and paid on receipt of the report. The commissioner will notify the provider, in writing, and the respective county welfare boards of the rate determined under these regulations as well as the effective date of such rate. Included in this notification will be a detailed statement of the reason for any difference between the rate requested by the provider and the rate determined.

c. Adjustment for error or omissions. All rates determined according to 12 MCAR S 2.052 may be subject to adjustment as a result of errors or omissions determined through audit of the provider's accounting and statistical records or by amended reports as provided by C.1.i. Such adjustments are limited to the three complete fiscal years preceding the date on which an audit commences. If the adjustment results in a payment from the provider, payment shall be made by the provider within 120 days after the date on which the provider received written notification of the adjustment. If the adjustment results in a payment to the provider, payment shall be made within 45 days after the date of receiving written notice of the adjustment.

3. Special rate-setting procedures.

a. New facilities.

(1) Required reports. Providers with newly constructed or established facilities can request an interim welfare rate. The provider must submit reports as required in B.1.a. for immediate future fiscal year forecast results.

(2) Report compliance. Reports will comply with all applicable sections of these regulations governing cost finding, reporting, and allowable costs, to the extent feasible in the individual circumstance. Noncompliance with any provision of these regulations must be so stated, together with the reasons why the provider cannot comply.

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(3) Interim-rate establishment. The commissioner will establish an interim rate in accordance with regulation B.1. retroactive to the first day on which a medical assistance recipient is placed in the home. Such rate shall be subject to retroactive upward or downward adjustment in accordance with all provisions of 12 MCAR S 2.052 except B.1.b. on the basis of first cost report covering actual results for the period to which the rate has been applied. Adjustments to the interim rate will be in accordance with B.1.a. and C.1.j. Such rate shall be subject to retroactive upward or downward adjustment based on occupancy of no less than 80 percent. The 80 percent occupancy factor shall apply only to facilities of more than ten beds. Adjustments to the interim rate may be made at the option of the provider either at the end of the provider's first fiscal year or after six months of historical cost experience. The settlement must be based on at least six months of historical cost and statistical experience. Occupancy for the immediate fiscal year must be based on an annualization of the last three months of the interim fiscal year but not less than 90 percent occupancy. Rate settlement requests which are in excess of the interim rates shall be subject to cost category ceilings according to section D.1.

4. Rate limitations.

a. Limitations based on private pay rates or relevant federal or state laws and regulations. Notwithstanding any other provisions of these regulations, the established provider rates for residential service will not exceed the normal provider's rate charged private residents for comparable residential services. This rate limitation shall be applied when the welfare rate is anticipated to exceed the private pay rate for a comparable time period. Welfare rates may further be limited by federal laws or regulations that affect the medical assistance program. Rates charged for respite beds must be identified as a private pay rate.

b. Over-all limitation. Welfare rates will be limited to a 15 percent increase over the previous welfare rate. The 15 percent limitation does not apply to the following cost changes identified under section B.1.c.(1):

(1) Salaries and payroll-related costs for additional personnel, depreciation and interest expense for physical plant improvements or other fixed assets, and changes in licensed capacity insofar as these cost changes are incurred to meet minimum and immediate requirements imposed by federal, state, or local laws and regulations.

(2) Salary cost changes which exceed 15 percent of the historical salaries if the salary cost changes are reasonable and are required to bring facility salaries to the salary range of comparable facilities. The salary cost changes for top management compensation, the administrator, and additional personnel are excluded from this exception.

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(3) Facilities that have a non-calendar year-end and have been previously subject to the rate limitation may adjust the rates to the new rate limitation if previously justified by the reports.

(4) The rate limitation will not apply to providers whose welfare rate request does not exceed 80 percent of the statewide weighted average rate determined annually on a calendar year basis utilizing the most recently completed fiscal year cost reports submitted on or before December 31.

(5) The overall rate limitation will be computed by dividing total allowable cost by the actual resident days.

5. Appeal procedures.

a. Scope of appeals procedures. These procedures describe the manner by which unresolved individual provider or county welfare board disputes that may arise about application of these regulations excluding regulation B.5. will be settled. Unresolved disputes are defined as those disagreements that cannot be resolved informally between the provider and the department staff normally assigned responsibility for administration, or the provider and a county welfare board.

b. Appeals examiner. Unresolved disputes will be heard by a staff person from the state of Minnesota's Hearings Examiner Office.

c. Time limit. The provider, or the county, has 30 days to appeal from the date of the department's notification of the new per diem rate.

d. Appeal procedure. If the provider and the department's staff normally assigned responsibility for administration or the provider and a county welfare board cannot agree to a settlement of the dispute, then each party will submit in writing the facts, arguments and any other appropriate data to the hearings examiner. The examiner will review the dispute, request additional information or analyses to be submitted by the department or the provider, and then recommend to the commissioner disposition of the dispute. Because existing state law does not permit the commissioner to delegate his powers, final authority on disposition of disputes must be retained by the commissioner.

e. Effective date of resolved disputes. If the dispute is related to a change in the provider's rate, the amount in dispute will not be adjusted until final determination according to these appeal procedures is made. The total dollar amount due the provider or the program resulting from the resolved disputes will be subject to the payment provision of B.2.c.

f. Findings and conclusions. Any findings, conclusions, or opinions of the hearings examiner about any

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appeal will be made available to the provider and will become part of the department record.

C. Reports.

1. General reporting requirements and submittal procedures.

a. Required reports. Except as provided by B.3.b. to receive a per diem rate for providing care to welfare recipients, the provider must submit reports covering the provider's normal fiscal year conforming to the uniform accounting system defined in forms supplied by the department. Reports, supporting documentation, and worksheets will consist of the following:

(1) General provider information and statistical data.

(2) Financial statements consisting of a comparative balance sheet, statement of changes in equity, and comparative statement of earnings or operations.

(3) Reports of historical costs and known changes together with supporting calculations and worksheets.

(4) Rate determination worksheets.

(5) All other data relevant to justification or support of the welfare rate as deemed necessary by the commissioner or designated representative.

Specific report formats and preparation instructions will be contained in a provider manual prepared and revised periodically by department personnel. Copies of said manual will be made available to all interested parties through the Documents Section of the Department of Administration. Newly established providers or providers who change their fiscal year must file short-period reports if the period covered is more than five months. Providers who have major program changes approved by the Department of Public Welfare may submit an amended report to show the change in costs due to the program change. The cost effect of the program change must be at least $2,000 for the remainder of the provider's reporting period in order for him to submit an amended report.

b. Method of accounting. The accrual basis of accounting in accordance with generally accepted accounting principles shall be the only method acceptable for purposes of satisfying reporting requirements. In a unique situation such as the use of government providers, the use of the accrual basis of accounting may not be applicable. In such an instance, the commissioner may permit the provider to use a cash or modified cash basis of accounting if the provider can establish that no difference in rate would result.

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c. Records. The provider, where applicable, will maintain statistical and accounting records to support information in no less detail than that required by C.1.a. required reports. The provider shall also make available federal and state income tax returns upon request of department personnel.

d. Report certification.

(1) Reports required in regulation C.1.a. will be accompanied by a certification of (1) the majority owner defined as the person having over 50 percent effective ownership, or the chief financial officer if there is no majority owner, and (2) the administrator or the chief operating executive. If reports have been prepared by someone other than the above individual, a separate statement signed by the preparer shall be included stating the terms of the preparer's employment.

(2) If the provider has either audited or unaudited financial statements prepared by an independent public accountant, such statements must be submitted as a part of reports required by C.1.a.

e. Reporting deadlines and extensions.

(1) Deadlines. Required reports shall be submitted directly to the department within three calendar months after the close of the provider's normal fiscal year.

(2) Report deadline exceptions. The commissioner may grant exceptions to the reporting deadline for just cause. A routine extension of 60 days will be granted when a written request is received by the department prior to the reporting deadline.

f. Penalties.

(1) Report preparation and submittal. The penalty for noncompliance with regulations C.1.a. and C.1.e. will be to reduce the reimbursement rate to 80 percent of the rate then in effect on the first day of the fourth calendar month after the close of the provider's normal fiscal year. This penalty is not to apply for minor errors and omissions on reports. If the required reports are subsequently submitted, retroactivity of the established rate will be limited to the first day of the month following the month in which acceptable reports are received, unless retroacitivity to a prior date is otherwise designated by the commissioner.

(2) False reports. Incorrect or false information supplied by the provider on required reports resulting in over-payments to the provider will result in one or more of the following:

(a) Immediate adjustment of the welfare rate, along with retroactive recovery of funds incorrectly paid to the

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provider.

(b) Termination of the provider contractual agreement.

(c) Prosecution under applicable federal and Minnesota statutes.

g. Audits. All reports will be subjected to desk audit and may be subjected to field examination of supporting records and compliance with regulations by state and federal auditors or auditing firms under contract to the state. If such audits reveal inadequacies in provider record keeping and accounting practices, the commissioner may require that the provider engage competent professional assistance to properly prepare required reports. Penalties of C.1.f.(1) or (2) may be applied to ensure compliance with this provision.

h. Application of reasonable cost principles. Reports required by C.1.a. must be prepared in accordance with reasonable cost principles in D.

i. Amended reports. Providers may file amendments to previously filed reports when mathematical errors or omissions are uncovered or when federal or state minimum wage law changes occur unexpectedly. The cost changes to comply with minimum wage laws will be limited to the wage increases required to meet the minimum standards of federal or state wage laws. Such changes in the welfare per diem rate must result in at least a five cent per patient day or $2,000 adjustment, whichever is less for each annual period.

2. Special provisions for multi-home providers and providers involved in other business activities.

a. Charges from related organizations. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. If the related organization in the normal course of business sells services, facilities or supplies to the outsiders, the cost to the provider shall not be greater than the outsider's price; however, sales to outsiders must constitute at least 25 percent of its sales.

b. Cost allocation of top-management salaries and management fees. The allocated portion of compensation for the chairman of the board, directors, presidents, or other similarly titled individuals and other corporate charges or costs allocated to a facility must represent the cost of services actually rendered and be identified according to the type of service provided.

3. Definitions.

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a. Cost categories. Costs used for rate-setting purposes and related to resident care are to be grouped according to major cost categories used in required reports. Such categories are defined as follows:

(1) Resident-living. All directly identifiable personnel costs associated with residential service. Personnel costs to be included are the salaries of the director of residential living, supervisors of residential-living staff, and residential-living staff.

(2) Developmental services. All directly identifiable costs of developmental services, such as training, rehabilitation, and social services not separately reimbursed according to C.3.a.(10).

(3) Health services. All directly identifiable costs related to health services not separately reimbursed according to C.3.b.(10). Costs will include personnel, purchased services, and supplies.

(4) Resident-related services. All directly identifiable costs of resident-related services, such as recreation, religion, arts, and crafts, and leisure time activities not separately reimbursed according to C.3.a.(10). Costs will include personnel, purchased services, and supplies.

(5) Food services. All directly identifiable costs of normal and special diet food, including food preparation and serving. Personnel costs to be included in dietary costs are the salaries of dieticians, chefs, cooks, dishwashers, and all other employees assigned to the kitchen and dining room.

(6) Laundry and linen. All directly identifiable costs of linen and bedding, laundering, and laundry supplies. Personnel costs to be included in laundry are the salaries of laundry employees, seamstresses, laundrymen, and ironers.

(7) Housekeeping. All directly identifiable costs of housekeeping, including cleaning and lavatory supplies. Personnel costs to be included are the salaries of housekeepers, maids, and other cleaning personnel.

(8) Plant operation and maintenance. All directly identifiable costs for maintenance and operation of the buildings and grounds, including fuel, electricity, water, supplies, and parts to repair and maintain equipment and facilities, and tools. Personnel costs to be included are the salaries of engineers, painters, heating plant employees, plumbers, electricians, carpenters, and watchmen.

(9) General and administration. All directly identifiable costs for administering over-all activities of the facility, including business-office functions, travel expense, motor vehicle operating expense, telephone charges, office supplies, advertising, licensing fees, and professional

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services. Personnel costs are the salaries of administrators, assistant administrators, accounting personnel, and all clerical personnel. Also included in administration are fringe benefits costs of all employees, such as employment taxes, health insurance, pensions, and life insurance; also included are other costs not otherwise classified under definitions in C.3.a.

(10) Miscellaneous nonreimbursable services and expenses.

(a) All directly identifiable costs of functions normally reimbursed by charges to residents, employees, or outsiders, such as the operating costs of a pharmacy, beauty shop, or coffee and gift shop, are included here.

(b) Also included are specific costs that may be incurred by the provider and reimbursed separately according to a fee schedule. These include but are not limited to the following:

(i) Services provided by licensed medical, therapeutic, or rehabilitative practitioners.

(ii) Oxygen at prevailing prices.

(iii) Wheel-chair alterations for specific medical assistance recipients.

(c) Also included in this section will be costs associated with operating activities financed by restricted or unrestricted gifts or grants from private or public funds. Costs deemed unallowable under section of the rule can be identified as offsets from such gifts or grants.

(d) All costs classified in C.3.a.(10) are not allowable for purposes of determining a per diem rate under these regulations.

b. Resident days.

(1) General definition. For purposes of determining a per diem rate, a resident day is defined as a day for which full and normal billings were rendered.

4. Cost-allocation procedures.

a. General provisions for all providers.

(1) Costs will be classified in accordance with categories defined in C.3.a.

(2) Classification of costs to cost categories C.3.a. will involve one or more of the following steps:

(a) Direct identification, without allocation, which will be accomplished in the routine classification of

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transactions when costs are recorded in the books and records of the provider.

(b) Other costs that cannot be classified to cost categories through use of procedure C.4.a.(2)(a) will be classified in the administrative category.

(3) Adjustments for costs otherwise reimbursed. Recorded costs will be reduced for costs related to other activities not subject to rate determination as defined in C.3.a.(10).

b. Allocation of non-allowable personal expenses for owners living in the facility. Allocation procedures are defined in the following sections and must be applied in the order stated for personal expense included in the expenses of the facility.

(1) Food services.

(a) Cost allocation based on the number of meals served.

(b) Cost allocation based on actual resident days.

(2) Laundry and linen, housekeeping, and plant operations and maintenance.

(a) Cost allocation based on actual resident days.

(3) Depreciation, interest, and real estate and personal property taxes.

(a) Allocation based on the ratio of square feet of floor space devoted to personal use.

(b) Cost allocation based on actual resident days.

c. Allocation of costs for providers of care other than mentally retarded services or nursing homes. Reasonable cost allocations must be made for costs associated with care other than mentally retarded services or nursing home.

D. Reasonable cost principles.

1. General provisions.

a. Reasonable costs. Costs to be allowable for rate-setting purposes must satisfy the following over-all criteria:

(1) They must be necessary and ordinary costs related to resident care.

(2) They must be costs that prudent and cost-conscious management would pay for a given item or service.

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b. Costs not allowable. Costs that relate to management inefficiency, unnecessary care or facilities, and activities not related to the MR field are not allowable.

c. Reasonable compensation. Reasonable compensation of individuals employed in the facility is an allowable cost, provided that the services are actually performed in a necessary function and the costs reported are actually incurred. To be reasonable the compensation allowance must be such an amount as would ordinarily be paid for comparable services by comparable facilities. To be necessary the function must be such that had the individual not rendered the services, the facility would have had to employ another person to perform the services. The function must also be pertinent to the operation and conduct of the facility. Where the services are rendered on less than a full-time basis, the allowable compensation should reflect an amount proportionate to a full-time basis. Compensation shall include payment to individuals as well as to organizations of non-paid workers that have arrangements with the provider for the performance of services by non-paid workers.

d. Substance over form. The cost effect of transactions that are conceived for the purpose of circumventing the regulations contained in 12 MCAR S 2.052 will be disallowed under the principle that the substance of the transaction shall prevail over form.

e. Costs due to changes in federal or state requirements. Costs incurred to comply with changes in federal or state laws and regulations on increased care and improved facilities are allowable costs for purposes of determining a historical per diem rate under B.1.a.

f. Reduction in costs. Purchase discounts, allowances, and refunds are a reduction of the cost of whatever was purchased.

g. Annual review of cost limitations. The commissioner shall review annually the depreciation basis limitation (D.3.b.) and adjust the limitations accordingly if justified by current data. The data used as a basis for this determination shall be made available to all providers.

h. Application of principles and specific limits. The reasonable cost principles defined in D.1. apply to all reported costs and have been specifically defined for certain cost elements in D.2. through D.5.

i. Top-management compensation limitation. Top management compensation includes that of administrators, board of directors and all other individuals receiving compensation as executives. The compensation must also be justified under the provisions of section D.1.c. of the rule. The annual compensation will be determined according to the total number of licensed beds per facility as follows:

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Number of beds.	Cumulative annual bed compensation.
1-30	$435
31-60	240
Over 60	180

For facilities of 30 beds or less the administrator's salary may be allocated between varied functions performed by the administrator if justified through review of personnel complement by licensing personnel. A top management individual who is compensated in more than two facilities with a total bed complement of more than 50 beds shall be subject to the compensation limitation on a cumulative basis of all facilities served by the individual. The maximum compensation limitation shall be $35,000 per facility.

For each full percentage point increase in the consumers price index in Minneapolis-St. Paul as published by the Bureau of Labor and Statistics for the month of October, 1974 and October, 1975, new series index (1967 = 100), the annual compensation limitation shall be increased by one percent. The increase, if any, generated by this formula shall be affected on January 1, 1976. Similar calculations shall be made for each successive year using the October indices for two successive years with the increases beginning effective the following January.

2. General and administrative expenses. Reasonable cost criteria for general and administrative expenses are as follows:

a. Owners life insurance. The costs of premiums are not allowable.

b. Personal expenses. Personal expenses of owners or employees such as homes, boats, airplanes, vacation expenses, etc., are not allowable costs. The costs of residences for administrators and key staff are allowable costs if such costs together with other compensation are reasonable.

c. Professional, technical, or business-related organizations. These costs are allowable if their function and purposes can be reasonably related to the development and operation of facilities and programs for the rendering of resident-care services.

d. Social, fraternal, and other organizations. Costs incurred in connection with memberships in all organizations not included in D.2.c. are not allowable.

e. Travel and automobile. These expenses are not an allowable expense unless they are related to activities of managing the facility.

f. Entertainment. These expenses are not allowable costs.

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g. Advertising. Costs incurred in connection with maintaining or maximizing occupancy are allowable.

h. Pension plans and profit sharing. Contributions to either an Internal Revenue Service-approved pension or profit-sharing plan, but not both, are allowable costs.

i. Employee education costs, orientation, and on-the-job training. Costs relating to providing improved resident care or, where required by state law, are allowable costs. If part or all of these costs are reimbursed by private or public funds, only the excess of cost over reimbursed funds are allowable costs. All such costs should be included in respective cost categories C.3.b. unless not identifiable.

j. Training programs for non-employees. Costs of training programs conducted for non-employees other than for volunteers are not allowable.

k. Telephone, television, and radio service. These are allowable costs where furnished to the general resident population in areas of the living unit, recreation rooms, lounges, etc. The costs of these services when located in a resident's private accommodation are not allowable.

l. Non-competitive agreement. Costs of these agreements are not allowable.

m. Pre-opening costs. One-time pre-opening costs of new facilities incurred prior to admittance of residents must be capitalized as a deferred charge. Costs in the form of amortization will be recognized as allowable costs over a period of no less than 60 consecutive months beginning with the month in which the first resident is admitted for care. Examples of these costs are wages paid for services rendered more than 30 days prior to the opening of the facility. Construction financing, feasibility studies, and other costs related to construction must be depreciated over the life of the building.

n. Bad debts. Amounts considered to be uncollectible resident accounts are not allowable costs.

o. Fund-raising costs. Costs incurred for such purpose including advertising, promotional, or publicity costs are not allowable in the year in which they are incurred except in the form of amortization as allowed by D.5.a.

p. Charitable contributions. These are not allowable costs.

3. Depreciation.

a. Basis for depreciation calculation.

(1) Cost. Historical cost of facilities shall be the basis for calculating depreciation as an allowable cost,

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except as provided by D.3.a.(2).

(2) Change in ownership of facilities. In a case in which a change in ownership of a facility occurs, and the new owner's investment is greater than the old owner's investment, if a bona fide sale is established by the new owner, the basis for depreciation will be adjusted as follows:

(a) In the case of a complete change in ownership, the basis for calculating depreciation will be the lower of:

(i) The portion of the purchase price properly allocable to depreciable facilities.

or

(ii) The appraised value of the depreciable facilities calculated under the reproduction-cost-depreciated method.

(b) In the case of a partial change in ownership, as defined below, the basis for calculating depreciation shall be determined according to provision of D.3.a.(2)(a), the case of a complete change in ownership, except that all relevant figures will be placed on a scale proportionate to the percentage of ownership change. For purposes of this provision, a partial change in ownership occurs only in the case of an organization with ten or fewer owners, after the change in ownership, and when the ownership change exceeds 20 percent. Any increase allowed by this section will then be adjusted according to D.3.a.(6).

(3) Redemption of ownership interests. In a case in which the remaining owners establish the fact that a bona fide redemption of an ownership interest has occurred, the basis for calculating depreciation will be increased by the excess, if any, of the redemption price over the former owner's investment. The adjusted basis shall be determined by applying the provision of D.3.a.(2)(b).

(4) Donated assets. The basis of donated assets, except for donations between providers or related parties, shall be fair market value defined as the price that an able buyer would pay a willing seller in an arms length sale or appraised value defined in D.3.a.(2)(a)(ii) whichever is lower. An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or the services. In the instance of the exception stated, the net book value to the donor shall be the basis for the donee.

(5) Subsequent acquisitions. The basis for calculating depreciation may be increased for the actual cost of equipment additions or facility modification or renovation.

(6) Recapture of depreciation resulting from sale of

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facility. The sale of depreciable property, or substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation used for purposes of computing allowable costs was greater than the actual economic depreciation.

(a) The amount of the recapture will be determined as follows:

(i) The gross recapture amount will be the lesser of the actual gain on the sale or the depreciation after the effective date of 12 MCAR S 2.052.

(ii) The gross recapture amount as determined in (i) above shall be allocated to fiscal periods from the effective date of 12 MCAR S 2.052 through the date of sale. The gross recapture amount shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed under 12 MCAR S 2.052. The amount allocated to each period shall be divided by the total actual resident days in that period, thereby determining a resident day cost for the period. The total net recapture shall then be determined by multiplying the actual welfare days times the resident-day cost for each fiscal period.

(iii) The total net recapture amount determined according to (ii) above will be reduced by one percent for each month of ownership since the date of acquisition of the facility. The net recapture paid to the State of Minnesota is includable in the new owner's basis for depreciation subject to the provisions of D.3.a.(2).

(b) The net recapture amount so determined in (iii) above will be paid by the new owner to the state of Minnesota within a time period agreed to by the commissioner and the new owner. The time period should effectuate an orderly payment schedule and must not exceed two years after the date of sale.

(7) Gains and losses on disposition of equipment. Gains and losses on the sale or abandonment of equipment are includable in computing allowable costs. A gain shall be an offset to depreciation expense to the extent that such gain resulted from depreciation reimbursed under these regulations. Gains or losses on trade-ins should be reflected in the asset basis of the acquired asset. Abandonment losses will be limited to five cents per resident day annually; however, any excess over this limitation can be carried forward to future years.

b. Limitations.

(1) The total basis of depreciable facility assets shall not exceed an average of $25,194 per bed for Class A beds and $29,452 per bed for Class B beds built or purchased after December 31, 1979. This limitation will be adjusted annually beginning January 1, 1981 according to a construction index as determined by the commissioner.

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(2) In no instance can accumulated depreciation calculated in accordance with D.3. exceed the basis defined in D.3.a.

(3) Accumulated depreciation as of the beginning of the first fiscal year covered by this regulation shall be calculated retroactively using the useful lives defined in D.3.c. and D.3.d.

(4) Regardless of the applicability of the limitation stated in D.3.b.(1) above, depreciation on investments in facility modifications and new equipment will be allowed if they were required by local, state or federal requirements. After the facility's first three complete fiscal years and every three years thereafter, the facility's investment per bed limitation will be adjusted to reflect the average annual increase for equipment additions and/or facility modification. The investment per bed revision does not apply to original construction and/or investment costs. The investment per bed revision will not be an exception to the overall maximum of section B.4.b. The change in the investment per bed limitation will be based on the consumer price index for housing in Minneapolis-St. Paul as published by the Bureau of Labor and Statistics for the period October through September.

c. Depreciation rates for new facilities and equipment. Depreciation shall be calculated using the basis determined under D.3.a., applying the following useful life schedule:

Building - 35 year.

Building improvements (depreciated over the remaining life of the principal asset or useful life, but not less than 15 years).

Land improvements - 20 years.

Equipment - five years.

Vehicle - four years.

d. Other useful lives.

(1) Depreciation rates for used facilities and equipment. The useful life shall be assigned by the provider, considering the individual circumstances; however, the useful life will not be shorter than one-half of the useful life provided by D.3.c.

(2) Leasehold improvements. The useful life of the improvement or the remaining term of the lease, including renewal periods, shall be used, whichever is shorter.

e. Depreciation method. The straight-line method of depreciation should be used except, at the option of the provider, when the principal payments on capital indebtedness

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exceed the total depreciation allowance calculated in accordance with D.3. In such an instance, depreciation may be increased to equal principal payments on capital indebtedness amortized over actual amortization periods; however, the amortization period cannot be less than 20 years for building and five years for equipment. Accumulated depreciation cannot exceed the basis defined in D.3.a.

f. Facilities financed by public funds. Depreciation will not be allowed on the portion of facilities financed by federal, state, or local appropriations or grants unless the intent of such appropriation or grant was that it be repaid through operating revenue of the facility.

g. Non-depreciable assets. Facility assets that are not depreciable include but are not restricted to:

(1) Land. Includes the land owned and used in provider operations. Included in the cost of land are the costs of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the provider, and other land expenditures of non-depreciable nature.

h. Capitalization vs. expense. Expenditures for equipment that has a useful life of more than one year shall be capitalized except that the provider may show as expenses small equipment purchases normally capitalized if such items do not exceed five cents per resident-day annually.

4. Leased facilities or equipment.

a. Rental charges. Rental charges incurred by a provider through reasonable bona fide leases between unrelated parties are includable in allowable costs unless:

(1) Rental charges result from a sale, lease-back arrangement, or lease with option to buy at a price less than anticipated value.

(2) Rental charges are paid to a related or controlled organization. If either D.4.a.(1) or D.4.a.(2) exists, the provisions of D.4.b. will be applied.

b. Allowable costs in lieu of disallowed rental charges. If rental charges are not allowed, the provider will be allowed depreciation computed in accordance with D.3. as if the disallowed transaction had not occurred. In addition, the provider will be allowed the reasonable cost of the facility assumed by the lessor such as interest on capital indebtedness up to 65 percent of net allowable assets, taxes, insurance, other costs, and earnings allowance provided by D.5.b. and D.5.d., if applicable.

c. Limitation. Allowable rental charges are subject to the investment per bed limitations of D.5.b.(1)(a),

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determined by calculating the present value of lease payments exclusive of real and personal property taxes and other costs assumed by the lessor. Interest rates used in capitalizing lease payments shall be the mortgage rate of the lessor or, if the mortgage rate is not available, 2.15 percentage points above the interest rate of Federal Hospital Insurance Trust Fund obligations as of the effective date of the lease.

5. Cost of capital.

a. Interest.

(1) Interest expense is an allowable cost and will be classified as follows:

(a) Interest on capital indebtedness includes amortization of bond premium and discount and related financing costs. Capital indebtedness is defined as any loan that is applied to purchased fixed assets related to providing residential care as defined in D.5.b.(1)(a). The form of indebtedness will include mortgages, bonds, notes, and debentures, when the principal is repaid over a period in excess of one year.

(b) Other interest for working capital and operating needs that directly relate to providing residential care is an allowable cost. The form of indebtedness will include, but not be limited to, notes, advances, and various types of receivable financing the principal of which will be generally repaid within one year.

(2) Interest income will be a deduction from interest allowable under provision D.5.a.(1)(a) or D.5.a.(1)(b). Interest income on restricted funds will not be deducted from interest expense. Restricted funds are defined as all unexpended donated funds carried by the facility that are restricted for other than operating costs. The operating or building funds cannot be included as part of restricted funds for this purpose.

(3) Interest rate. The interest rate incurred must not be in excess of what a borrower would have had to pay in an arms-length transaction in the money market when the loan was made. When a non-proprietary provider borrows from its own restricted fund, interest paid by the general fund to the restricted fund is allowable at a rate not to exceed the interest rate the fund is currently earning. Interest on loans between operating and building funds is not allowable.

(4) Construction interest. Interest cost incurred during and related to construction must be capitalized as a part of the cost of the facility. The period of construction is considered to extend to the date the facility is put into use for resident care.

(5) Allowable interest limitation for proprietary

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providers. Because of provision of D.5.b. for proprietary providers, the allowable interest expense defined in D.5.b.(1)(a) shall not exceed the provider's average interest rate times 65 percent of net allowable assets as defined in D.5.b.(1)(a).

b. Earnings allowance for proprietary providers.

(1) Determination of allowance. An allowable cost for rate setting purposes is a reasonable return on capital provided by owners of proprietary facilities. The return will be applicable only to the portion of investment devoted to welfare recipients, and the return represents an earnings opportunity, not a guarantee. This return does not represent an attempt to regulate the actual return realized by proprietary providers. The earnings allowance will be determined individually for each provider, considering the following factors:

(a) Net allowable fixed assets employed will include actual cost of land, land improvements, buildings and equipment minus cumulative depreciation calculated in accordance with regulation D.3. and further limited to $1,000 in excess of the limitations provided in D.3.b.(1).

(b) The amount of capital provided by owners will be assumed to be 35 percent of the net allowable fixed assets employed in providing residential care.

(c) The after-tax rate of return allowed on capital provided by owners, calculated on the basis of D.5.b.(1)(a) and D.5.b.(1)(b), will be ten percent.

(d) To obtain an after-tax rate of return of ten percent requires that the earnings allowance include an amount for average effective federal and Minnesota corporate income tax rates of 31.3 percent to 54.24 percent, depending upon the tax bracket that would result from applying the rate of return to net allowable fixed assets.

(e) An additional earnings allowance will be allowed on the remaining 65 percent of net allowable fixed assets not otherwise covered by capital indebtedness. The allowance will be six percent of this amount.

c. Minimum cost of capital allowance for providers. Notwithstanding the provision of D.5.a.(5) and D.5.b., the cost of capital allowance shall be no less than the combination of:

(1) Actual interest on capital indebtedness.

(2) An earnings amount determined by multiplying resident days for a fiscal year, or part thereof if a short period report is being filed, by 35 cents.

The minimum cost of capital allowance will be adjusted

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annually on a calendar year basis according to the consumer price index for all items in Minneapolis-St. Paul as published by the Bureau of Labor and Statistics for the period October through September. The initial revised minimum cost of capital allowance will be $.58.

E. Effective date of 12 MCAR S 2.052 revisions.

1. All revisions of this revised DPW Rule 52 shall be effective January 1, 1981 for cost reports submitted for fiscal years ended after December 31, 1979.

2. Providers may request by letter, no later than March 31, 1977, a revised rate as affected only by section B.4.b. of the rule. The revised rate may be effective as of January 1, 1977.

F. Severable provisions.

1. If any provisions of the rule as adopted by the commissioner of public welfare are found through judicial procedures to be invalid, the remaining provisions shall remain valid.

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MINNESOTA CODE OF AGENCY RULES

RULES OF THE DEPARTMENT OF PUBLIC WELFARE

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Repealed 7SR 1375
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12 MCAR S 2.053 Medical assistance.

(a) Definitions. All definitions contained in this rule are intended to comply with the requirements of Title XIX of the Social Security Act of the United States of America, as amended by Public Law 89-97, and Laws of Minnesota 1965, chapter 755. For the purpose of this rule, the terms defined in this section have the meanings given them.

(1) "Reside" means to have an established place of abode in one state or county and not to have an established place of abode in another state or county.

(2) "County of financial responsibility" means:

(a) For an applicant who resides in this state, the county in which he last resided for one year without receiving public assistance. If he does not have one year of unexcluded time, the county in which he resided for the longest period of unexcluded time.

(b) For an applicant who has not resided in this state for a full year, the county in which he has resided the longest time without receiving public assistance.

(c) For an applicant who has not resided in this state for any period of time without receiving public assistance, the county in which he resides at the time of making application.

(d) For the purposes of paragraphs (a) and (b) above, any period of time an applicant spends in a hospital, sanatorium, rest home, nursing home, boarding home, or similar institution, as defined in Minnesota Statutes 1961, section 144.50, shall be excluded in determining the county of financial responsibility.

(e) Any person who does not meet the requirements of (a), (b), (c), or (d) above shall be the financial responsibility of the county in which he has resided for the longest period of time during the year preceding the filing of his application, whether that year is excluded or non-excluded time.

(3) "Medical institution" means any licensed medical facility that receives a license from the Minnesota Health Department or Department of Public Welfare.

(4) "State agency" means the commissioner of public welfare.

(5) "County agency" means a county welfare board operating under and pursuant to the provisions of Minnesota Statutes, chapter 393.

(6) "Vendor of medical care" means any person or persons

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furnishing, within the scope of his respective license, any or all of the following goods or services: medical, surgical, hospital, optical, visual, dental and nursing services; drugs and medical supplies; appliances; laboratory, diagnostic, and therapeutic services; nursing home and convalescent care; and such other medical services or supplies provided or prescribed by persons authorized by state law to give such services and supplies.

(7) "Medical assistance" or "medical care" means payment of part or all of the cost of the following care and services for eligible individuals whose income and resources are insufficient to meet all of such cost:

(a) Inpatient hospital services.

(b) Skilled nursing home services.

(c) Physicians' services.

(d) Outpatient hospital or clinic services.

(e) Home health care services.

(f) Private duty nursing services.

(g) Physical therapy and related services.

(h) Dental services.

(i) Laboratory and x-ray services.

(j) The following if prescribed by a licensed practitioner; drugs, eyeglasses, dentures, and prosthetic devices.

(k) Diagnostic, screening, and preventive services.

(l) Health care insurance premiums if paid direct to a vendor.

(m) Transportation costs incurred solely for obtaining medical care when paid direct to a recognized ambulance service or similar transportation company.

(n) Any other medical or remedial care licensed and recognized under state law.

(b) Payments to vendors. All payments for medical assistance hereunder must be made to the vendor.

(c) Duties of state agency. The state agency shall:

(1) Supervise the administration of medical assistance for eligible recipients by the county agencies hereunder.

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(2) Make uniform rules and regulations, not inconsistent with law, for carrying out and enforcing the provisions hereof in an efficient, economical, and impartial manner, and to the end that the medical assistance system may be administered uniformly throughout the state, having regard for varying costs of medical care in different parts of the state and the conditions in each case, and in all things to carry out the spirit and purpose of this program, which rules and regulations shall be made with the approval of the attorney general on form and legality, shall be furnished immediately to all county agencies, and shall be binding on such county agencies.

(3) Prescribe the form of, print, and supply to the county agencies, blanks for applications, reports, affidavits, and such other forms as it may deem necessary or advisable.

(4) Cooperate with the Federal Department of Health, Education, and Welfare in any reasonable manner as may be necessary to qualify for federal aid in connection with the medical assistance program, including the making of such reports in such form and containing such information as the Department of Health, Education and Welfare may, from time to time, require, and comply with such provisions as such department may, from time to time, find necessary to assure the correctness and verifications of such reports.

(5) Within 60 days after the close of each fiscal year, prepare and print for the fiscal year a report that shall include a full account of the operations and the expenditure of all funds hereunder, adequate and complete statistics divided by counties about all medical assistance hereunder within the state, and such other information as it may deem advisable.

(6) Prepare and release a summary statement monthly showing by counties the amount paid hereunder and the total number of persons assisted.

(7) Establish and enforce safeguards to prevent unauthorized disclosure or improper use of the information contained in applications, reports of investigations and medical examinations, and correspondence in the individual case records of recipients of medical assistance.

(8) Furnish information to acquaint needy persons and the public generally with the plan for medical assistance of this state.

(9) Cooperate with agencies in other states in establishing reciprocal agreements to provide for payment of medical assistance to recipients who have moved to another state, consistent with the provisions hereof and of Title XIX of the Social Security Act of the United States of America.

(d) Administration by county agencies. The county agencies shall administer medical assistance in their respective counties under the supervision of the state agency and shall make such

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reports, prepare such statistics, and keep such records and accounts in relation to medical assistance as the state agency may require.

(e) Eligibility requirements. Medical assistance may be paid for any person:

(1) Who is eligible for or receiving public assistance under the old age assistance, aid to families with dependent children, aid to the blind, or aid to the disabled programs; or

(2) Who, except for the amount of income or resources, would qualify for old age assistance, aid to families with dependent children, aid to the blind, or aid to the disabled and is in need of medical assistance; or

(3) Who is under 21 years of age and in need of medical care that neither he nor his relatives responsible under this rule are financially able to provide; or

(4) Who is residing in a hospital for treatment of mental disease or tuberculosis and is 65 years of age or older and without means sufficient to pay the per capita hospital charge; and

(5) Who resides in Minnesota, or, if absent from the state, is deemed to be a resident of Minnesota in accordance with the regulations of the state agency; and

(6) Who alone, or together with his spouse, does not have equity in real property in excess of $15,000; and

(7) Who, if single, does not have more than $750 in cash or liquid assets or, if married, whose assets do not exceed $1,000 plus $150 for each additional legal dependent; and

(8) Who has or anticipates receiving an annual income not in excess of $1,600 if single, or $2,200 if married, plus $400 for each additional legal dependent or for any person and other eligible member of his family living in the household who has current or anticipated annual income in excess of the foregoing when such person or persons spend or obligate the excess income for health care purposes; and

(9) Who has applied or agrees to apply all proceeds received or receivable by him or his spouse from health and accident insurance policies on the costs of medical care for himself, his spouse, and/or children.

(f) Exceptions in determining resources. A county agency may waive the requirement of liquidation of excess assets when the liquidation would cause undue hardship. Household goods and furniture in use in the home, wearing apparel, insurance policies with cash surrender value not in excess of $1,000 per person, a prepaid funeral contract not in excess of $600, and a lot in a burial plot shall not be considered as resources

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available to meet medical needs.

(g) Application. An applicant for medical assistance hereunder, or a person acting in his behalf, shall file his application with a county agency in such manner and form as shall be prescribed by the state agency.

(h) Investigations. When an application for medical assistance hereunder is filed with a county agency, such county agency shall promptly make or cause to be made such investigation as it may deem necessary. The object of such investigation shall be to ascertain the facts supporting the application made hereunder and such other information as may be required by the rules of the state agency. Upon the completion of such investigation the county agency shall promptly determine eligibility.

(i) Appeal procedure. Any applicant or recipient aggrieved by any order or determination by any county agency may appeal from such order or determination to the state agency. An appeal may also be taken by any applicant if his application is not acted upon within 30 days by the county agency with which his application has been filed. Upon receipt of such an appeal, the state agency shall notify the county agency and review the case, giving the applicant or recipient an opportunity for a fair hearing before the state agency. The state agency may upon its own motion review any decision made by any county agency. The state agency may make such additional investigation as it may deem necessary and shall make such decision about the granting of medical assistance and the amount and nature of medical assistance to be granted the applicant or recipient as in its opinion is justified and in conformity with the provisions hereof. All decisions of the state agency shall be binding upon the county involved and upon the applicant or recipient and shall be complied with by the county agency unless modified or reversed on appeal as hereinafter provided.

(j) Appeal to district court. If a decision or determination by the state agency is not in conformity herewith, in the opinion of the county agency or the applicant or recipient, either may within 30 days after such decision appeal from the decision or determination of the state agency to the district court of the county in which the application was filed by serving a copy of a written notice of such appeal upon the state agency and the adverse party and filing the original of such written notice, together with proof of service, with the clerk of the district court of such county. Such appeal may be brought on for hearing by either party by mailing ten days written notice to the other parties, stating the time and place of such hearing. Upon serving of such notice the state agency shall, if demanded, furnish the county agency and the applicant or recipient a summary of the issues involved, a copy of all supporting papers, a transcript of any testimony, and a copy of its decision. The court shall summarily, upon ten days written notice, try and determine the appeal upon the record of the state agency as certified to it, and its determination shall be

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limited to the issue as to whether the order of the state agency was based upon an erroneous theory of law or was arbitrary, capricious, or unreasonable. No new or additional evidence shall be taken on such appeal or introduced by any party to such hearing on appeal in the district court unless such new or additional evidence, in the opinion of the court, is necessary to a more equitable disposition of the appeal. If new or additional evidence is taken on such appeal, the case shall be remanded to the state agency for reconsideration in the light of such new or additional evidence and thereafter for proceedings in accordance with the provisions of this section. If the court shall find the order of the state agency was based upon an erroneous theory of law or was arbitrary, capricious, or unreasonable, the court shall make an order declaring the order of the state agency null and void, giving its reasons therefor, and shall order the state agency to take further action in the matter not inconsistent with the determination of the court.

(k) Legal representation. The attorney general shall be the attorney for the state agency, and the county attorney of each county shall be the attorney for the county agency of such county in all matters pertaining hereto.

(l) Subpoenas. Each county agency and the state agency shall have the power to issue subpoenas for witnesses and compel their attendance and the production of papers and writing; and officers and employees designated by any county agency or the state agency may administer oaths and examine witnesses under oath in connection with any application or proceedings hereunder.

(m) Relative's responsibility. The financial responsibility of a relative for an applicant or recipient of medical assistance may not be considered to extend beyond the relationship of a spouse, or a parent of an applicant who is blind, permanently and totally disabled, or is under 21 years of age.

(n) Claims against estates. If a person receives any medical assistance hereunder, on his death, if he is single, or on the death of such person and his surviving spouse, if he is married, and only at a time when he has no surviving child who is under 21 or is blind or totally disabled, the total amount paid for medical assistance rendered for such person, after age 65, without interest, shall be filed as a claim against the estate of such person in the court having jurisdiction to probate the estate. Such claim shall be considered an expense of last illness for the purpose of Minnesota Statutes 1961, section 525.44. Any statute of limitations that purports to limit any county agency or the state agency, or both, to recover for medical assistance granted hereunder shall not apply to any claim made hereunder for reimbursement for any medical assistance granted hereunder.

(o) False statements. Any person who obtains or attempts to obtain, by means of willfully false statement or representation, by impersonation, or by any other fraudulent device, any medical

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assistance to which he is not entitled; or transfers any real or personal property for the purpose of, or with the intent of, obtaining or remaining eligible to obtain medical assistance hereunder shall be ineligible for medical assistance hereunder and, upon conviction thereof, shall be guilty of a gross misdemeanor. The amount of any medical assistance paid incorrectly because of aforementioned fraudulent means established by a judicial determination shall be recoverable from such recipient or his estate by the county as a debt due the county.

(p) Transfer of property. Any person who has transferred any real or personal property within three years immediately preceding the date of application for medical assistance hereunder or who transfers any such property while receiving medical assistance hereunder without receiving a reasonable consideration therefor shall be presumed to have done so in order to become or remain eligible for medical assistance hereunder or to have deprived himself and/or his spouse of a resource that might otherwise have been used to meet his or their current needs. Such person shall have the burden of overcoming such presumption to the satisfaction of the county agency.

(q) Methods of administration. The state agency shall prescribe such methods of administration as are necessary for compliance with requirements of the Social Security Act, as amended, and for the proper and efficient operation of the program of assistance hereunder. The state agency shall establish and maintain a system of personnel standards on a merit basis for all such employees of the county agencies and the examination thereof, and the administration thereof shall be directed and controlled exclusively by the state agency except in those counties in which such employees are covered by a merit system that meets the requirements of the state agency and the Social Security Act, as amended.

(r) Division of cost. The cost of medical assistance paid by each county of financial responsibility shall be borne as follows:

(1) Payments shall be made by the state to the county for that portion of medical assistance paid by the federal government and the state on or before the 20th day of each month for the succeeding month upon requisition from the county showing the amount required for the succeeding month.

The expense of assistance not paid by federal funds available for that purpose shall be shared equally by state and county.

(2) Federal funds available for administrative purposes shall be distributed between the state and the county in the same proportion that expenditures were made.

(s) County appropriations. The providing of funds necessary

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to carry out the provisions hereof on the part of the counties and the manner of administering the funds of the counties and the state shall be as follows:

(1) The board of county commissioners of each county shall annually set up in its budget an item designated as the county medical assistance fund and levy taxes and fix a rate therefor sufficient to produce the full amount of such item, in addition to all other tax levies and tax rate, however fixed or determined, sufficient to carry out the provisions hereof and sufficient to pay in full the county share of assistance and administrative expense for the ensuing year; and annually on or before October 10 shall certify the same to the county auditor to be entered by him on the tax rolls. Such tax levy and tax rate shall make proper allowance and provision for shortage in tax collections.

(2) Any county may transfer surplus funds from any county fund, except the sinking or ditch fund, to the general fund or to the county medical assistance fund in order to provide moneys necessary to pay medical assistance awarded hereunder. The money so transferred shall be used for no other purpose, but any portion thereof no longer needed for such purpose shall be transferred back to the fund from which taken.

(3) Upon the order of the county agency the county auditor shall draw his warrant on the proper fund in accordance with the order, and the county treasurer shall pay out the amounts ordered to be paid out as medical assistance hereunder. When necessary by reason of failure to levy sufficient taxes for the payment of the medical assistance in the county, the county auditor shall carry any such payments as an overdraft on the medical assistance funds of the county until sufficient tax funds shall be provided for such assistance payments. The board of county commissioners shall include in the tax levy and tax rate in the year following the year in which such overdraft occurred, an amount sufficient to liquidate such overdraft in full.

(4) Claims for reimbursement shall be presented to the state agency by the respective counties in such manner as the state agency shall prescribe, not later than ten days after the close of the month in which the expenditures were made. The state agency shall audit such claims and certify to the state auditor the amounts due the respective counties without delay. The amounts so certified shall be paid within ten days after such certification, from the state treasury upon warrant of the state auditor from any moneys available therefor. The moneys available to the state agency to carry out the provisions hereof, including all federal funds available to the state, shall be kept and deposited by the state treasurer in the revenue fund and disbursed upon warrants in the same manner as other state funds.

(t) Change of residence. When a recipient changes his place of residence, he shall notify the county agency by which his

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medical assistance hereunder is paid. If he moves to another county, he shall declare whether such absence is temporary or for the purpose of residing therein.

(u) Compliance with Social Security Act. The various terms and provisions hereof, including the amount of medical assistance paid hereunder, are intended to comply with and give effect to the program set out in Title XIX of the Federal Social Security Act as amended by Public Law 89-97, and Laws of Minnesota 1965, chapter 755. In the event that federal funds shall not be available or shall be inadequate to pay in full the federal share of all medical assistance contemplated hereunder, then and in such case, and until federal funds are available in full, the county agency of each county may reduce its payments by an amount equal to such deficiency.

(v) Use of federal funds. All federal funds made available for the purposes hereof are hereby appropriated to the state agency to be disbursed and paid out in accordance with the provisions hereof.

(w) Prohibitions. No enrollment fee, premium, or similar charge shall be required as a condition of eligibility for medical assistance hereunder.

(x) Payments to licensed facilities. Payments may not be made hereunder for care in any private or public institution, including but not limited to hospitals and nursing home, if not licensed by the state or operated by it.

(y) Agreements with other state departments. The Commissioner of the Department of Public Welfare is authorized to enter into cooperative agreements with other state departments or divisions responsible for administering or supervising the administration of health services and vocational rehabilitation services in the state for maximum utilization of such service in the provision of medical assistance under this rule and regulation.

(z) Effective date. This rule shall become effective on January 1, 1966.

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§ 2.055 General assistance.

A. Introduction.

This rule governs the administration of the General Assistance Program as enacted by Article XXI, Laws of 1973, ch. 650.

The purposes of the General Assistance Program are (1) to provide financial assistance and services to persons unable to provide for themselves, who have not refused suitable employment, and who are not otherwise provided for by law; (2) to strengthen and preserve the family unit; (3) to aid those persons who can be helped to become self-supporting or to attain self-care; and (4) to provide property tax relief by providing state financing for some welfare costs historically financed by county property tax levies.

B. Definition.

The terms defined in this section shall have the meanings given them unless otherwise provided or indicated by the context.

1. "Commissioner" means the Commissioner of Public Welfare or his designee.

2. "Department" means the Department of Public Welfare.

3. "General Assistance" means cash payments to persons who are unable to provide themselves with a reasonable subsistence compatible with decency and health and who are not otherwise provided for under the laws of this state or the United States. It shall include cash payments for goods, shelter, fuel, food, clothing, lights, necessary household supplies, and personal needs items. General Assistance shall not include payments for foster care, child welfare services, medical care, dental care, hospitalization, nursing care, drugs, or medical supplies. It is the intent of Laws of 1973, ch. 650, Article XXI, that these items be provided by local agencies in accordance with programs in effect at the time of the passage of Laws of 1973, ch. 650, Article XXI. Vendor payments may be made only as provided for in Laws of 1973, ch. 650, Article XXI, §§ 245A.09 and 245A.11.

4. "Family" means two or more individuals who are related by blood, marriage, or adoption who are living in a place or residence maintained by one or more of them as his or their own home and at least one of whom is a child who is not married to another of such individuals and is in the care of or dependent upon another of such individuals.

5. "Child" means an individual who is under the age of 18.

6. "Childless couple" means two individuals who are related by marriage and who are living in a place of residence maintained by them as their own home.

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7. "Income" means earned and unearned income reduced by amounts paid or withheld for federal and state personal income taxes and federal social security taxes. General Assistance shall be administered according to law and rules and regulations promulgated by the Commissioner pursuant to the provisions of Laws of 1973, ch. 650, Article XXI.

8. "Earned income" means remuneration for services performed as an employee, and net earnings from self-employment.

9. "Unearned income" means all other income including any payments received as an annuity, retirement or disability benefit, including veteran's compensation; old age, survivors and disability insurance; railroad retirement benefits; unemployment benefits; and benefits under any federally aided categorical assistance program, supplementary security income, or family assistance program; rents dividends, interest and royalties; and support and alimony payments except that such payment may not be considered as available to meet the needs of any person other than the person for whose benefit they are received, unless that person is under a legal duty to support another family member.

10. "State aid" means state aid to local agencies for general assistance expenditures as provided for in Laws of 1973, ch. 650, Article XXI.

11. "Local agency" means the county welfare boards in the several counties of the state except that it may also include any multicounty welfare boards or departments where those have been established in accordance with law.

C. Eligibility requirements.

General Assistance shall be granted to any person or family who has all of the following qualifications:

1. Who is not eligible for or receiving Aid to Families with Dependent Children, Emergency Assistance - AFDC, or any successor to these public assistance programs.

2. Whose net equity in real and personal property does not exceed the maximum standards established in the AFDC Program except as follows:

a. Whose cash resources are valued at less than $50.00.

b. Who retains life insurance policies with total cash surrender value of less than $250.

c. Who does not own or have an equivalent to ownership of an automobile with a trade-in value in excess of $1500 according to current N.A.D.A. schedules.

The local agency may waive the limitations recited in Section C. 2. above, to

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the extent not greater than 100 per cent above the maxima set forth therein, when the circumstances of the application show that the need for General Assistance will not exceed 30 days and that an undue hardship will be imposed by a forced disposal of such property. Extraordinary cases shall be determined by the local agency and shall be referred to the State Agency.

3. Who, if employable, has currently registered for employment with the Minnesota Department of Employment Services, has not refused to accept any suitable employment that was offered, and has not declined to accept any assignment to the local agency's work program. Furthermore, recipients shall be required to participate in local agency programs designed to identify and maximize their employability. Eligibility for a maintenance grant may exist where an applicant or recipient is engaged in an academic or vocational program, approved by the local agency, where employment is the immediate goal of such program. The state agency shall not reimburse the local agency for the cost of such programs.

4. Who has not transferred property without receiving reasonable consideration for the purpose of qualifying for General Assistance.

5. Whose maintenance needs as determined by General Assistance standards exceed his current income or the average of his seasonal income for any three month's period.

6. Who, if apparently eligible for participation in the federally sponsored Supplemental Security Income Program, has executed an authorization form (DPW 1795) permitting the Secretary of Health, Education, and Welfare, in accordance with Public Law 93-368, to make his initial SSI payment to the county welfare agency which provides him General Assistance during the interim period while he awaits his first SSI check.

D. General assistance standards and state participation.

1. Local agencies shall determine need in individual cases up to the standards promulgated by the Department.

2. Except as provided in 3. below, the total amount of General Assistance payment shall be the difference between the amount of recipients needs as determined pursuant to D. 1., above minus available, non-exempt income. The local agency may average seasonal income over a three months period.

3. Any local agency may issue grants in amounts above those described in D. 1., 2., above provided that it deletes the additional costs thus incurred from its claim for state aid reimbursement, except the state aid may be available for payments made in excess of General Assistance standards in emergent situations wherein the request was for a period of less than 30 days. As used herein, an "emergency situation" refers to a circumstance that:

a. places in jeopardy one or more persons in an eligible family unit,

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b. cannot be resolved by the applicant with his or her current resources; and

c. in the absence of other resources, requires immediate financial assistance.

4. Grants of General Assistance shall be issued by the local agencies to the recipient in the form of county warrants immediately redeemable in cash. Such payments shall cover his unmet needs and may be issued in monthly, semimonthly, weekly, or daily installments as the local agency deems to be appropriate in individual situations. Vendor payments shall be made in the following situations:

a. When the county determines that the recipient has not used his resources in the best interest of his needs and that of his dependents. Evidence of the recipient's inability to manage his resources must be documented in the case record.

b. When an individual has remained uncooperative about registering for employment services or in seeking and/or accepting suitable employment, vendor payments shall be made for the maintenance needs of his dependents. (Suitable employment is defined in Minn. Stat., § § 268.09, subd. 1 (4).)

c. Issuance of General Assistance by vendor payment is permissible in emergent situations when a cash payment cannot be processed on weekends or holidays to resolve the current crisis.

5. The State will reimburse local agencies on a monthly basis for actual General Assistance Payments made pursuant to D. 2., above, subject to the following limitations:

a. 50 per cent of the actual grant paid to the recipient, or

b. 50 per cent of the appropriate standard in D. 1., above, whichever is less.

6. The State will participate in actual emergency payments made pursuant to D. 3., up to 50 per cent of each such grant.

E. Determination of county of financial responsibility.

1. In all matters involving legal settlement of the poor, "county of financial responsibility" means:

a. The county in which an individual resides;

b. An individual shall be held to reside in a particular county if he has established a home there and has not established a home elsewhere;

c. If, at the time of making application, the applicant is a patient in

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a hospital, nursing home, or boarding-care home, as defined in Minn. Stat., § 144.50, or is placed in a county as a result of a correctional program or a treatment plan for health, rehabilitation, foster care, child care or training, and immediately prior thereto he had resided in another county in an established abode that was not such a like care facility, it is in the former county;

d. The above provisions not withstanding, if an individual is a recipient of Medical Assistance, the county from which he is receiving Medical Assistance.

e. The above provisions not withstanding, the county of financial responsibility shall not change as a result of successive placements in one or more counties pursuant to a plan of treatment for health, rehabilitation, foster care, child care or training; nor as a result of placement in any correctional program.

2. If, upon investigation of an application for General Assistance, the local agency finds that the applicant is otherwise eligible for assistance but that his county of financial responsibility is some other county, it shall within 15 days, while providing assistance in the meanwhile, transmit a copy of the application together with a record of its investigation to the local agency of the other county. If, within 15 days, the local agency of such other county concludes that it is not the county of financial responsibility for the applicant, it shall forward concurrently copies of the application and the investigation reports of both counties to the State Agency and to the county of origin. The State Agency shall thereupon promptly decide the question of which county is the county of financial responsibility and issue an order referring the application to the proper county and include therein directives as necessary for any reimbursement of General Assistance advanced to the recipient in the meanwhile. The order of the State Agency shall be binding on the local agency so named and shall be complied with until such State Agency decision is changed upon appeal to the district court.

F. The effective date of this Rule is February 19, 1976.

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§ 2.056 State financial participation in county welfare administration cost.

A. This rule governs State financial participation in County Welfare costs of administration as authorized by Minn. Stat. § 256D.22.

B. The purposes of this rule are to provide:

1. A system of calculating state reimbursement for certain County Welfare Administrative costs.

2. Property tax relief by providing state financing for certain County Welfare Administrative costs.

C. Subject to the provisions herein, the Department of Public Welfare shall reimburse counties on a quarterly basis up to 50 per cent of all salary expenses incurred and paid by the counties in providing financial assistance and social services in connection with all public assistance programs and for which no other payment or Federal reimbursement has been made. If the appropriation is insufficient to pay all approved claims the Commissioner of the Department of Public Welfare shall make a pro-rata reduction in payments based upon earnings. Such reimbursement may be available for salary expenses of employees of the county welfare agency who are permanent; probationary; provisional limited term; when such employee is filling an established job while the incumbent is on leave; and for intermittent or trainees, when such trainees are employed on a full time established training program performing the duties of the classified position for which they will be eligible to receive immediate appointment at the completion of the training period.

1. No reimbursement shall be made for salary costs of

a. single county welfare directors;

b. fiscal personnel and their supporting clerical staff who spend 30 per cent or more of their time-involvement in the processing of public assistance claims and payments;

c. emergency employees, trainees other than those defined above as eligible for reimbursement, consultants, Emergency Employment Act personnel and any other non-regularly assigned employees.

2. Reimbursement for salary expenses shall be limited to regular compensation not in excess of that paid similarly situated state employees; the employer's cost of hospitalization, medical and major medical health insurance, Social Security, Public Employees Retirement Association and Municipal Employees Retirement Association, life insurance, disability insurance, unemployment compensation and worker's compensation. No reimbursement shall be made for travel or any other reimbursable expenses including bonuses.

3. The Merit System Supervisor shall after consultation with appropri-

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ate state personnel and appropriate personnel from other civil service systems, which have been approved by the Federal Civil Service Commission to cover county welfare personnel in Minnesota, develop comparability schedules between positions in all county welfare departments and classes established by the State Personnel Department or its successor. In making such schedules the likeness of job duties and qualifications shall be considered.

a. Such comparability schedules shall apply to welfare personnel under the Minnesota Merit System, Hennepin County Personnel Department, St. Louis County Civil Service Department, Ramsey County Civil Service or under any other civil service system approved in the future by the Federal Civil Service Commission to cover county welfare personnel in the state.

b. As new classes are established by the Minnesota Merit System, the Hennepin County Personnel Department, the St. Louis County Civil Service Department, the Ramsey County Civil Service Department or by any other approved civil service system for welfare personnel, the Merit System Supervisor shall determine the comparability of the new class to a state personnel class and incorporate the new class into the comparability schedule. Comparability may be determined on an aggregate formula basis. In instances where the county welfare department is not covered by the Minnesota Merit System, it shall be the responsibility of the director of the county welfare agency requesting the new classification to notify the supervisor prior to the establishment of the new class.

c. The Merit System Supervisor shall conduct a review of any changes in state personnel classifications and/or compensation plans each time these schedules change and make such changes in the comparability schedule as appropriate. In making the review, input shall be requested and used from state personnel department personnel as well as from personnel of other concerned civil service systems. The review shall be completed within one month after the state personnel schedules change and if needed, new schedules printed and distributed within two months.

d. Decisions of the Merit System Supervisor in developing the original comparability schedules and in making revisions to them shall be appealable to the Merit System Council under the provision of DPW Rule No. 108 (f) (1). The decision of the Merit System Council shall be final.

D. Within 30 days after the end of each calendar quarter, each county welfare agency is required to submit figures showing the total number of employees whose salary is reimbursable along with the total amount reimbursable.

Date Effective: July 17, 1978.

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§ 2.057 Minnesota supplemental aid.

A. Introduction.

This rule governs the administration of the Minnesota Supplemental Aid Program as enacted by Laws of 1974, ch. 487.

The purpose of the Minnesota Supplemental Aid Program is to provide financial assistance to recipients of Supplemental Security Income for the Aged, Blind, Disabled (SSI), or to persons who, but for excess income or resources, would be receiving SSI, and who are found to have maintenance needs as determined by the application of the state standards in effect for the adult categories in December of 1973, which exceed their income from SSI and other sources, and who would otherwise have qualified for the benefits under the Programs of OAA, AB, or AD as such former programs were then in effect.

B. Definitions.

The terms defined in this section shall have the meanings given them unless otherwise provided or indicated by the context.

1. "Supplemental Security Income" means benefits paid under the federal program of Supplemental Security Income for the Aged, Blind, and Disabled, Title XVI of the Social Security Act, as enacted by Section 301 of the Social Security Amendments of 1972.

2. "Applicant for Supplemental Security Income" means an individual who has applied for Supplemental Security Income and who, but for excess income or resources, would be a recipient of Supplemental Security Income.

3. "Supplemental Aid" means state and county payments to eligible applicants for or recipients of Supplemental Security Income, in accordance with the provisions of this act and rules and regulations promulgated by the Commissioner of Welfare.

4. "Commissioner" means the Commissioner of Public Welfare or his designee.

5. "Department" means the Department of Public Welfare.

6. "Local Agency" means the county welfare boards in the several counties of the state except that it may also include any multi-county welfare boards or departments where those have been established in accordance with law.

7. "Income" means earned and unearned income from any source whatsoever, reduced by amounts paid for federal and state personal income taxes and federal social security taxes.

C. Eligibility requirements.

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Minnesota Supplemental Aid shall be granted to any person:

1. Who has attained the age of 65 years or who has met SSI criteria for blindness or disability; and

2. Whose net equity in real property:

a. If aged or disabled, does not exceed $10,000, which maximum will be increased to $12,000, effective July 1, 1974, and to $15,000 effective January 1, 1975; or

b. If blind, does not exceed $15,000; and

3. Whose net equity in personal property:

a. If aged or disabled, convertible into cash does not exceed $300 if single or if married does not exceed $450;

b. If aged, does not have in excess of $1,000 in cash surrender value of life insurance; or

c. If disabled, does not have in excess of $500 in cash surrender value of life insurance; or

d. If aged, blind or disabled, does not have in excess of $750 in prepaid funeral contract plus accrual of interest therein not exceeding $200;

e. If blind and single, does not have in excess of $2,000 in undifferentiated liquid assets, or if blind and married, together with his spouse does not have in excess of $4,000 in undifferentiated liquid assets, including therein up to $750 per person for a prepaid funeral contract plus an accrual of interest not over $200 per person.

f. In the form of a mobile home used as a living abode will not be a bar to eligibility; and

4. Whose current income and resources, and those of his spouse if married, are insufficient for maintaining a standard of living necessary for health and decency as determined by the application of the standards of allowances in effect in the adult categories of OAA, AB, and AD in December of 1973 in the county wherein he is presently residing.

D. Evaluation of property transfers.

The establishment of an applicant's initial eligibility for, or a recipient's redetermination of eligibility for Minnesota Supplemental Aid in situations wherein the applicant or recipient has divested himself of resources without receiving a reasonable consideration therefor and which resources might otherwise have been available for his support, is contrary to public policy and, in some instances, may constitute a criminal offense on behalf of both

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the donor and the donee of the resource. To prevent this practice, county agencies shall employ the following procedure and presumptions in assessing eligibility for Minnesota Supplemental Aid.

1. Each applicant or recipient shall be required to divulge whether within the preceding three years he has transferred any property, real or personal, totalling in excess of $300 if single, or $450 if married, to any person or persons without receiving adequate consideration therefor.

2. Any property transfer as defined in D. 1. shall be presumed to be a gift in contravention of public policy, and the property so transferred shall be presumed to remain available for the support of the applicant or recipient if reasonable effort is expended for its recovery.

3. The applicant or recipient who has transferred property in violation of this section shall be required to provide to the county agency a description (including value) of the property, the name or names of all persons who received such property, and the circumstances under which the property was transferred.

4. The applicant or recipient who has transferred property in violation of this section shall be required to make a reasonable effort, in cooperation with the county agency, to reacquire the property so transferred.

5. The information required by D. 3. and the efforts made to reacquire the property under D. 4. shall be entered on the appropriate application or eligibility redetermination forms.

6. If the county agency is unable to persuade the donor and/or donee of the transferred property to have it returned to the applicant or recipient for his current support, then the matter of the property transfer shall be reported with full documentation to the County Attorney for possible criminal prosecution.

7. A transfer of property in violation of this section shall not of itself constitute grounds for ineligibility for Minnesota Supplemental Aid if application of sections D. 3. through 6. has failed to make the transferred property available for the support of the applicant or recipient.

E. Determination of county of financial responsibility.

1. In all matters concerning payment of the county administered Minnesota Supplemental Aid, "county of financial responsibility" means:

a. The county from which the applicant is receiving the Federally administered Supplemental Aid; or

b. If the applicant was receiving Old Age Assistance or Aid to the Blind or Aid to the Disabled in December of 1973, but did not qualify for the Federally administered supplement and now qualifies for the county admin-

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istered supplement, that county from which he was receiving OAA or AB or AD in December of 1973; or

c. If the applicant is a recipient of Medical Assistance either as an "MA Only" case, or by having qualified for SSI benefits after January 1, 1974, the county from which he is receiving Medical Assistance; or

d. If the applicant does not qualify under 1. a. or b. or c. above, it means the county in which he was residing as of the date his effective application for the county administered supplemental aid was signed.

2. The county thus determined to be financially responsible for payment for the county administered supplemental aid shall remain responsible for so long as his application remains in effect irrespective of his residence in other counties within this state thereafter. This supplemental grant is to be cancelled whenever the recipient has been absent from the state for one calendar month or more.

F. Minnesota supplemental aid standards and state participation.

1. Local agencies shall determine need in individual cases in accordance with the standards of assistance and related income exemptions as were in effect in the adult programs of OAA, AB, and AD in December of 1973.

2. The amount of the Supplemental Aid grant is the difference between what the applicant would have received in an OAA, AB, or AD grant in December of 1973 and his current SSI including the Federally administered supplement. If the applicant is not eligible for SSI by reason of excess income and resources, then the supplemental grant shall be the difference between what he would have received in December of 1973 in an OAA, AB, or AD grant and the total of his current income.

3. The county administered supplemental aid grants shall be issued by the local agencies to the recipient or his protective-representative payee or his conservator or guardian of estate in the form of county warrants immediately redeemable in cash.

4. The state will reimburse local agencies on a monthly basis for 50 per cent of the actual payments made under this county administered supplemental aid program. Payment for non-recurring special needs is to be allowed for catastrophic major home repairs or replacement of a furnace, water heater, plumbing or the electrical system. Other allowable special needs are for necessary repairs or replacement of household furniture and appliances, for moving expenses and for annual fuel and utility adjustments for the difference between the standard allowances and verified consumption by recipients.

5. An applicant or recipient may allocate all his net income to provide for the basic unmet needs, not to exceed the total amount of the needs as determined by state-wide standards, of persons that he is legally responsible

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to support, before he is expected to use such income for his own needs in all instances except: 1) statutes exist which make provision for support of legal dependents in institutions and; 2) the income is from a trust fund or other source which designates its use only for the applicant or recipient, or for some specific purpose.

G. The effective date of this Rule is April 1, 1974, except for Section D. which is effective September 1, 1974.

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§ 2.058 General assistance medical care.

A. This rule establishes a state-wide General Assistance Medical Care Program and governs state financial participation in county welfare medical costs as authorized by Article II, Laws of 1975, ch. 437.

B. The purposes of this rule are (1) to provide medical services to persons financially unable to provide it for themselves, and whose medical needs are not otherwise provided for by law; and (2) to provide property tax relief by providing state financing for some medical costs historically financed by county property tax levies.

C. Definitions.

The terms defined in this section shall have the meanings given them unless otherwise provided or indicated by the context.

1. "Commissioner" means the Commissioner of Public Welfare or his/her designee.

2. "Department" means the Department of Public Welfare.

3. "Local Agency" means the county welfare boards in the several counties of the state except that it may also include any multi-county welfare boards of departments where those have been established in accordance with law.

4. "General Assistance Medical Care" means payment of part or all of the cost of the following care and services not provided by Titles XVIII, XIX or XX of the Social Security Act for eligible individuals whose income and resources are insufficient to meet all such costs:

a. Inpatient hospital services

b. Skilled nursing home and intermediate care facility services

c. Physician's services

d. Outpatient hospital or clinic services

e. Home health care services

f. Private duty nursing service

g. Physical therapy and related services

h. Dental services

i. Laboratory and x-ray services

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j. The following if prescribed by a licensed practitioner: drugs, eyeglasses, dentures and prosthetic devices

k. Diagnostic, screening and preventive services

l. Transportation costs incurred solely for obtaining medical care

m. Any other medical or remedial care licensed and recognized under state law to the extent that such services are provided for in the Medical Assistance Program.

To be excluded from the services recited above are the following:

Jejuno-ileal by-pass surgery

Cosmetic surgery

Contact lenses unless prescribed for Kerotoconus or where functional vision is impossible to achieve by other means.

Orthodontia unless prior authorization has been obtained from the local agency subject to review by the State Dental Advisory Committee.

Psychiatric and psychological services unless the need for them has been pre-authorized by the local agency in accordance with the conditions and limitations prevailing in the Medical Assistance Program.

Autopsies

Air conditioners, humidifiers, dehumidifiers and orthopedic mattresses even though they may have some health treatment values.

5. "Provider of Medical Care" means any persons or facility furnishing, within the scope of his or its respective license, any or all of the services or goods recited in Section C. 4., above.

6. "Income" means earned and unearned income from any source whatsoever, (including windfalls, income tax refunds and rebates) reduced by amounts paid or withheld for federal and state income taxes, federal social security taxes and employment expenses. The local agency may adopt a standardized allowance schedule for usual employment expenses.

7. "Relatives Responsibility" means that the financial responsibility of a relative for an applicant or recipient of General Assistance Medical Care shall not extend beyond the relationship of a spouse, or a parent of an applicant or recipient who is a child under the age of 18 years.

D. Eligibility requirements.

General Assistance Medical Care benefits shall be granted to any person or family who has all of the following qualifications:

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1. Who is currently receiving General Assistance in accordance with Minn. Stat., §§ 256D.01 to 256D.22; or

2. Who is not eligible for or receiving medical care through the programs of Aid to Families with Dependent Children, or Emergency Assistance-AFDC, or Medical Assistance, or Cost-of-Care for mentally retarded, epileptic or emotionally handicapped children, or State Reimbursement for State Wards per Minn. Stat., § 260.38, or Social Services under Title XX of the Social Security Act, but who otherwise meets eligibility requirements for this General Assistance Medical Care program; and

3. Whose net equity in real and personal property does not exceed the maximum standards established in the Medical Assistance Program according to Minn. Stat., §§ 256B.06 and 256B.07; and

4. Who does not own or have an equivalent to ownership of more than one family automobile; and

5. Who has not transferred property without receiving reasonable consideration for the purpose of qualifying for General Assistance Medical Care; and

6. Who has or anticipates receiving an annual income not in excess of $2,600 for a single person, or $3,264 for two family members (husband and wife, parent and child, or two siblings), or $3,960 for three family members, or $4,620 for four family members, or $5,184 for five family members, plus $625 for each additional legal dependent, or who has income in excess of these maxima and in the month of application (or during the three months prior to the month of application) incurs expenses for medical care that total more than one-half of the annual excess income in accordance with the regulations of the Department. In such excess income cases, eligibility shall be limited to a period of six months beginning with the first of the month in which these medical obligations are first incurred; and

7. Who has or agrees to apply all proceeds received or receivable by him or his spouse from private health care coverage or the Minnesota No-Fault Auto Insurance law to the costs of medical care for himself, his spouse and legal dependents. The local agency or the Department may require from any applicant or recipient of General Assistance Medical Care the assignment of any rights accruing under such health and accident care coverage. Any rights or amounts so assigned shall be applied against the cost of medical care paid for by the General Assistance Medical Care Program.

E. Duties of the department and the local agency.

1. Applications for General Assistance Medical Care shall be reduced to writing on forms prescribed by the Department and be filed with the local agency of the county wherein the applicant is residing. The determination of the county of financial responsibility shall be made in accordance with Minn. Stat., § 256D.18 and the procedures prescribed therein for referral of applications to other counties shall be followed.

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2. The local agency shall, within 45 days thereafter, selectively ascertain the facts supporting the application and inform the applicant by written notice of the action taken on his application. Any applicant or recipient aggrieved by any order or determination of the local agency may appeal therefrom to the Commissioner in accordance with Minn. Stat., § 256D.12.

3. Upon approval of such application (for a period of eligibility not to exceed six months), the local agency shall advise the recipient whether he may select the medical providers which are to provide him with the necessary medical services and goods or if the local agency is reserving the right to designate the medical providers for him.

4. Upon prior approval from the Commissioner, a local agency may delegate its responsibility for determining an applicant's eligibility for benefits of this program to other legally established units of county government.

5. Each local agency shall notify the Commissioner whether it will:

a. Pay the medical providers directly and claim state reimbursement (90%) in accordance with procedures established by the Commissioner; or

b. Require that all medical providers submit their claims to the Department's Central Disbursement Center for state payment directly to the providers after which the Department will bill the local agency for the county share (10%) of the payments thus made. In selecting this alternative, the local agency also agrees to:

(1) Accept all reimbursement standards and edits of the system which are applied to Title XIX payments;

(2) Maintain current eligibility records on all recipients of General Assistance Medical Care on the Title XIX recipient subsystem through the use of Form DPW-106;

(3) Reimburse 50% of the Department's costs of processing these medical provider claims.

6. Any local agency may, from its own resources, make payments for medical care for persons not otherwise eligible for this General Assistance Medical Care Program.

7. The local agencies shall administer the General Assistance Medical Program in their respective counties under the supervision of the Department, and shall make such reports, prepare such statistics, and keep such records and accounts as the Commissioner may require.

8. The local agency shall not allow payment of medical provider claims which exceed the fee schedules established by the Commissioner for the Medical Assistance Program.

F. The effective date of this Rule is January 1, 1976, for medical services and goods rendered to eligible recipients after that date.

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§ 2.060 Catastrophic Health Expense Protection.

A. Introduction.

1. Scope and purpose of rule. This rule governs administration of the Catastrophic Health Expense Protection Program (CHEPP, CHEP Program) in Minnesota. It is issued pursuant to Minn. Stat., § 62E.54, subd. 1. It provides the basis for implementation of § § 62E.51 to 62E.55.

2. Persons regulated. This rule is binding on the Department of Public Welfare, on all county welfare and human services boards (hereinafter called local welfare agencies), on all persons and organizations contracting to perform functions under the CHEPP act, on providers of health services who are paid or who request payment under the act, and on people who apply for or receive benefits under the act.

3. Uniform implementation of the rule. The Commissioner of Public Welfare shall issue handbooks and informational materials to local welfare agencies, to persons and organizations that contract to perform functions required under the CHEPP act, to providers of health services which may be paid for under the act, and to people who apply for or receive benefits under the act, so that the act and this rule are put into effect in an orderly and uniform way.

4. Civil rights protections. The CHEP Program shall be administered so as not to deny people who apply for or receive benefits their individual and civil rights. The program shall give due regard to the rights of its beneficiaries as to privacy of their personal medical records. No disclosure shall be made of such records or of personally identifiable data from them except as permitted by law and then only such pertinent data as is clearly required for proper administration of the program by those persons and organizations responsible for it.

5. Subordination of rule to State and Federal laws. Any provision of this rule which is inconsistent with any State or Federal law applicable to the CHEP Program is superseded thereby.

B. Definitions. For the purposes of this rule, the terms defined in this section have the meanings given them.

1. "Eligible person" means any person who is a resident of Minnesota and who, while a resident of Minnesota, has been found by the commissioner to have incurred an obligation to pay:

a. qualified expenses for himself and any dependents in any 12 consecutive months exceeding:

(1) 40 percent of his household income up to $15,000, plus 50 percent of his household income between $15,000 and $25,000, plus 60 percent of his household income in excess of $25,000, or

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(2) $2,500, whichever is greater; or

b. qualified nursing home expenses for himself and any dependents in any 12 consecutive months exceeding 20 percent of his household income.

Where clearly indicated by the context, "eligible person" shall also mean the dependents of an eligible person as defined below.

2. "Resident of Minnesota" means a person who is presently residing in Minnesota, having there his principal and permanent abode, and having no intent to return to some other state to live upon completion of a course of medical care. In deciding whether an applicant for CHEPP benefits is a resident of Minnesota, all important aspects of the applicant's situation shall be considered, and the decision shall be made on the preponderance of the evidence. In doubtful cases, the following forms of evidence of residence may be included in those examined:

a. The place of residence of the applicant's family members who would be eligible for CHEPP benefits;

b. The number of months that the applicant has lived in Minnesota, and, in the case of retired persons who maintain residences in two or more states, the proportion of each of the past two years which the applicant has spent in Minnesota;

c. The state in which the applicant and his spouse are:

(1) Registered to vote;

(2) Licensed to drive;

(3) Registering their car(s);

(4) Claiming a homestead for property tax relief;

(5) Employed;

(6) Doing their banking;

d. The state in which the applicant lived for a substantial period before retiring and establishing residences in two or more states.

3. "Qualified expense" means any charge incurred subsequent to July 1, 1977 for a health service which is included in the list of covered services described in Minn. Stat., § 62E.06, subd. 1, and for which no third party is liable. Such qualified expenses shall include the usual and customary charges for the following services and articles when prescribed by a physician:

a. Hospital services;

b. Professional services for the diagnosis or treatment of injuries,

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illnesses or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction;

c. Drugs requiring a physician's prescription;

d. Services of a skilled nursing facility which meets the requirements for participation as such in the Medicare program or the Medical Assistance Program, for not more than 120 days in an individual elegible person's year-long eligibility period, if the services would qualify as reimbursable services under Medicare, and if the services do not fall into the class of "qualified nursing home expenses" defined in paragraph B. 31 below, and if, in addition, the patient's attending physician certifies in writing that the services are not primarily of a custodial or residential nature;

e. Services of a home health agency if the services would qualify as reimbursable services under Medicare;

f. Use of ionizing radiation or radioisotopes for therapeutic or diagnostic purposes;

g. Oxygen;

h. Anesthetics;

i. Prostheses other than dental, but including cataract lenses;

j. Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;

k. Diagnostic X-rays and laboratory tests;

l. Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

m. Services of a physical therapist; and

n. Transportation provided by licensed ambulance service to the nearest facility qualified to treat a condition, if such ambulance transportation is medically necessary.

4. "Dependent" means a spouse, unmarried child under the age of 19 years, a child who is a student under the age of 25 and financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent, provided such spouse or child is not currently eligible for benefits under the Medical Assistance Program or the General Assistance Medical Care Program. The term "child" as used here includes legally adopted children, and it also includes financially dependent step children, foster children, and children under the guardianship of the applicant or his spouse. Eligibility for

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benefits of children reaching age 19 or 25 shall end on the last day of the birthdate month, in the eligibility year.

5. "Household income" means the gross income of an eligible person and all his dependents 23 years of age or older for the calendar year preceding the year in which an application is filed for CHEPP benefits. A dependent's age, for the purposes of this paragraph, shall be his age on the last day of the calendar year preceding the year in which application is filed for CHEPP benefits. Income paid to the applicant or his spouse on behalf of children included in the application shall be considered the applicant's income rather than the children's unless an accounting must be made for its use to some person outside the applicant family; this interpretation of children's income applies in particular to Social Security survivors' benefits. Child support legally required to be paid to a custodial parent by an absent parent shall be considered income of the custodial parent if and only if the custodial parent is not entitled to claim the child(ren) as tax dependents.

6. "Gross income" means income as defined in Minn. Stat., § 290A.03, subd. 3. Cash benefits paid to eligible persons in lieu of payments to providers of health services shall not be included in "gross income" as defined here, but payments made by the United States Veterans' Administration for "Aid and Attendance" shall be considered to be a part of "gross income" rather than medical benefits.

7. "Commissioner" means the commissioner of public welfare, or, as applicable, the commissioner's designated agent in the Department of Public Welfare, a local welfare agency, or a person or organization contracting to perform functions required for administration of the CHEP Program.

8. "Third party" means any person other than the eligible person or his dependents.

9. "CHEPP deductible" means the sum of qualified expenses which an applicant must have incurred an obligation to pay in order to become an eligible person, as defined in paragraph B.1. above.

10. "Copayment" means the 10 percent share of a reasonable charge or qualified expense, in excess of a CHEPP deductible, for which an eligible person remains liable to a provider of health services after payment of the 90 percent share by the commissioner under the provisions of the CHEPP act and this rule.

11. "Adjustment" means a payment by or to the State of Minnesota intended to change the net amount of an earlier payment made by the CHEP Program.

12. "Private health care coverage" means any plan regulated by Minn. Stat., ch. 62A, 62C, 62D, 64A, or §§ 62E.01 to 62E.17. Private health care coverage also includes any self-insurance plan providing health care benefits.

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13. "Hospital services" means any and all reasonable and medically appropriate services provided on an inpatient or outpatient basis on the direction of a physician or under his supervision by a hospital which meets the requirements for reimbursement as such by the Medical Assistance Program. Hospital services do not include outpatient mental or dental health services, drugs dispensed on an outpatient basis for consumption at some other location, home health services, outpatient oral surgery, prostheses for outpatient use, or durable medical equipment for use outside the hospital, to the extent that such services are not covered under the other provisions of the CHEP Program. Ambulance services and other medical transportation are not hospital services, per se, unless they lead to an inpatient hospital admission and are chargeable as hospital services under the rules and procedures of the Minnesota Medical Assistance Program.

14. "Physician" means a medical doctor or osteopath, a chiropractor, or a dentist acting within the scope of CHEPP coverage of dental services; licensed in the state in which he practices and acting within the scope of his license. The term does not include podiatrists, optometrists, or psychologists. The inclusion of chiropractors here within the definition of "physician" shall not imply any authority within the CHEP Program for chiropractors to prescribe other health services for coverage under the program if prescribing such services would constitute the prescribing of internal drugs, the practice of medicine, or the practice of physical therapy.

15. "Physical therapist" means an individual who meets the requirements for enrollment as such in the Minnesota Medical Assistance Program.

16. "Home health agency" means a public or private agency which specializes in giving nursing and other therapeutic and rehabilitative services in patients' homes and which is eligible for enrollment as such in the Minnesota Medical Assistance Program.

17. "Illness" means disease, injury, or a condition involving bodily or mental disorder of any kind, including pregnancy and fertility, and also including the state of reasonable personal concern for maintenance of individual health.

18. "Nursing home" means an institution which is licensed as a nursing home by the state in which it is located. The term includes facilities which meet the standards of the Minnesota Medical Assistance Program for enrollment as skilled nursing facilities or as intermediate care facilities (I), but it excludes facilities (or beds, in the case of multi-level facilities) which are classified as intermediate care facilities (II) or as intermediate care facilities (Mental Retardation).

19. "Medically necessary" means reasonable and prudent according to commonly accepted standards of medical practice as applied to a particular case at a particular point in time in the light of such information as is or could reasonably be available to the treating physician.

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20. "Medical Assistance Program" means that program of medical assistance to the poor and needy established by Title XIX of the Federal Social Security Act as of July, 1977 and, in Minnesota, by Minnesota Statutes, ch. 256B.

21. "Medicare" means that program of payment for health services for the aged and disabled established by Title XVIII of the Federal Social Security Act as of July 1, 1977.

22. "General Assistance Medical Care" (GAMC) means that program of medical assistance for the poor and needy established by Minn. Stat., ch. 256D.

23. "Health maintenance organization" (HMO) means an organization offering prepaid health services, as defined in Minn. Stat., ch. 62D.

24. "CHEPP beneficiary" means an eligible or formerly eligible person or his dependent, someone on whose behalf CHEPP benefits have been or may be paid.

25. "Provider" means a provider of health services to an applicant for CHEPP benefits or to a CHEPP beneficiary.

26. "Regular provider" means a provider of health services to a CHEPP applicant or beneficiary who (which) wishes to be reimbursed for such services directly by the CHEP Program.

27. "Usual and customary charge" means a provider's normal charge, in the absence of insurance or other plan of health coverage, for a service or supply, but not more than the prevailing charge in the state for a like service or supply.

28. "Reasonable charge" means the charge for a service or supply which would be allowable for payment under the Medical Assistance Program as administered by the Minnesota Department of Public Welfare, except that customary charge audits by provider may be omitted uniformly for practitioners and that determinations of the reasonableness of charges which require professional review may be contracted to a review organization.

29. "Review organization" means a professional standards review organization as defined in the Federal Social Security Act as of July 1, 1977, or a similar organization as defined in Minn. Stat., § 145.61.

30. "Out-of-pocket" means the personal liability of an applicant, eligible person, or a dependent of one of these. A charge or expense for a service covered by CHEPP must be an out-of-pocket expense for the applicant or eligible family. Except as provided below, this means that no third party is legally liable to pay it, and no third party has been liable to pay it and has then paid it to or on behalf of the family. If part of an expense for a covered service is paid by a liable third party or is the liability of a third party, that

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part is not a qualified expense under the CHEP Program and may not be used to satisfy the CHEPP deductible and may not be reimbursed by CHEPP. However, expenses for covered services actually paid by liable health insurance companies may be considered eligible out-of-pocket expenses for the purpose of satisfying the CHEPP deductible to the extent that the applicant or one of his dependents actually paid or contributed toward the insurance premiums, the contributions were made during the deductible period, and the services for which the insurance payments were made were received during the deductible period.

31. "Qualified nursing home expense" means any per diem charge (as "per diem charge" is defined by the Minnesota Medical Assistance Program) incurred subsequent to July 1, 1977, for nursing home services after 36 months of continuous care provided to a person less than 65 years of age in a licensed nursing home bed certified at the skilled nursing facility (SNF) or intermediate care facility "1" (ICF-1) level. Periods of inpatient hospital care and short periods of therapeutic leave from nursing home care which occur after the initial admission to nursing home care shall count as part of the 36 months.

32. "Subsequent to July 1, 1977" means on or after July 1, 1977.

33. "Residual spend-down amount" means any portion of the CHEPP deductible which for administrative convenience is arranged to be deducted from CHEPP payments after an applicant has been accepted as an eligible person.

34. "Catastrophic Health Expense Protection Program coverage 1 (CHEPP-1)" means the set of CHEPP benefits available to persons who have become eligible under the provisions of paragraph B.1.a. above. This coverage is the regular and broad coverage of the CHEP Program. It makes no restrictions on benefits on account of age, except as regards defining who may be included in a single family group.

35. "Catastrophic Health Expense Protection Program coverage 2 (CHEPP-2)" means the coverage of some part of the routine per diem costs of nursing home care for persons less than 65 years of age who have become eligible under the provisions of paragraph B.1.b. above.

36. "Applicant" means a person who has directly, or through his attorney, guardian, or personally designated representative, made application for benefits from the CHEP Program with his local welfare agency. Additionally, an applicant may be a deceased person's estate, on behalf of which an application is filed by the personal representative of the estate, subject to the restrictions in section C.2. below.

C. Establishment and duration of CHEPP eligibility.

1. Where to apply. Applications for benefits from the Catastrophic

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Health Expense Protection Program shall be taken by the local welfare agency responsible for the county in which the applicant makes his home.

2. Who may apply. Applications for CHEPP benefits may be made by a single adult person, by either spouse of a family, or by an individual's attorney, guardian, or personally designated representative, or by the administrator or court-appointed representative of a deceased individual's estate. A personally designated representative shall present written proof of his designation and shall not be an employee of or a contractor with any provider of medical services which has provided services to the applicant. No application may be made on behalf of a deceased person's estate unless the apparent heirs of the estate include the decedent's children, spouse, former spouse, or parents and these do not qualify to apply for CHEPP benefits because of age or relationship to the decedent. An applicant (that is, the person on whose behalf application is made) must be a resident of Minnesota at the time of application.

3. Delegation of authority. The director of each local welfare agency is designated as the commissioner's agent authorized to review and determine applicants' eligibility for CHEPP benefits. This authority may be further delegated to the supervisor of the administrative unit within each agency which is responsible for processing CHEPP applications.

4. Provision of information by local welfare agencies. Local welfare agencies shall answer questions from the public about the CHEP Program, using information and literature supplied by the commissioner. Local agencies shall explain the program's benefits and requirements to people who apply or who are eligible for benefits. Local agencies shall explain the state's privacy-protection law to people who apply for CHEPP benefits.

5. Filing and processing applications. Application forms and records of applicants' income and expenses for health services shall be kept in the local welfare agency for at least as long as such records are required to be kept by the Medical Assistance Program. Local agencies shall provide copies of CHEPP applications, applicants' medical bills, and other documents submitted at application, to the Department of Public Welfare as required by the commissioner. Local agencies shall determine whether an applicant is eligible for CHEPP benefits within 30 days of receiving all information and documents needed to determine eligibility. When an applicant has been found eligible, the local agency shall take whatever action is necessary to establish the applicant family as an eligible case in the State computerized Welfare Information System (the Case Information System); this updating of the Case Information System shall be completed within 10 work days of determining the applicant's eligibility.

6. Consideration of alternative welfare programs. Local welfare agencies shall request from CHEPP applicants enough information to decide whether they can qualify for Medical Assistance, General Assistance Medical Care, or some other form of welfare medical assistance such as certification of need for care at the University Hospitals. Applicants entitled to benefits

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under such other welfare programs shall be considered ineligible for CHEPP benefits if such other benefits are clearly equal to or greater than those available under CHEPP. If an applicant becomes eligible for CHEPP in preference to some other welfare program to which he is entitled, justification of the selection shall be recorded in the case record.

7. Information and documents to be supplied by CHEPP applicants. Applicants for CHEPP benefits shall provide such information and documents as are needed to establish their eligibility for the program, including as applicable the following:

a. Application data:

(1) Full names of family members included in the application;

(2) Birthdates of all family members;

(3) Current addresses of all family members included in the application;

(4) The main address of the household one month before the date of the first service offered in satisfaction of the CHEPP deductible;

(5) The Social Security Number of each family member whose income would be relevant to determining the family's eligibility for CHEPP benefits;

(6) The amount of the family's household income in the previous year, including an itemization of all such income not reported on a State or Federal income tax return or on an application for the Minnesota Renter's Credit, Income-adjusted Homestead Tax Credit, or Senior Citizen's Property Tax Freeze Credit;

(7) The Health Insurance Claim Number of each Medicare-eligible member of the applicant family;

(8) The names of all private or public plans or programs of health coverage from which one or more family members are entitled to benefits, the addresses of such plans, the policy numbers or beneficiary identification numbers for each plan, and the name of the plan group if necessary for claim filing;

(9) The names of all automobile insurance companies with which family members have no-fault medical coverages, the policy numbers, and the addresses of the companies;

(10) The names of any other third parties who are or may be liable for the cost of health services or health insurance for any family member, and current information about the status of any actions pending or contemplated for recovery of damages or benefits for health services;

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(11) The Medical Assistance Program, General Assistance Medical Care, or CHEPP identification number of each family member who has been eligible for one of those programs within the two years before the current application for CHEPP;

(12) The telephone number of the family's main home and the telephone number at work of the employed head of household;

(13) The sex and marital status of all adult family members;

b. A signed warranty by the applicant that the information supplied is true and complete, to the best of his knowledge and ability to make it such;

c. A signed assignment of third party benefits to the extent of the State's payments on the eligible family's behalf; an assignment shall be signed by the competent family member for each separate set of entitlements; each assignment shall include an authorization to release pertinent medical information for purposes of collecting health plan and other third party benefits for health services;

d. A signed authorization from each family member, other than dependent children under age 23 years, for the commissioner to inspect tax returns and applications for tax credits submitted to the Minnesota Department of Revenue, and for the commissioner to receive copies of such documents pertinent to verifying the income reported by the applicant family; the authority to inspect and receive copies of documents shall extend also to data from microforms and computer storage devices;

e. Copies of invoices from the providers of all health services whose charges are offered in satisfaction of the CHEPP deductible or for CHEPP payment, together with current information as to which charges have been billed to third parties and the extent to which such third parties have paid or are expected to pay for the charges, information as to which charges have been paid by the family out-of-pocket (with proof of payment), and a signed statement that no insurance company or other third party payment has been received or is expected to be received for charges offered in satisfaction of the CHEPP deductible or for which CHEPP payment is requested, except as explained above.

f. Proof of out-of-pocket payments for prepaid health coverages used to justify partial inclusion of payments by such prepaid plans in the eligible expenses used to satisfy the CHEPP deductible.

8. The CHEPP deductible is out-of-pocket. Eligible expenses offered in satisfaction of the CHEPP deductible must be out-of-pocket expenses and/or liabilities as defined in paragraph B.30. above. Eligible expenses attributed to the CHEPP deductible need not have been paid in advance of CHEPP eligibility, and failure of an applicant to pay them shall not affect the applicant's eligibility. Payment of such deductible expenses by relatives, friends, or other persons having no legal duty to pay shall not defeat the out-of-pocket char-

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acter of the expenses. If a payment by a liable third party is not available within a reasonable period of time (normally 120 days from the date of application), and if the applicant cannot otherwise qualify for the CHEP Program, the charges whose payment is in question may be treated as eligible expenses for satisfaction of the CHEPP deductible, provided all required assignments of benefits are signed by the member of the applicant family who appears to be entitled to the delayed or disputed third party payment.

9. Satisfaction of the CHEPP deductible. The applicant for CHEPP benefits may select which of his qualified expenses for services received subsequent to July 1, 1977 is to be the earliest for satisfaction of the CHEPP deductible. Having selected a beginning date, the applicant shall then offer his remaining qualified expenses incurred after that date in satisfaction of the deductible, in the order in which such remaining expenses were incurred. The date of an expense shall be deemed to be the date of the earliest service occasioning any part of the expense or charge. Applicants must be Minnesota residents at the time each service is received whose charge is used to satisfy the CHEPP deductible, but the services may be received in other states.

10. Income considered in special cases. If a widow or widower applies for CHEPP benefits, the income received prior to death by the deceased spouse which was paid during the calendar year preceding the application year shall be disregarded in determining the CHEPP deductible which must be met by the applicant. Similarly, if an applicant or the applicant's spouse has petitioned for a dissolution of marriage and there exists a temporary decree or other legally binding agreement specifying the terms of separation, the gross income of the non-applicant spouse shall not be considered in computing the amount of the applicant's CHEPP deductible, provided the applicant is in fact separated from and living apart from the non-applicant spouse.

11. Duration of eligibility. Eligibility for CHEPP-1 benefits shall run for 12 calendar months, beginning on the first day of the month and year of the earliest service occasioning a qualified expense offered in satisfaction of the CHEPP deductible. Such eligibility shall not cover the portion of any qualified expense offered in satisfaction of the deductible, but it may cover other qualified expenses incurred during the deductible period if such expenses were not known to be qualified at the time of application. Children who reach an age at which they become ineligible for CHEPP benefits during the 12 month period shall remain covered until the last day of the month in which they reach that age.

Eligibility for CHEPP-2 benefits shall run from the date of satisfaction of the CHEPP-2 deductible until the last day of the state fiscal year, this being currently June 30th. CHEPP-2 eligibility shall end, however, not later than the last day of the month in which the eligible nursing home patient reaches the age of 65 years.

Eligible persons who establish residence in another state shall be ineligible for CHEPP payments for services they receive after their change in residence.

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12. Eligibility for payment of qualified nursing home expenses. A CHEPP applicant's eligibility for payment of qualified nursing home expenses as defined in section B.31. above shall be figured separately from eligibility for other CHEPP benefits. Qualified nursing home expenses as defined in section B.31. shall not be used to satisfy the CHEPP deductible for other CHEPP benefits, and other qualified expenses shall not be used to satisfy the CHEPP deductible for reimbursement of qualified nursing home expenses.

13. Application for payment of qualified nursing home expenses. Persons desiring CHEPP payment of qualified nursing home expenses shall apply for payment in a timely way. Application shall be made not later than 60 days after the end of the earliest month for which payment will be requested. Applications for payments for the last month of the State fiscal year (i.e. June) shall be made not later than the last day of the following month.

Persons who wish per diem charges of nursing homes to be limited to those allowed by Medical Assistance must establish eligibility for CHEPP reimbursement in the month before the month in which the limitation on charges is claimed against the nursing home.

14. Termination of eligibility. Eligibility for CHEPP benefits may be terminated or interrupted by the commissioner if third party payments are made for services whose expenses were offered in satisfaction of the CHEPP deductible, regardless of whether they are made to the beneficiary, a provider of care, or the State. If a third party payment interrupts a family's CHEPP eligibility, the commissioner shall notify the family by letter. If the amount of deductible the family must re-incur to become eligible for CHEPP again is small, it shall be entered into the computerized central payments system as a residual spend-down amount. Then the family shall be permitted to continue to have medical claims billed to the CHEP Program, but amounts payable by the State shall be used to satisfy that residual spend-down before any actual payment is made on a family's behalf. Families which choose to re-establish eligibility for CHEPP benefits in this way are liable to providers of care for both their own copayment amounts and for State-share payments held back to satisfy the residual spend-down. Such families shall tell providers of health services of their interrupted CHEPP eligibility at the time of receiving health services.

Eligibility for CHEPP benefits may also be terminated by the commissioner upon a clear determination by the commissioner that incorrect or fraudulent data was submitted by an applicant in order to become eligible. Such a determination shall not be made until 14 days have passed from notice to the family by letter that it is being considered and that the matter may be discussed with a designated representative of the commissioner. If eligibility is terminated because of errors made in good faith in figuring a family's deductible or its satisfaction, the family may be allowed to continue in the CHEP Program with the unsatisfied deductible amount being treated as a residual spend-down amount as provided in the preceding paragraph.

Families whose CHEPP eligibility is terminated or interrupted to satisfy addi-

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tional deductible amounts shall return their CHEPP eligibility identification cards to the Department of Public Welfare, which shall issue replacement cards for families on interrupted eligibility.

15. Appeals. The final decision of the commissioner denying an application for status as an eligible person, suspending it, or revoking it, or denying all or part of the charges for a health service may be appealed by any interested party pursuant to Minn. Stat., ch. 15.

D. Administration of benefits and payments.

1. Benefits payable. Except for qualified nursing home expenses, the Department of Public Welfare shall pay 90 percent of the reasonable charge for an eligible person's qualified expenses in excess of his CHEPP deductible. The eligible person shall remain liable to the provider of health services for the remaining 10 percent of the reasonable charge for each service.

For qualified nursing home expenses, the Department of Public Welfare shall pay, at the end of each State fiscal year, an amount for each eligible person calculated as follows, unless some other formula is set by law:

+ (Reasonable cost of eligible person's qualified nursing home care during the State's fiscal year)
- (20 percent of the eligible person's household income in the calendar year before the year application is filed for CHEPP)
= Eligible person's raw entitlement

The CHEP Program will not pay more than the raw entitlement, but if there are insufficient funds earmarked for qualified nursing home expenses, the program's payments will be calculated as follows:

$$\text{Payable Amount} = \left(\begin{array}{c}\text{State Appropriation}\\ \text{for qualified}\\ \text{nursing home}\\ \text{expenses}\end{array}\right) \times \left(\frac{\text{Eligible person's raw entitlement}}{\begin{array}{c}\text{The sum of all eligible}\\ \text{persons' raw entitlements}\end{array}}\right)$$

2. Forgiveness of disallowed charges. If a charge for a covered service to an eligible person is billed to CHEPP, any part of the charge determined by the Department of Public Welfare to be more than a reasonable charge, or the entire charge if the service is determined to have been not medically necessary, shall be deemed to be an unconscionable fee, against the public policy of this state and unenforceable in any action brought for the recovery of moneys owed. Charges for qualified nursing home expenses shall be considered billed to CHEPP and subject to limitation on the first day of the month following written notice to the nursing home of a patient's eligibility.

In the case of nursing home care which occasions qualified nursing home expenses, any per diem charge for qualified nursing home care given to a person eligible for CHEPP benefits shall be deemed to be a reasonable charge if it is

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not more than the charge per diem allowed in that section of that facility for that level of care by the Minnesota Medical Assistance Program.

3. Persons to whom payment are made. CHEPP-1 benefits shall be paid only to providers of health services, and then only after receipt of a proper billing for review and adjudication; provided, however, that benefits shall be paid to eligible persons directly if the eligible person has already paid the provider and the services were received before the date of the eligible person's application for CHEPP. CHEPP-2 benefits shall be paid to the eligible nursing home resident or on his behalf to his spouse or guardian.

4. Post-payment adjustments. Adjustments to amounts paid by the CHEPP Program shall be settled between the provider and the Department of Public Welfare at 100 percent, with no payment or collection of copayments to or from CHEPP beneficiaries.

5. Enrollment of regular providers. Regular providers of services to CHEPP beneficiaries shall give the Department of Public Welfare the same enrollment information and provider agreements that are required for enrollment in the Medical Assistance Program, if these have not been given already to the program. Providers already enrolled in the Medical Assistance Program will be enrolled automatically as providers of services for CHEPP beneficiaries unless they ask in writing not to be. Acceptance of payments on behalf of CHEPP beneficiaries by providers enrolled in the Medical Assistance Program shall be deemed to be an acceptance of the terms of this Rule and to extend the provider's agreement with the Medical Assistance Program to cover services to CHEPP beneficiaries.

6. Invoicing procedures. Regular providers of service to CHEPP beneficiaries shall bill the CHEP Program directly, using approved Minnesota Medical Assistance Program invoices and forms. This requirement for billing by providers may be waived by the Department of Public Welfare for services provided and billed before the date an applicant for CHEPP benefits is told that he or she is eligible.

If a provider of health services knows that a patient is eligible for CHEPP benefits, other than qualified nursing home expenses, he shall not try to collect charges from the patient or his family for services which are to be billed to CHEPP until the amount of the CHEPP beneficiary's copayment liability has been reported to the provider by the Department of Public Welfare. (A provider may, however, seek third party payments for services to CHEPP beneficiaries, provided that any third party recoveries of charges for services paid for in part by CHEPP are reported to the CHEP Program.)

Providers who bill the CHEP Program shall accept the program's determination of what will constitute reasonable charges for services to CHEPP beneficiaries, and they shall not attempt to collect from beneficiaries any charges disallowed by the program as excessive or as being for services deemed not medically necessary.

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7. Third party (insurance) claims. Providers shall bill third parties known to be liable for health services provided to CHEPP beneficiaries or shall supply sufficient information to the Department of Public Welfare to allow the department to claim reimbursement under its rights of assignment or subrogation. Providers shall not supply known CHEPP beneficiaries with invoices requesting payment for services to be billed to the CHEP Program unless such invoices are prominently marked to indicate that payment by the CHEP Program will be or has been requested.

8. CHEPP beneficiary identification cards. CHEPP beneficiaries shall be provided with identification cards giving the dates of their eligibility and their identification numbers. Beneficiaries shall show these cards to providers of health services before they receive services for which they expect part payment by CHEPP. CHEPP beneficiaries eligible only for part payment of qualified nursing home expenses shall receive separate and distinct identification cards or letters.

9. Non-qualifying expenses. Charges for the following shall be considered to be not qualified expenses, not covered by the CHEP Program:

a. Cosmetic surgery, except to repair an injury or birth defect;

b. Private hospital or nursing home rooms, to the extent that the charges exceed the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician. If an institution has no semi-private rooms, its most common semi-private room charge shall be deemed to be 90 percent of its lowest private room charge;

c. Trans-sexual surgery;

d. Artificial insemination;

e. Reversals of sterilizations entered into originally with free and informed consent;

f. Autopsies;

g. Missed appointments;

h. Costs of billing;

i. Inpatient psychiatric care substituted for outpatient care primarily to acquire reimbursability of the services under the CHEP Program.

Procedures used by the Minnesota Medical Assistance Program for review of the appropriateness or medical necessity of health services shall be used for the review of claims for CHEPP payments to the extent that they are not incompatible with this rule or with the Catastrophic Health Expense Protection

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Act. Providers of care shall observe such procedures, including prior-authorization procedures, as a condition of receiving payments from the CHEP Program.

10. Termination of provider enrollments. Providers may be terminated from enrollment as eligible payees under the CHEP Program according to the procedures established for such termination in the Minnesota Medical Assistance Program. Providers terminated from the Medical Assistance Program for misconduct shall be simultaneously terminated from the CHEP Program.

Effective Date: May 15, 1978.

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§ 2.061 Early and periodic screening, diagnosis and treatment.

A. Introduction. This rule governs the administration of the Early and Periodic Screening, Diagnosis and Treatment Program (hereinafter referred to as the EPSDT Program). This program is mandated by Section 1905(a)(4)(B) of the Social Security Act.

The purpose of the EPSDT Program is to identify potentially handicapping conditions in children eligible for Medical Assistance, to provide diagnosis and treatment for conditions identified, and to encourage the entrance of children into the health care system.

Note: It is the intention of the Department, in order to ensure effective delivery of EPSDT services, that parents be involved with the child throughout the screening, diagnosis and treatment process. However, since the program includes "children" through age twenty, the Department recognizes that some children, including teenagers and adults who are eighteen through twenty, may be able to supply requested information themselves and may not wish to have their parents involved in the screening process. To allow for such cases, references in this rule are made to "parent/child". In using this language, the Department intends that health providers and local welfare agencies involve the parent whenever possible in the program, but also recognize the right of the child to privacy.

B. Definitions.

1. Child: For purposes of this rule, any individual from birth through twenty years of age who is eligible for Medical Assistance.

2. Commissioner: The Commissioner of Public Welfare.

3. Department: The Department of Public Welfare.

4. Diagnosis: Determination of the nature or cause of physical or developmental disease or obnormality through the use of health history, physical, developmental, and psychological examination, laboratory tests and x-rays.

5. EPSDT equivalent clinic: A facility which provides screening services according to Minnesota Department of Health EPS standards, provides follow-up services, and is monitored by the Minnesota Department of Health. Such facilities provide comprehensive care in a sequence incompatible with the completion of the EPSDT billing form.

6. EPSDT provider agreement: An agreement between a provider of screening services and the Department that the provider, in order to qualify for Medical Assistance reimbursement, will screen each Medical Assistance child according to the appropriate screening standards specified in Section D. of this rule, will report all findings on the EPSDT billing form, and will refer children according to procedures specified in Section G.2. of this rule.

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7. Follow-up: Efforts by local agencies to ensure that the screening, diagnosis and treatment services needed by a child are obtained.

8. Local agency: The county welfare board, multi-county welfare board, or human service agency established in accordance with state law and responsible for the administration of the EPSDT Program at the county level.

9. Medical Assistance: Program authorized under Title XIX of the Social Security Act to provide medical care for individuals whose resources do not enable them to purchase such care.

10. Minnesota Department of Health-Approved EPS Clinic: An agency which provides screening services according to Minnesota Department of Health screening and administrative standards, which operates under the supervision of a registered nurse, public health nurse, or pediatric/family nurse practitioner, and which qualifies for Medical Assistance and other public third party reimbursement.

11. Nurse-supervised EPSDT clinic: A facility or individual which provides screening services according to Minnesota Department of Health screening standards and Department of Public Welfare administrative standards. Such clinics operate under the supervision of a registered nurse, public health nurse, or pediatric/family nurse practitioner, and qualify for Medical Assistance reimbursement.

12. Outreach: Efforts by the Department or local agencies to inform and encourage persons to avail themselves of services which they might not otherwise request without such assistance.

13. Periodic: At regular, fixed intervals established for screening by health care experts to assure that disease or abnormality is not incipient or has not appeared since the child's last evaluation.

14. Physician-supervised EPSDT clinic: A facility or individual which provides screening services according to physician screening standards, which operates under the supervision of a licensed physician, and which qualifies for Medical Assistance reimbursement.

15. Screening: The use of quick, simple procedures to sort apparently well children from those who need more definitive study of possible physical or developmental problems.

16. Treatment: The use of medical care and services to prevent, correct or ameliorate disease or abnormalities detected by screening and diagnostic procedures.

C. Eligibility.

1. All persons from birth through age twenty who are eligible for Medical Assistance are eligible for the EPSDT Program.

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2. Eligibility for the EPSDT Program terminates when Medical Assistance eligibility terminates, regardless of the child's status in the EPSDT process.

D. Physician screening standards. A licensed physician must provide the following components in order for an examination to be reimbursed as a screening under the EPSDT Program.

1. Health history: A health and developmental history must be obtained from the child, the parent, and/or another responsible adult who is familiar with the child's health history and must include information on lead and tuberculosis exposure, nutrition intake, and seizure history.

2. Assessment of physical growth: The child's height and weight must be measured and compared with the ranges considered normal for children of that age. Head circumference measurements must be taken for children under three years of age.

3. Physical examination: The following areas must be checked according to accepted medical procedures: pulse, respiration, blood pressure, head, eyes, ears, nose, mouth, pharynx, neck, chest, heart, lungs, abdomen, spine, genitals, extremities, joints, muscle tone, skin, and neurological examination.

4. Dental inspection: The mouth must be examined for any obvious dental problems. A child who is three years of age or older must be referred to a dentist for preventive care if she/he has never been to a dentist or if it has been one year since the last dental appointment.

5. Vision:

a. Children under the age of three years:

(1) Must be checked for a history of:

(a) Maternal and/or neonatal infection.

(b) Family history of ocular abnormalities.

(2) Must be observed for:

(a) Pupils and light following reflex.

(b) Presence/absence of nystagmus.

(c) Muscle balance—examination for esotropia, exotropia, large phorias.

(d) External examination of eyes, including lids, conjunctiva and cornea.

(e) Parental concern regarding child's vision.

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b. Children over the age of three years:

(1) Must be checked for all of the items contained in Section D.5.a.

(2) Must, in addition, be checked for visual acuity. A test such as the STYCAR, the Snellen E Cube, the Snellen E Chart, and the Snellen Alphabet Chart, or their equivalent, must be used.

6. Hearing:

a. Children under the age of three years must be observed for:

(1) Retardation of language acquisition or history of such retardation.

(2) Failure to directionalize to sounds.

(3) History of repeated otitis media during early life.

(4) Parental concern regarding child's hearing.

b. Children over the age of three years:

(1) Must be observed for all of the items contained in Section D.6.a. (1) through (4) above.

(2) Must receive a pure tone audiometric test or referral for pure tone audiometric testing if items (1) through (4) above indicate the need for audiometric testing.

7. Developmental screening:

a. For children ages birth through five years, the Denver Prescreening Developmental Questionnaire (PDQ) must be completed. All children who fail the PDQ must be screened further by use of the Denver Developmental Screening Test (DDST). If the screener does not provide the DDST, referral must be made to an agency that does provide it.

b. For children ages six through twenty years, the provider must screen for the following areas according to his/her standard procedures: fine/gross motor development, speech, and socialization. Developmental questions must be included on the health history for this age group.

8. Sexual development:

a. Sexual development appropriate to the child's age must be checked for all children, with special emphasis given to children who have reached puberty.

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b. At the request of the parent/child, counseling on normal development, birth control and venereal disease, as well as appropriate prescriptions and testing, must be provided by the screener, or referral to appropriate resources must be made.

c. The option to receive a pelvic examination with appropriate testing (GC, Pap Smear, other tests at provider's discretion) must be offered to all females who have reached puberty.

9. Nutritional status:

a. A child having any detectable nutritional deficiencies must receive nutritional counseling or must be referred for such counseling.

b. When a child's history reveals that his/her diet regularly lacks two or more daily servings from one of the four basic food groups, the parent/child must receive nutritional counseling or must be referred for nutritional counseling even if there are no objective signs of poor nutrition.

10. Immunizations: The immunization status of all children must be checked. Needed immunizations must be offered and provided if requested. Immunizations must be administered according to the Recommended Schedule of Immunizations developed by the Minnesota Department of Health and approved by the Minnesota State Medical Association.

11. Laboratory tests:

a. Tuberculin testing: Must be performed for all children once at fifteen months of age or at their first screening, if this screening occurs later than fifteen months. A child may receive additional tuberculin testing at later ages if his/her history indicates the possibility of exposure.

b. Lead absorption testing: Must be performed on all children whose history and physical findings indicate the possibility of exposure to undue levels of lead in the environment or atmosphere.

c. Urine testing: All children over the age of two years must be tested at their first screening for the presence of glucose, ketones, protein and other abnormalities in the urine. Females (at or near the ages of four and ten) must be tested for bacteriuria.

d. Anemia testing: All children must be tested for anemia by use of either a microhematocrit determination or a hemoglobin concentration. This test should be done near the ages of six months, one year, two years, four years, and fifteen years.

e. Sickle cell testing: Tests for sickle cell disease or trait must be offered to all children known to be at risk and must be provided if requested by the parent/child. Only one sickle cell test is needed. If sickle cell trait is found, parent/child must be referred for genetic counseling if they so desire.

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f. Other laboratory tests: Tests for cervical cancer, venereal disease, pregnancy and parasites should be performed when indicated and charged as part of the screening examination.

12. Variation from screening procedures: If a provider wishes to substitute other procedures for those contained in Section D.1. through D.11., or wishes to omit any of the required procedures, written application must be made to the EPSDT Section in the Department. All such requests shall be reviewed by a Physician Advisory Committee and a decision on the request shall be made by the Committee, in writing within 30 days of the receipt of the request.

E. Nurse screening standards. The Department will recognize as screening providers all nurse-supervised EPS and EPSDT clinics which follow the screening standards and periodicity schedule devised by the Minnesota Department of Health. Screenings performed by these providers will be reimbursed under the EPSDT Program.

F. Periodicity schedule.

1. The department will offer all children who have been screened the opportunity for re-screening at the following ages: six months, nine months, one year, eighteen months, two years, four years, and every three years thereafter. The department will notify all eligible recipients of the availability of screening services at least once a year if they have not received an initial screening.

2. For physician-supervised EPSDT clinics, screening components must be provided according to the attached Physician EPSDT Periodicity Schedule.

G. Conditions of screening provider participation in the EPSDT program.

1. All screening providers must complete the EPSDT billing form with one total charge submitted for the complete screening package.

a. The parent/child must be provided with a copy of the billing form.

b. Screening providers which are designated as EPSDT Equivalent Programs by the Department need not complete the billing form. In order to receive such a designation, a facility must screen children according to Minnesota Department of Health standards, must provide follow-up services to those children, and must be monitored by the Minnesota Department of Health. EPSDT Equivalent Programs may submit screening statistics in aggregate form.

2. All screening providers must complete a screening referral form, supplied by the Department, and provide this form to the parent/child in every instance when a child is referred for further diagnosis and treatment.

3. All screening providers must sign an EPSDT Provider Agreement whereby they agree to the provisions of Sections G.1. and G.2. above.

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4. In order to qualify for Medical Assistance reimbursement, screening providers must follow all requirements for Medical Assistance Program participation as specified in DPW Rule 47 (12 MCAR § 2.047).

5. All screening providers shall be reimbursed according to their usual and customary fee until six months after this rule is published. At that time, the Department will establish one maximum screening fee for physician supervised clinics and another maximum screening fee for nurse supervised clinics.

Each of these maximum fees shall be equal to the seventy-fifth percentile of all screening charges submitted by each group during that six month period. After the maximum fees are established, screening providers shall be reimbursed according to their usual and customary fee or the Department's maximum fee, whichever is lower. The maximum fee shall be updated yearly.

6. Health Maintenance Organizations which participate in the Medical Assistance Program must provide EPSDT services as part of their contract with the Department for their enrollees at no extra charge to the Department, and must complete the EPSDT billing form for each child screened.

7. Screening providers may, after notifying the Department, elect to provide one or more of the screening components by referral to other providers. In such cases, the screening provider must ensure that the child receives the components for which he/she was referred before the screening is billed.

8. Screening providers may provide an outreach component as part of the screening and may charge for the extra outreach service after they have submitted a budget to the Department which justifies the outreach charge.

9. The Department must provide:

a. Training on screening components to all providers who sign the EPSDT Provider Agreement and who request such training.

b. Assistance in obtaining the forms and materials needed in the screening process.

10. The parent/child who requests screening services has free choice of all local screening providers who have signed EPSDT Provider Agreements.

H. Conditions of diagnosis and treatment provider participation in the EPSDT program.

1. Any health care provider licensed under state law who has signed a Medical Assistance Provider Agreement is eligible to provide appropriate diagnostic and treatment services to a child who has been screened.

2. Diagnosis and treatment providers must bill according to regular

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Medical Assistance procedures as outlined in DPW Rule 47 (12 MCAR § 2.047). In addition, providers who diagnose or treat a child who has been screened, pursuant to Sections D. and E., above, must complete the billing invoice so as to indicate that this child is being diagnosed or treated as part of the EPSDT Program. The Department will make payments according to regular Medical Assistance procedures as specified in DPW Rule 47 (12 MCAR § 2.047).

3. Diagnosis and treatment providers must follow all requirements for Medical Assistance Program participation as specified in DPW Rule 47 (12 MCAR § 2.047).

4. The child or parent of the child who is referred for diagnosis and treatment as a result of a screening has free choice of all local diagnosis and treatment providers who are enrolled in the Medical Assistance Program.

I. Local agency responsibilities.

1. Outreach.

a. The local agency must notify all applicants for programs which include Medical Assistance eligibility about the EPSDT Program if the applicant or any of his/her children are under 21 years of age.

(1) The notification must include an oral and written explanation of the program.

(2) The notification must take place within thirty days of the date of application.

(3) The local agency must obtain a definite response in writing from each applicant for each child in the family within thirty days of the date of notification.

b. The Department will notify, in writing, parents, whose children have been screened, of their eligibility for re-screening at periodic intervals. The Department will also re-notify parents whose children have never been screened of their continuing eligibility for an initial screening. The local agency will receive the response and must handle the response per Section I.2. through I.6.

2. Response to a screening request.

a. The local agency must provide each parent/child who accepts EPSDT services with a written list of screening providers in the area.

b. The local agency must, in writing, offer transportation to each parent/child who accepts EPSDT services and must provide transportation to the screening site to each child who requests such transportation or for whom such transportation is requested.

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c. The local agency must, in writing, offer assistance in making the screening appointment to each parent/child who accepts EPSDT services and must provide such assistance to each child who requests it or for whom such assistance is requested.

3. Follow-up after a screening request.

a. The local agency must make one additional offer of assistance to each parent/child who accepted screening services and was not screened within sixty days.

b. This offer of assistance may be done by a home visit, telephone call, or letter.

4. Follow-up for diagnosis and treatment.

a. The Department, through the screening provider, will notify each parent/child who is referred for diagnosis and treatment, in writing, that the local agency will provide assistance, including transportation, in obtaining the needed diagnosis and treatment.

(1) If requested, the local agency must provide names and addresses of providers of the needed diagnostic and treatment services.

(2) If requested, the local agency must provide transportation to the diagnostic and treatment site.

b. The local agency must make one additional contact, within sixty days of the screening, with each parent/child who was referred for diagnosis and treatment in order to ascertain if needed diagnosis and treatment has been obtained.

(1) This contact must be made by either a home visit or telephone call.

(2) If diagnosis and treatment has not been obtained, the local agency must offer assistance, including transportation and/or a list of diagnosis and treatment providers, and must provide such assistance if requested.

(3) If the local agency has previously been informed that the child has received the needed diagnosis and treatment, this contact need not be made.

5. Local agencies must provide EPSDT notification and follow-up services to non-English speaking, illiterate and disabled applicants and recipients by a mode of communication which will enable them to fully understand and utilize the program.

6. Children in foster care eligible for Medical Assistance.

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a. The local agency must accept EPSDT services for all foster children who are dependent/neglected state wards and who are eligible for Medical Assistance, except when such acceptance would not be in the best interests of the child.

b. The local agency must discuss the availability of EPSDT services with the parents of all foster children who are eligible for Medical Assistance and who are under the legal custody of the local agency or whose parents have entered into a voluntary placement agreement with the local agency except when the natural parents are not available for such a discussion. If the parent is not consulted, the local agency must decide whether or not to accept EPSDT services for the child and must document the reasons for such a decision. The local agency must assist the parent in deciding whether to accept EPSDT services.

c. The local agency must provide the case management services defined in Section I.2. through I.4. above to all foster children for whom EPSDT services are accepted.

d. The Department will notify the local agency in writing when foster children who are eligible for Medical Assistance are eligible for periodic re-screenings. The local agency must handle these notifications as specified in Section 6.a. and 6.b. above.

7. Documentation. Local agencies must document the completion of requirements in Section I.1. through I.4. above on forms prescribed by the Department.

8. Inter-agency coordination. Local agencies must cooperate, whenever possible, with other agencies which provide health services to children so that duplication of services is avoided. Examples of such agencies are local nursing services, local Head Start agencies, and local school districts.

9. Reimbursement for EPSDT staff.

a. Local agencies which intend to claim Title XIX federal financial participation at seventy-five percent for salaries and expenses of EPSDT administrative support staff must obtain written authorization from the Department by submittal of a plan that meets state and federal program requirements.

b. Local agencies which intend to claim Title XIX federal financial participation at seventy-five percent for contracts with outside agencies to perform EPSDT administrative support services must obtain written authorization from the Department by submittal of a plan that meets state and federal program requirements.

Effective Date: June 6, 1978.

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PHYSICIAN EPSDT PERIODICITY CHART

INTERVALS	MONTHS						YEARS					
	0-5	6-7	8-11	12-15	16-19	20-35	3-4	5-7	8-10	11-13	14-17	18-21
Health History	X	X	X	X	X	X	X	X	X	X	X	X
Assessment of Physical Growth:												
-Height	X	X	X	X	X	X	X	X	X	X	X	X
-Weight	X	X	X	X	X	X	X	X	X	X	X	X
-OFC	X	X	X	X	X	X						
Physical Examination	X	X	X	X	X	X	X	X	X	X	X	X
Dental Inspection	X	X	X	X	X	X	X	X	X	X	X	X
Vision	X	X	X	X	X	X	X	X	X	X	X	X
Hearing	X	X	X	X	X	X	X	X	X	X	X	X
Developmental:												
-PDQ/DDST	X	X	X	X	X	X	X					
-Interview/History Only								X	X	X	X	X
Sexual Development	X	X	X	X	X	X	X	X	X	X	X	X
Nutrition Review	X	X	X	X	X	X	X	X	X	X	X	X
Immunization Review	X	X	X	X	X	←	←	X	←	←	X	←
Tuberculin				X	←	←	←	←	←	←	←	←
Lead Absorption Testing	IF HISTORY INDICATES											
Urine						X	←	←	←	←	←	←
Bacteriuria (females)							X	←	X	←	←	←
Anemia Testing		X	←	X	←	X	X	←	←	←	X	←
Sickle Cell	AT PARENT'S OR CHILD'S REQUEST											
Other Lab Tests	AS INDICATED											

← Procedure to be completed if not done at the previous visit, or on the first visit.

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Repealed 7SR 1376
3-28-83

§ 2.063 Administration of Work Equity Project.

A. Introduction.

1. This rule governs administration of the Work Equity Project (WEP) as authorized by Minn. Stat. § 256.736 (amended, 1977) and § 256D.04 (amended, 1977). WEP is a work and training demonstration project jointly administered by the Minnesota Department of Public Welfare (DPW), the Minnesota Department of Economic Security (DES), and the City of St. Paul, and funded through an initial grant of $6.8 million by the United States Department of Labor (DOL) through the Comprehensive Employment and Training Act (CETA) and the Work Incentive Program (WIN). The purpose of the project is to provide employment opportunities, training, and services in a uniform manner to applicants and recipients of General Assistance, Aid to Families with Dependent Children, and Food Stamps, and to provide a model for evaluation of certain national welfare reform proposals. The provisions of this rule are to be read in conjunction with Title IV of the Social Security Act, 42 U.S.C. § 601 et seq. (amended, 1977); the Food Stamp Act of 1964, 1977, 7 U.S.C. § 2011 et seq. (amended, 1977); the Comprehensive Employment and Training Act (CETA) of 1973, as amended, 29 U.S.C. § 801 et seq. (amended, 1977); Titles 7, 29, and 45 of the Code of Federal Regulations; Minn. Stat. Chaps. 256, 256D, and § 268.10; and DPW 44, 55, and 202.

2. This rule is binding on DPW and DES, all county welfare and human services boards (hereinafter called local welfare agencies), and applicants and recipients as defined and outlined in this rule.

3. The Commissioner of DPW and the Commissioner of DES shall issue handbooks and informational materials to local welfare agencies, to local offices of the Department of Economic Security and the Prime Sponsors, and to people who are referred to WEP, to implement this rule in an orderly and uniform manner. For those participants whose primary language is not English, translation services shall be made available at all phases of an individual's participation in WEP.

B. Administration.

1. WEP is a pilot project designed to extend the scope and services available through the WIN program, the General Assistance Work Program, and Food Stamp work registration. In those counties selected by the Commissioner of DPW for participation in WEP, this rule shall be read in conjunction with DPW 44, 55, and 202; any irreconcilable differences shall be resolved in favor of this rule. In these counties not selected for participation in WEP, provisions of DPW 44, 55 and 202 shall apply without change.

2. WEP shall combine the efforts and resources of DPW, DES, and the City of St. Paul to provide appropriate employment or training for designated public assistance applicants and recipients and shall operate in conjunction with the St. Paul and Minnesota Balance of State Prime Sponsors designated pursuant to CETA.

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3. Agreements between, among, or within DPW, DES, St. Paul CETA Prime Sponsor and the Balance of State CETA Prime Sponsor shall specify the obligations that they have for the administration of WEP. A representative of each agency shall be named to a Management Board which shall meet regularly to coordinate implementation and operation of WEP. All parties to the agreements shall have copies of the agreements on file, which are public documents available for examination during business hours.

4. WEP shall provide to its participants all services available to WIN participants and shall increase the opportunities for training and jobs available through a work incentive program to additional numbers of public assistance recipients. WEP shall comply with all applicable federal statutory, regulatory, and administrative requirements of the WIN program unless specifically waived by the United States Departments of Labor or Health, Education and Welfare.

5. The Commissioner of DPW shall select the counties to participate in WEP, shall determine the date such participation shall begin and shall supervise WEP in the local welfare agencies in accordance with this Rule and with equitable standards for assistance and administration which shall be mandatory for all counties selected for participation in WEP.

6. No funds allocated to WEP shall be used for any political activity or to further the election or defeat of any candidate for public office; nor shall they be used to provide services, or for the employment or assignment of personnel in a manner supporting or resulting in the identification of programs conducted pursuant to the Social Security Act with:

a. Any partisan or non-partisan political activity or any other political activity associated with a candidate, or contending faction or group, in an election for public or party office, or lobbying for any matter at public issue;

b. Any activity to provide voters or prospective voters with transportation to the polls or similar assistance in connection with any such election;

c. Any voter registration activity.

7. The local welfare agencies shall be fully reimbursed for increased local expenditures resulting from operation of the Work Equity Project. DPW shall establish pre-WEP baseline data on county income maintenance, medical, social service, and administrative costs. Local welfare agencies shall provide WEP with staff and other resources equivalent to the resources the agency would otherwise be required to allocate to other work and training programs and related services if the applicants and recipients had not been placed in WEP. WEP shall reimburse counties for any additional costs incurred by the counties which are directly attributable to WEP, in a manner to be agreed upon between DPW and DES.

In order to determine the reimbursement formulae, counties shall provide

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necessary information to DPW and shall enter GA and Food Stamp information on the DPW case information system, as required by the Commissioner of DPW.

Payments to or from WEP and the local welfare agencies shall be made on a quarterly basis.

8. Income maintenance funds which are not expended by local welfare agencies as a result of a recipient's participation in WEP shall be diverted to WEP, in accordance with internal management procedures to be established by DPW and DES. The reimbursement formulae, referred to in Section B. 7. above, shall be used to determine the amounts, if any, to be diverted to WEP.

Payments to or from WEP and the local welfare agencies shall be made on a quarterly basis.

9. WEP administration shall not deny any person his/her civil rights. The program shall give due regard to the privacy rights of applicants and/or recipients, in accordance with 45 CFR Part 205 and the Minnesota Data Privacy Act, Minn. Stat. § 15.162 et seq. (amended, 1978). No disclosure shall be made of personally identifiable data from records or from applicants or recipients except as permitted by law.

If any participant is requested to supply information to an outside evaluation group or individual evaluating, critiquing or monitoring WEP or its participants or the effect of WEP on its participants, or if an individual is requested to submit to any testing or interviewing by such group or individual, the participant shall be fully informed that participation is voluntary and shall be fully informed that refusal to participate in the evaluation shall not result in deregistration from WEP or disqualification from public assistance benefits. Prior to requesting information for this purpose, the evaluation group or individual shall obtain the participant's informed consent. The evaluation group or individual shall use the information acquired solely for the purposes explained to the participant at the time the consent was obtained, and as permitted by law.

10. Notwithstanding any provisions of this rule, administration of WEP is subject to changes in state or federal law. The Commissioner of DPW shall notify the local welfare agencies of changes affecting the participation of public assistance recipients in WEP. The Commissioner of DES shall notify the local offices of the Department of Economic Security and the Prime Sponsors of changes in WEP and related programs.

11. Operation of WEP is subject to approval by the United States Department of Health, Education, and Welfare (DHEW) for the participation of AFDC participants; the approval of the United States Department of Agriculture for the participation of Food Stamp recipients; and the approval of the entire project by the United States Department of Labor (DOL). Operation of WEP is also contingent upon sufficient funding from the DOL. The Prime Sponsors shall give prompt notice to each participant of the project's

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termination and shall make every reasonable effort to assist each participant to obtain substitute services.

12. Work Equity shall contract with, or obtain voluntary assistance from, outside agencies, groups, or individuals, to provide advocacy services at each WEP Center. With the consent of the participants, one or more advocates shall be present at each group orientation to inform participants of the availability of advocacy services. Literature or forms provided to participants which mention the WEP grievance and adjudication system shall state that participants are entitled to the assistance of an advocate.

C. Definitions.

1. AFDC (Aid to Families with Dependent Children): A program authorized by Title IV of the Social Security Act, 42 U.S.C. § 601 et seq. (amended, 1977), to provide financial assistance and social services to needy families with dependent children.

2. Applicant: A person who requests AFDC, GA, or Food Stamps from the local welfare agency, whose eligibility has not yet been determined.

3. Appraisal: The interview of a WEP participant by WEP Center staff including support service staff to determine employability potential, the need for support services, and to initiate an employability plan.

4. Certification: A written notice by the support service staff that necessary support services have been arranged or are available to enable a WEP participant to accept employment, training, or services; or that no such services are needed and that the individual is at that time ready for employment or training.

5. Classroom Training (CT): Vocational or other institutional training, including basic or remedial education, conducted in a non-worksite setting.

6. Commissioner of Economic Security: The Commissioner of the Minnesota Department of Economic Security or his/her designee.

7. Commissioner of Public Welfare: The Commissioner of the Minnesota Department of Public Welfare or his/her designee.

8. Community Work Project (CWP): A subsidized work component that fulfills a public service and provides an individual an opportunity to develop skills and basic work habits helpful in securing unsubsidized employment.

9. Complaints: (See Grievance).

10. Component: A structured, regularly scheduled program activity for certified WEP participants.

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11. Deregistration: Termination of an individual's WEP registration.

12. DES: The Minnesota Department of Economic Security.

13. DHEW: The United States Department of Health, Education, and Welfare.

14. DOL: The United States Department of Labor, specifically, its Employment and Training Administration.

15. DPW: The Minnesota Department of Public Welfare.

16. Employability Plan: A written plan for a WEP participant that sets forth that individual's occupational goal, and the employability and support services necessary for him/her to reach that goal.

17. Employability Services: Employment and training services provided by the WEP Center to improve the work skills of a participant and aid him/her to find employment.

18. Exempt: An AFDC, GA, or FS applicant or recipient who is not required to register for employment or training under the Work Equity Project as a condition of eligibility for welfare benefits.

19. Food Stamp Program: A program authorized by the Federal Food Stamp Act of 1964, 1977, 7 U.S.C. § 2011 et seq. (amended 1977), to provide assistance to needy families and individuals.

20 General Assistance (GA): A program authorized by Minn. Stat. Chap. 256D to provide financial assistance to needy families and individuals.

21. General Assistance Medical Care (GAMC): A program authorized by Minn. Stat. Chap. 256D to provide assistance to families and individuals in need of medical care.

22. Grievance: A written complaint initiated by a WEP participant. Grievances may include, but are not limited to, disputes over assignments where the participant is not refusing the assignments; alleged discrimination; and complaints about eligibility for or amounts of WEP allowances.

23. Hearing Officer: The hearing officer designated by DES to hear and decide issues relating to grievances and sanctionable issues involving WEP participants.

24. Incentive Payment: A cash payment to an individual, who is participating in a non-wage WEP component. The incentive payment is to be an inducement to the participant to engage intensively in WEP activities as preparation for entering employment; it does not compensate or reimburse a participant for any costs that are incurred in connection with WEP participation.

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25. Income Maintenance Funds: Amounts of AFDC or GA to meet basic living costs of eligible individuals in accordance with established standards of need.

26. Income Maintenance Unit (IMU): The unit of the local welfare agency which determines individual eligibility for AFDC, GA, or Food Stamps.

27. Intensive Manpower Services (IMS): Structured employment-related services; including job development and placement services offered to WEP participants so they may more readily obtain unsubsidized employment.

28. Job Service (also known as State Employment Service): A program within the Department of Economic Security, established in accordance with the provisions of the Wagner Peyser Act, 29 U.S.C. § 981 et seq. (amended, 1977).

29. Management Board: Representatives from the City of St. Paul CETA, Balance of State CETA, DES, DPW, and WEP responsible for the design and administration of WEP.

30. Mandatory: A person who is not exempt.

31. Medical Assistance (MA): A program authorized by Title XIX of the Social Security Act to provide assistance to needy families or individuals in need of medical care, implemented in Minnesota by Minn. Stat. Chap. 256B.

32. Medical Verification: A statement signed by a physician or licensed psychologist which attests to an individual's ability or inability to accept employment or participate in other WEP activity. Oral testimony presented in person by such physician or licensed or certified psychologist may also be accepted as medical verification.

33. Non-Wage Component: An activity, such as IMS, Employability Development Plan (EDP), and Classroom Training, wherein allowances and incentives are paid for suitable participation.

34. On-the-Job Training (OJT): Employment of a WEP participant during which he/she is provided with employment training at a work site under a contractual agreement between a public or private employer and the Prime Sponsor. The employer is reimbursed for the extraordinary costs of such training.

35. Participant: An AFDC, GA or Food Stamp applicant or recipient who has registered with WEP.

36. Prime Sponsor: A public agency (or private, non-profit corporation) which operates WEP within the jurisdiction(s) in which it is expressly authorized by the DOL to administer funds authorized pursuant to CETA Titles I and II.

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37. Public Service Employment (PSE): Subsidized transitional employment with non-profit employers or public employers, funded by CETA.

38. Recipient: An individual who has been determined eligible to receive AFDC, GA or Food Stamps.

39. Referring Agency: The local welfare agency, or local Job Service office responsible for referring applicants and recipients to the WEP center.

40. Sixty-Day Counseling: Counseling and other services provided by the support service staff to certified WEP participants who have been determined to have refused to participate without good cause. Its purpose is to encourage such individuals to return to active WEP participation.

41. Subsidized Employment: Work in a job for which the individual's wages and benefits are directly federally subsidized.

42. Suitable Employment: Employment consistent with the participant's employability plan; meets the criteria stated in Section I of this rule.

43. Support Services: Those social services provided or arranged by support service staff necessary to enable an individual to engage in employment or other WEP activity.

44. Support Service Staff: Those counselors from local welfare agencies or WEP Center Offices who provide support services to WEP applicants or recipients.

45. Title XX Services: A program authorized by Title XX of the Social Security Act to provide social services to families and individuals in need.

46. Transfer: A period during which a participant is assigned to active participation in a program other than WEP as part of an approved WEP employability plan. Necessary employability and support services including incentive and transportation payments not provided under the assigned program shall be provided under WEP.

47. Unsubsidized Employment: Work in a job for which the wages and benefits are not subject to a direct federal subsidy for the individual.

48. Volunteer: An AFDC, GA, or Food Stamp applicant or recipient who, though exempt from WEP registration, volunteers for and registers for WEP.

49. Wage Component: An activity such as Public Service Employment (PSE), OJT and CWP, whereby a participant performs work for specified hours, and is paid wages and benefits.

50. Welfare Appeals Referee: The hearing officer designated by the welfare agency to hear and decide or make recommendations on issues relating to

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exemption or non-exemption for WEP registration or any program-related AFDC, GA or Food Stamp benefit reductions, suspensions or terminations which result from deregistration from WEP.

51. Welfare Benefits: Those payments or services other than those provided in this rule that are available to applicants and recipients of AFDC, GA, or Food Stamps.

52. WEP Center: A field office of a Prime Sponsor from which WEP services are administered.

53. WEP Center Staff: Prime Sponsor staff in a WEP Center, or satellite office thereof, part or all of whose time is compensated by WEP funds and staff from other agencies assigned to work in a WEP Center and performing WEP functions.

54. WIN: The Work Incentive Program for AFDC applicants and recipients, authorized by Title IV-C of the Social Security Act.

55. WIN Registrant: An AFDC applicant or recipient who has registered with the Work Incentive Program.

D. Partificpation of AFDC and GA Applicants and Recipients.

1. All AFDC and GA applicants and recipients eligible for WEP shall be informed of its availability by the local welfare agency and shall register for WEP unless exempt or otherwise excluded from registration by the Commissioner of Public Welfare because of program or budgetary constraints.

2. The local welfare agency shall determine exemptions. The following AFDC and GA applicants and recipients shall be exempt from WEP registration:

a. children under 16;

b. children age 16 through 18, and attending school full time;

c. persons who are ill (for purposes of this Section, D. 2., "illness" shall be defined as an illness or injury which is medically diagnosed as preventing him/her from engaging in suitable work activities, and which is expected to last less than 90 days);

d. persons who are incapacitated (for purposes of this Section, D. 2., "incapacity" shall be defined as an impairment which either by itself or in conjunction with age prevents him/her from engaging in suitable work activities, and which is expected to last more than 90 days; AFDC recipients whose WEP exemption is based on incapacity shall be referred to the Division of Vocational Rehabilitation in the Department of Economic Security);

e. persons over age 65;

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f. persons who live so far away from their WEP Center or placement that more than 2 hours per day (by reasonably available public or private transportation) would be required to travel to and from work or training (exclusive of time necessary for transporting children to or from child care), unless such commuting time is normal to the community;

g. persons whose presence in the home is needed because of the illness or incapacity of another person in the household;

h. AFDC caretaker of a child under age 6 or GA caretaker of a child under age 18 (only one such exemption is allowed per household);

i. the spouse of a WEP or WIN registrant;

j. persons receiving General Assistance who are working at least 30 hours per week, at a wage consistent with that paid in the community for similar work;

k. persons who are registered in WIN and are in a suitable employability development plan;

l. persons receiving General Assistance who have been referred to or applied for work training, work experience, or a similar program, if approved by the local agency and if the waiting period for acceptance into the program does not exceed 30 days.

3. All GA and AFDC recipients who are mandated to or volunteer to register with WEP shall be referred for registration to the local WEP office by the local welfare agency which shall ensure that transportation to and from such registration is available.

4. AFDC and GA recipients exempt from WEP registration may voluntarily register with WEP, unless the Commissioner of Public Welfare limits participation of volunteers because of program or budgetary constraints.

5. Treatment of Income for AFDC and GA WEP Participants.

a. WEP incentive payments of not more than $30 per week shall be disregarded in determining the grant amount for WEP participants.

b. Reimbursement for actual cost of training-related expenses shall be disregarded as income for WEP participants.

c. Wages paid in Work Equity community work projects shall be considered as earned income.

d. All other income shall be handled in accordance with DPW 44 and DPW 55.

e. Receipt of earned income by WEP participants shall not cause

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ineligibility for public assistance benefits (including Title XX services, Food Stamps and MA or GAMC), even though the household would be otherwise ineligible for a public assistance grant payment, until income from unsubsidized employment meets the need as computed in the existing applicable manner.

f. AFDC-Unemployed Fathers who are registered with WEP shall be exempt from the 100 hour-per-month employment limitation.

g. An amount paid to a participant for taking part in an outside evaluation, as described in Section B. 9., shall not be counted in determining public assistance grant amount.

E. Participation of Food Stamp Recipients.

1. Eligibility for the Food Stamp Program shall be determined by the local welfare agency according to applicable federal law. All Food Stamp applicants or recipients eligible for WEP shall be informed of the program's availability by the local welfare agency.

2. An individual receiving Food Stamps who is required to register with the Job Service in the Department of Economic Security shall be referred to WEP on a timely basis after 30 days of Job Service registration by the Job Service Office, unless WEP-exempt. An individual shall be considered WEP-exempt if he/she:

a. has gained employment of at least 30 hours per week; or

b. has been referred to and accepted in a work and training program sponsored by a public agency; or

c. has a job attachment as defined in Section E. 7. below.

WEP-exempt status shall be reviewed monthly thereafter by the Job Service and individuals who become non-exempt shall be referred to WEP on a timely basis.

3. Individuals referred to WEP shall be required to register with WEP and shall also:

a. Report to the local WEP office where he/she is registered, for an appraisal interview, upon reasonable request;

b. Supply additional information regarding employment status or availability for work, if requested;

c. Interview for, accept bona fide offers of, and/or continue in suitable work to which he/she is referred by the local WEP office.

4. Food Stamp recipients exempt from WEP registration may volun-

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tarily register with WEP, unless excluded from registration by the Commissioner of Public Welfare because of program or budgetary constraints, and shall be referred to the local WEP office by the local Job Service office.

5. Food Stamp recipients exempt from the Job Service registration may voluntarily register with WEP, unless excluded from registration by the Commissioner of Public Welfare because of program or budgetary constraints, and shall be referred directly to the local WEP office by the local welfare agency.

6. A person who becomes ineligible for Food Stamps because of excess income attributable to his/her mandatory participation in WEP may continue in WEP until placed in permanent unsubsidized employment.

7. An individual with a job attachment shall be defined for purposes of this section as one who is on strike; lock-out; seasonal layoff; temporary layoff; has a bona fide job prospect with a definite starting date not to be later than 45 days from the date of registration with the Job Service; or is a member in good standing of a union which provides to its members free placement service and exposure to full employment. "Strike" shall be defined in accordance with Minn. Stat. § 179.01, Subd. 8; "lock-out" shall be defined in accordance with Minn. Stat. § 179.01, Subd. 9.

8. An amount paid to a participant for taking part in an outside evaluation described in Section B. 9., shall not be counted in determining Food Stamp eligibility.

F. Exemption Determination Disputes.

1. The referring agency shall inform all applicants and recipients of AFDC, GA, and Food Stamps of their rights to contest determination of WEP non-exempt status in accordance with the provisions of this Rule. The referring agency determination is binding on the individual, unless the individual disagrees with the determination and requests a hearing on the issue. If such a request is made, he/she shall be considered exempt until his/her status is determined by the welfare appeals referee.

2. If an individual contests a determination of non-exemption on the basis of incapacity or illness, the allowable period for receipt of medical verification of such status will be thirty (30) days from the date that the client is notified of the determination. WEP shall arrange to cover the cost to the individual of obtaining the medical verification. If the individual is a WEP participant, and medical verification or other information is necessary and cannot be obtained within 30 days, the local welfare agency must notify WEP prior to the end of the initial 30-day period of any arrangements that have been made to obtain such information. An acceptable response can also be notification that the determination will be delayed, in which case WEP should not deregister the individual until and unless the referring office's determination necessitates deregistration.

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3. If, after referral, WEP Center Staff believe an individual referred as "mandatory" should be exempt, WEP shall register the individual and then state the reasons in writing to the referring office and request a review of the case.

a. The referring office shall inform WEP in writing of its findings within 30 days of the request. The decision of the referring office is then binding on WEP.

b. If WEP receives no response from the referring office within 30 days of its request, it shall contact the referring office to determine what action has been taken.

c. If no action has been taken, the individual shall be deregistered as exempt at the end of the 30-day period. However, if an individual is deregistered and the referring office later determines that he/she is non-exempt, he/she shall be re-registered in order to ensure eligibility for welfare benefits.

4. The responsibilities of the agencies described in Sections F. 1. and G. 1. shall include providing information to the participant that he/she shall receive without cost medical evaluations necessary to determine whether an aspect of project participation is inappropriate for medical or health reasons. Brochures and posters containing such information shall be developed and used including those directed toward women who are or may be pregnant.

G. Registration Procedures.

1. WEP Center staff shall register all individuals referred by the respective IMU, Job Service or WIN office within 3 working days of the day the individual appears for registration. Registration is not complete until all registration requirements are met. WEP Center staff shall:

a. Inform all participants about WEP and its requirements;

b. Work History: Obtain from each applicant a complete work history, complete the WEP registration forms and provide each participant with written proof of registration;

c. Job Market Information: Provide all participants, at the time of registration, with job market information and referral to available employment. All appropriate job market information available to WEP, including the Job Service Job Bank, shall be used to provide this information and facilitate such referrals;

d. Registration: Notify the referring office, within 3 working days of registration, that registration has been completed.

H. Appraisal and Certification.

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and services, including associated testing, shall be voluntary. Participants using services or testing shall be fully informed of their scope, nature, and use and shall sign an agreement that acknowledges his/her voluntary use of the services. This provision applies to appraisal interviews described in this Section, employability plans described in Section H. 4. following, Employability Development Planning in Section M. 1. and Support Services in Section O. 1. c.

2. Appraisal sequence: All participants shall be appraised in the order in which they are registered. Notwithstanding the above, all AFDC-Unemployed Fathers must be appraised within 2 weeks of registration with WEP, and must be certified no later than 30 days after registration. All appraisals shall be completed prior to certification. Certification shall be completed within 30 days of registration.

3. Appraisal interview: The appraisal interview shall be conducted by WEP Center staff, including support service staff, and is intended to assess the registrant's employability potential and need for supportive services. Whenever possible, individuals shall be appraised at the time of registration. An employability plan for each participant shall be initiated at the appraisal interview.

4. Employability Plan: The employability plan shall contain an employment and training services section and a support services section, and shall be designed to lead to employment and ultimately to self support and shall contain a definite employment goal attainable in the shortest time period consistent with the participant's skills, needs, knowledge, ability, support services needs, project resources, and job market opportunities. The employability plan shall be developed jointly by the participant and WEP staff including support service staff. Final approval of the employability plan rests with WEP staff.

5. Certification: Support service staff shall certify in writing that the necessary immediate and ongoing support services have been provided or arranged, or that no such services are required for those individuals who have been selected for participation in WEP. Certification shall be completed within 30 days of registration. At any point during participation certification may be made for additional services.

6. Support services: Until a participant is certified, only pre-appraisal and appraisal services shall be provided by the WEP support service staff. The participant shall be certified before receiving WEP support services, listed in Section "O" of this rule. A WEP participant shall be certified at any time that support services are needed, and additional certifications shall be done as needed. After certification a participant who is not employed shall receive certified support services until successful completion of his/her EP. Upon entering employment (either unsubsidized or subsidized), WEP support services shall be provided for a period of 30 days. Such services shall continue for 90 days if they are necessary for the participant to continue such employment. In an emergency, such services shall be provided for an additional 30

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days beyond the 90 days if the same are necessary for the participant to continue such employment.

7. Benefits and job referral: Welfare benefits shall not be denied by reason of the individual's referral to a job, to WEP, or solely by reason of an individual's participation therein.

I. Appropriate Employment and Training Criteria.

1. Standards for employment and training assignments: Except as otherwise provided in this Rule, WEP participants shall accept assignment to employment or other WEP activity as determined appropriate by WEP Center staff or shall be subject to deregistration. The following standards must be met before participants shall be required to accept employment or training assignments, including OJT, PSE, classroom training and Community Work Projects:

a. Employability plan: An employment or training assignment must be within the scope of an individual's employability plan. This plan may be modified jointly by the participant and WEP staff including support service staff. Final approval of the employability plan rests with WEP Center staff. If the participant disagrees with the decision, he/she may initiate a grievance;

b. Performance capability: The job or training assignment must be related to the capability of the individual to perform the task on a regular basis. Any claim of adverse effect on physical or mental health shall be verified by a physician or a licensed or certified psychologist, and shall attest to the individual's ability or inability to accept employment or participation in other WEP activity. Pending verification the participant shall be assigned to the EDP component as defined in Section M. 1. below;

c. Commuting distance: The total daily commuting time from home to the assigned work or training site and return shall not normally exceed 2 hours, not including time required to transport a child/children to and from a child care facility. If a longer commuting distance and time is normal to the community, the round trip commuting time shall not exceed the norm for that community;

d. Child care standards: Required child care shall meet the standards specified by the Department of Public Welfare in Rules 2 and 3, and shall be licensed as required and defined therein, and shall be available during the hours the individual is engaged in a WEP assignment plus any additional necessary commuting time;

e. Health and safety standards: The employment or training site to which the individual is assigned shall be in compliance with applicable federal, State and local health and safety laws and regulations;

f. Non-discrimination: No assignments shall be made which discriminate in terms of age, disability, sex, race, creed, color, national origin, or

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public assistance status. Employment and training assignments shall in no way contribute to discriminatory hiring practices;

g. Employability and support services: No individual shall be referred to employment or training unless employability and support services necessary for participation are available. The cessation or withdrawal of such necessary services while the individual is participating in an assignment shall constitute good cause for refusal to participate.

2. Other Employment Criteria: In addition to criteria in paragraph 1 of this section, appropriate employment criteria shall include the following:

a. Appropriate employment: Appropriate employment may be temporary, permanent, full-time, part-time or seasonal, if such employment meets the other employment standards of this section;

b. Prevailing wages: All participants in WEP employment components shall receive a wage which shall meet or exceed the statutory federal or State minimum wage, whichever is higher, and which is not less favorable than the wage normally paid for similar work by the employing agency or service;

c. Hours of work: The daily and weekly hours of work shall not exceed those customary to the occupation;

d. Exemption from employment: No individual shall be required to accept employment if:

(1) The individual would be required to work for an employer contrary to the conditions of his/her existing membership in the union governing that occupation. However, employment not governed by the rules of a union in which he/she has membership may be deemed appropriate.

(2) The job offered would interrupt a program in progress under an approved WEP employability plan, or would impede return to his/her regular job. This does not, however, preclude temporary employment during the interval prior to an individual's return to his/her regular job.

(3) The individual would be required to join a union, or refrain from joining a bona fide labor union as a condition of being employed, unless union membership is a requirement of a collective bargaining agreement.

e. WEP shall not knowingly refer an individual to a position vacant due to strike, lock-out, or other bona fide labor dispute. If WEP should inadvertently make such a referral, no individual shall be required to accept such employment.

f. WEP shall not knowingly contract with any employer if full or partial displacement of currently employed, full-time or part-time workers will result. Full displacement occurs when an employed worker loses his/her

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job for reasons other than normal turnover or the job is altered so as to effect a reduction of pay. Partial displacement occurs when the use of WEP registrants leads to a reduction of non-overtime hours in a normal work-week of workers presently employed in the same activity.

3. Other training criteria: In addition to criteria in paragraph 1 of this section, appropriate training criteria shall include the following:

a. The quality of the training must meet local employers' requirements so that individuals will be in a competitive position within the local labor market;

b. The training shall also be likely to lead to employment which will meet the appropriate employment criteria.

J. General Benefits for Program Participants.

1. Worker's compensation: Each participant in an On-the-Job Training or Community Work Project program under WEP shall be assured of worker's compensation at the same level and to the same extent as other employees of the employer who are similarly employed or engaged and are covered by a State or industry worker's compensation statute. Whether provided through the State's compensation agency or a private insurance carrier, this coverage includes medical and accident insurance as well as income maintenance insurance.

2. Insurance: Where a participant is employed or engaged in a Community Work Project, On-the-Job Training, or classroom training, where others similarly employed or engaged are not covered by an applicable worker's compensation statute, the participant shall be provided with medical and accident insurance coverage. Whether provided through the State's worker's compensation agency or a private insurance carrier, WEP shall provide such participants with medical and accident insurance coverage comparable to the medical and accident insurance provided under the applicable State worker's compensation statute. However, WEP shall not be required to provide these participants with the income maintenance insurance coverage in the statute.

3. Other fringe benefits: Each participant in an On-the-Job Training or Community Work Project program shall also be assured of health insurance, unemployment insurance (to the extent such benefits are allowable), coverage under collective bargaining agreements and other benefits at the same levels and to the same extent as other employees similarly employed, except that retirement benefits shall be limited pursuant to 29 CFR § 98.25 and Chapter 720, Minnesota Laws (1978), and to working conditions neither more nor less favorable than such other employees similarly employed. Nothing in this section shall be interpreted to require coverage for health insurance, unemployment insurance and similar benefits for participants, such as Community Work Project participants, where there is no employee of the employer performing the same or similar work in the employment situation. In determining whether the work is the same or similar to that of a person regularly em-

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ployed, the WEP Center staff shall take into consideration, but shall not be limited to, employment status, type of work performed, job classification and method of appointment to the position.

K. Allowances and Incentives for WEP Participants.

1. Incentive payments: Individuals shall receive incentive payments at a rate of $6 per day (maximum of $30 per week) for each day in which they participate in a non-wage WEP component. No incentive pay shall be authorized for participation in the intake functions of registration, orientation, appraisal and initial employability planning, or while assigned exclusively to support services.

2. Transportation expenses:

a. Shall be paid to individuals for actual costs they incur because of their participation in non-salaried components such as classroom training, Intensive Manpower Service, or Employability Development Planning. Expenses are based on actual costs of public transportation or car pool payments, or 13 cents per mile for actual number of miles driven, not to exceed 100 miles per day (unless the participant can establish higher transportation costs that are both necessary and reasonable).

b. Shall also be authorized for individuals placed in employment, OJT, PSE, or CWP. Payments for transportation expenses shall be continued for no more than 4 weeks or until these individuals receive their first full paychecks, or grant adjustments reflecting new work-related expenses, whichever occurs first.

3. WEP Center staff shall determine the amount of subsistence allowances, in addition to incentive and transportation payments, to be paid to individuals for separate maintenance when they are in training facilities beyond normal daily commuting distance from their homes. These allowances shall be paid for each calendar day within the training period, including holidays and weekends, during which individuals are participating in such training, and are residing away from home.

4. Transportation expenses in amounts equivalent to two one-way trips shall be paid to individuals enrolled at training facilities located beyond normal commuting distance. These payments are to cover the initial trip to the training facility and for the final trip home at the completion or other termination of such training. The rate of reimbursement shall be based on actual costs of public transportation or car pool payments, or 13 cents per mile for actual number of miles driven.

5. WEP Center staff shall determine and authorize allowances for nonrecurring expenses which are required for employment or training including but not limited to, payments for auto repairs, auto insurance, special clothing, tools and equipment; participants shall not be required to reimburse the WEP Center for any such allowances received.

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6. Petty cash: WEP Center may establish petty cash funds to meet participants' small cash needs incidental to training, transportation, or referral to employment which cannot be met by other procedures; participants shall not be required to reimburse the WEP Center for any such funds received.

L. Relocation Assistance.
WEP shall assist a certified individual to relocate his/her place of residence when WEP staff determines such relocation is necessary in order to enable him/her to become permanently employed and self-supporting. Relocation of AFDC participants is subject to the approval of the Secretary of Labor or his/er designee. Such assistance whall be given only to an individual who concurs with the relocation and who has a bona fide job offer at the place of relocation at a wage rate which meets full need, as determined by the state in which the individual relocates. Assistance under this section shall not exceed the reasonable costs of transportation for the individual, dependents, and household belongings, plus such relocation allowance as WEP determines reasonable.

M. The WEP Components.

1. Employability Development Planning (EDP): The EDP component may include:

a. Orientation to services available in WEP or through referral to other resources;

b. In-depth assessments of those individuals who have problems which must be resolved before they can participate in other WEP components or activities;

c. Special WEP support services, such as help with money management, marital or emotional problems, for individuals who need such services in order to participate in WEP;

d. Those services arranged or provided for by the support service staff for those individuals whose barriers to employment are great and cannot be removed by normal WEP services.

2. Intensive Manpower Services (IMS):

a. The Intensive Manpower Services component provides employment services which shall include vocational counseling, job development, exposure to labor market information, job placement, job seeking skills training, and job finding clubs to assist the individual to obtain unsubsidized employment.

b. If unsubsidized employment is not available, the IMS component shall be used to develop opportunities for individuals in community work projects, OJT, and CETA public service employment. Subsidized employment is intended to provide an individual a work-related experience until such time as he/she can be placed in an unsubsidized position.

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c. Participation in IMS shall be limited to three weeks; if the participant has not completed the IMS portion of his/her employability plan so that the participant is not ready for placement in another WEP component additional three week periods shall be authorized if approved by the WEP Center Staff supervisor.

3. Classroom Training (CT): Classroom training includes vocational, college or other institutional training, as well as basic or remedial education, conducted by a qualified instructor. Classroom training shall be limited to one year and may be further limited by budgetary constraints. Classroom training shall lead to employment and self-sufficiency in the shortest time possible, consistent with the participant's employability plan.

4. On-the-Job Training (OJT):

a. OJT is an employment opportunity which includes training. Under this component, a certified participant is hired by a private or public employer, who provides training subsidized under contract with WEP. Employers provide increased supervision and training for which they shall be reimbursed by WEP for the extraordinary costs of such training and supervision.

b. An OJT participant is considered to be employed, insofar as employment affects AFDC, GA, or Food Stamp benefit determinations. However, an OJT participant shall remain an active participant, and shall not be deregistered from WEP.

5. Transfer: Certified individuals referred to and accepted by other eligible federal or state-funded employment or training programs, and who meet all eligibility requirements under those programs, shall be temporarily suspended from WEP, if it is appropriate to the employability plan. Such individuals shall normally be compensated in accordance with and through the provisions of those programs. However, when such compensation is not available or would be disadvantageous to the individual, the participant may choose to accept WEP benefits instead. Notwithstanding such transfer, support and job services which are not provided, under the alternative program, but which are necessary to permit the individual to continue in the program, shall be provided or arranged for by the support service staff.

6. Community Work Projects (CWP's):

a. CWP's provide participants with subsidized employment until they are able to move into other components or activities or into unsubsidized employment. CWP slots shall be developed to meet the individual needs of the participants and shall meet the employment criteria set forth in Section I of this rule.

b. CWP's shall not result in the displacement of currently employed workers, including partial displacement (see Section I. 2. f. of this rule). CWP's shall be used to support positions for public service needs which have

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not been met, or to provide new public services in a unit of State or local government, a public agency or institution, or a private nonprofit organization.

c. When developing a CWP position, the WEP staff shall determine if there is a collective bargaining agreement between the employer and the employees, or their representatives. Where an agreement exists and is applicable to the establishment and the occupation, the CWP contract shall not conflict with the agreement. A statement to this effect, signed by the employer shall be made a part of or affixed to the WEP/CWP contract.

7. Public Service Employment (PSE): CETA PSE Title VI positions shall, to the extent possible, be available to WEP participants. Slots shall not be set aside for WEP participants by position or job; the Prime Sponsor shall accept referral of WEP participants for CETA Title VI vacancies. When participants are transferred to CETA Title VI positions, efforts shall be made to place individuals in jobs where they will have an opportunity to retain those positions as unsubsidized employment.

N. Employee Status.

A WEP participant shall not by virtue of registration in WEP be deemed an employee of any public agency, and shall not be subject to the provisions of law relating to State or federal employees, including those relating to hours of work, rates of compensation, leave, unemployment compensation, and State or federal employee benefits.

O. Support Services.

1. Support services available to WEP registrants for the purpose of facilitating employability plans and self-support goals shall include:

a. Day care service (children): Personal care during the day (for less than 24 hours) in the child's own home or in a nurturing and protective setting to substitute for or supplement the child rearing provided by the child's parents or caretaker, as well as integral but subordinate medical service.

Child care shall be suitable for the individual child, and the caretaker shall be involved in the selection of the child care facility if more than one facility is available. If only one facility is available, the caretaker shall accept it, unless the caretaker can show that it is unsuitable for the child. Such child care arrangements shall be maintained until the caretaker is able to make other satisfactory arrangements. Child care arrangements shall be in compliance with the standards set forth in 45 CFR § 228.42.

b. Family planning: Services provided to enable individuals to voluntarily limit family size or plan time intervals between children. These are available to participants on a voluntary basis.

c. Counseling services: Professional services to assist individuals and families in coping with and resolving any personal or relationship concerns.

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d. Health services (employment related): Arranging and facilitating access to and use of physical and mental health resources, to identify any physical or mental limitations which would restrict vocational options.

For GA and AFDC recipients, this medical examination is a Medical Assistance or General Assistance Medical Care expenditure and is not to be paid for under WEP.

e. Vocational rehabilitation services: Special employment assistance for individuals who are disabled for social, economic, or mental or physical health reasons (including such things as surgery, psychiatric treatment, prosthetic devices, speech or hearing therapy, visual services, dental care, etc.) to correct or modify a physical or mental condition which inhibits employment.

Vocational rehabilitation services shall be provided with WEP funds only when not available through the Division of Vocational Rehabilitation in the Department of Economic Security, and when there is reasonable expectation that the services will lead to unsubsidized employment and the services can be provided within the constraints of the WEP program and budget.

2. The following support services shall be arranged for or provided when determined necessary by the WEP Center staff to successful completion of an employability plan.

a. Homemaking service: Providing substitute care in the absence or disability of the caretaker, personal care for ill or disabled individuals, and instruction on effective home management, self-care and social skill methods.

b. Housing services: Assisting individuals to obtain, maintain, and improve housing, and/or to modify existing housing.

c. Legal services: Arranging for assistance in resolving noncriminal legal matters and the protection of legal rights.

d. Money management services: Arranging and providing assistance in developing effective budgets and managing indebtedness.

e. Transportation services: Arranging and providing travel and escort to and from community resources and facilities.

P. WEP Adjudication System.

1. General: All Work Equity participants shall have available to them an appropriate system for appealing agency actions within the Project. The particular system used will depend on the conditions under which the participants are registered in WEP; i.e., whether they are applicants for or recipients of AFDC, GA, or Food Stamps; and whether they are mandatory participants or volunteers.

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2. Disputes involving WEP registrations: A welfare appeals referee shall conduct welfare hearings pursuant to the procedures prescribed in 45 CFR § 205.10, 7 CFR § 271.1, and Minn. Stat. § 256.045 (1976), in cases where applicants or participants contest the registration or exemption requirements, or any program-related AFDC, GA, or Food Stamp grant reductions, suspensions, or terminations which result from deregistration from WEP. These procedures are available to all AFDC, GA, or Food Stamp participants who are required to register with WEP as a condition of eligibility.

3. Issues to be decided under the WEP adjudication system: Grievances and sanctionable actions shall be resolved through the WEP adjudication system. Written records of all disputes shall be maintained by the WEP Center.

a. Grievances are written complaints which do not involve the threat of WEP sanctions. Such complaints may arise over questions of actions by the WEP Center staff or work site staff including:

(1) Wages or allowances;

(2) Hours of work or training;

(3) Work or training assignments;

(4) Disciplinary action; and/or,

(5) Any disputes involving volunteers.

b. While adjudication is pending, the welfare grant amounts shall be determined in relation to the income actually available to the recipient.

c. Grievances shall be initially handled informally by the WEP Center Supervisor. Within 5 working days of receipt of written notice from the participant the matter will be reviewed and a decision issued. An individual who is not satisfied with the disposition of the grievance may request a hearing at the WEP Center. This hearing will be conducted according to the WEP adjudication process described in Sections P. 4., 5., and 6. below.

d. Grievances involving discrimination on the basis of race, religion, color, national origin, sex, or age shall be handled according to Equal Opportunity provisions established in 29 CFR Part 31, and 45 CFR Part 80, and to the extent applicable, in compliance with Title VI of the Civil Rights Act of 1964 and the regulations issued thereunder. This section is not intended to abridge the rights of WEP participants to seek redress for unlawful discrimination through other available administrative and judicial processes.

e. Sanctionable actions are those for which a participant may be deregistered from WEP for failure or refusal to participate without good cause. All sanctionable issues, if appealed, shall be processed through the WEP adjudication system, described in this rule. They include:

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(1) Failure or refusal without good cause to attend scheduled WEP appraisals or other interviews;

(2) Failure or refusal without good cause to accept appropriate child care as may be provided for the purpose of enabling the individual to participate in WEP;

(3) Failure or refusal without good cause to accept offers of, or referrals to appropriate employment or training;

(4) Quitting an appropriate job without good cause, or being fired from an appropriate job for cause;

(5) Failure or refusal without good cause to accept assignment to WEP components or to otherwise participate in WEP.

4. Initial conciliation efforts and WEP hearing:

a. If the WEP staff believes that a mandatory WEP participant has committed a sanctionable action, it shall make every effort toward an informal conciliatory resolution of the underlying reasons. The conciliation period shall not exceed 30 days, and may be terminated earlier if it appears no resolution is possible. When all such efforts are exhausted, WEP may issue a Notice of Intended Deregistration.

b. When WEP determines that all informal, conciliatory measures have been exhausted, the Notice of Intended Deregistration shall be issued to the participant. The Notice shall state that the participant has failed or refused to participate in required WEP activities without good cause, and is subject to deregistration. The Notice shall also inform the individual of his/her right to a fair hearing if the individual believes the proposed action is unwarranted. The Notice shall be accompanied by the forms required to file for a hearing and the instructions necessary to complete and file the forms. If the individual desires a hearing he/she must request the same within 10 days of the date of mailing of the Notice;

c. Such hearing shall be held by a hearing officer of the Department of Economic Security in the manner prescribed by Minn. Stat. § 268.10, Subd. 3 (1976); and if an AFDC registrant is involved, also in accordance with 29 CFR §§ 56.66 - 56.68.

The hearing officer shall rule:

(1) That the individual has failed or refused to participate without good cause in WEP and that appropriate deregistration shall be initiated.

(2) That good cause has been shown for failure or refusal to participate and the individual should be retained in the program.

(3) That the request for a hearing is dismissed because:

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(a) It was filed untimely without good cause;

(b) It has been withdrawn in writing;

(c) The individual failed to appear at the hearing without good cause; or

(d) Reasonable cause exists to believe that the request for a hearing has been abandoned or repeated requests for rescheduling are arbitrary and for the purpose of unduly delaying or avoiding a hearing.

(4) That the participant was appropriately or inappropriately assigned to a WEP activity by the WEP staff, or

(5) Render such other rulings as are appropriate to the issues in question.

d. DES shall mail copies of the hearing officer's decision to the participant, the WEP Center and WEP Central, the local welfare agency, the Department of Public Welfare and other parties to the hearing. Copies to the participant and his/her representative, if any, shall be accompanied by the forms required to file an appeal from an adverse decision, and the instructions necessary to complete the forms. Upon receipt of the decision, the local welfare agency shall notify the participant of the sanctions that may be imposed by the county, and the individual's right to appeal.

e. If any party disagrees with the decision of the hearing officer and desires a review of said decision, he/she must, within 10 days of the date of the decision, request a review of the decision. If the county agency or WEP requests review, notice must be given to the registrant at the same time as the request for review is filed. A request for review by any party shall not stay implementation of the hearings officer's decision.

5. Appeal process for AFDC registrants:

a. If the issues decided by the hearing officer involve an AFDC participant, the party who disagrees with the decision of the hearing officer may file the request for review with the Commissioner of Economic Security.

b. A hearing shall be held before the Commissioner of Economic Security or his duly-authorized representative, in the manner prescribed by Minn. Stat. § 268.10, Subd. 5 (1976), and in accordance with 29 CFR § 56.64. The Department of Economic Security shall mail to all interested parties a notice of the filing of and a copy of the findings and the decisions of the Commissioner or his/her representative.

c. Any party may file an appeal from the decision of the Commissioner of Economic Security in either of two ways:

(1) With the National Review Panel of the U.S. Department of

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Labor, in accordance with the provisions of 29 CFR §§ 56.70 - 75 and 45 CFR §§ 224.70 - 75; or;

(2) With the Minnesota Supreme Court pursuant to Minn. Stat. § 256.736, Subd. 4 (4) (amended, 1977) and Minn. Stat. § 268.10, Subd. 8 (1976).

6. Appeal process for GA and Food Stamp participants:

a. If the issues decided by the hearing officer involve a GA or Food Stamp participant, the party who disagrees with the decision of the hearing officer shall file the request for review with the Department of Public Welfare. Such a hearing shall be held in the manner prescribed by Minn. Stat. § 256.045, Subd. 2 or Subd. 3 (amended, 1978).

b. Subsequent appeals may be made pursuant to Minn. Stat. § 256.045, 3 et. seq. (amended, 1978).

7. Post-determination actions, counseling:

a. WEP benefits shall cease, protective or vendor payments shall be initiated, and a 60-day counseling period by WEP support service staff shall begin the fifth business day following:

(1) The expiration of the prescribed time period for filing a request for a hearing and proposed deregistration from WEP, or the date on which the request for such hearing is withdrawn; or

(2) The date of the DES hearing officer's decision that the registrant has failed or refused to participate in WEP without good cause; or

(3) A decision by the appellate body, referred to in Section P. 5. or 6. supra, which reverses a decision favorable to a WEP registrant.

b. Counseling shall be provided by support service staff for a period of up to 60 days, unless:

(1) The individual is not a certified WEP participant, or

(2) The individual has already received such a counseling period during the current registration, and is therefore not eligible for further counseling and is to be deregistered.

c. The purpose of the counseling period is to encourage the individual to participate in WEP. Upon completion of the 60-day counseling period, if the WEP support service staff determines that the individual has continued to refuse to participate without good cause, he/she shall be deregistered and sanctions shall be initiated. Counseling may be terminated at any time during the 60-day period, when the WEP support service staff determines that counseling efforts are unsuccessful and the individual will not participate in WEP.

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The WEP support service staff shall notify WEP that 60-day counseling is unsuccessful, and WEP shall deregister the individual for failure or refusal to participate without good cause.

8. Post-determination actions: Sanctions.

a. A voluntary participant shall not have his/her welfare benefits terminated, reduced, or suspended because of failure or refusal to participate in WEP. However, all WEP benefits shall be terminated when the individual is deregistered for failure to participate. The volunteer may subsequently participate in WEP according to the provisions of Section P. 9.

b. The following sanctions apply to a mandatory WEP participant who has been deregistered:

(1) If the individual is the only dependent child in an AFDC family, assistance for the entire family is terminated;

(2) Any other individual shall have his/her portion of the GA or AFDC grant deleted. Assistance to the other family members will be provided through protective or vendor payments;

(3) Food Stamp benefits shall be terminated in accordance with procedures outlined in the Food Stamp Act.

9. Post-determination actions: Readmittance to WEP. If, during the 60-day counseling period, the WEP support service staff determines that a participant is progressing satisfactorily, he/she shall be reassigned to an active WEP component. If the 60-day counseling period is unsuccessful, as determined by the WEP support service staff, and an individual is deregistered from WEP for failure to participate without good cause, he/she must remain deregistered from WEP for 90 consecutive calendar days from the date the welfare grant was reduced or terminated. The individual must give evidence of willingness to participate before he/she may again register for WEP. The person's verbal agreement to cooperate is sufficient evidence of "willingness to participate". If an individual has failed to participate in WEP without good cause two or more times, he/she must remain deregistered for six months from the date the welfare grant was adjusted. WEP need not register any recipient whose prior failure to participate was the result of criminal or other activities which presented a hazard to WEP staff or to other WEP participants.

Q. Deregistration.

1. All deregistrations shall be performed by WEP.

2. Deregistration is necessary when:

a. An individual is found to have failed or refused to participate in WEP without good cause;

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b. An incorrect determination of non-exemption has been made;

c. An individual becomes exempt, and the local welfare agency informs WEP Center that he/she does not wish to volunteer;

d. An individual becomes ineligible for welfare benefits, except where he/she is participating in a WEP component or is employed and receiving WEP-funded support services.

3. The local welfare agency shall notify the WEP Center of any change which will affect a welfare recipient's welfare or exemption status in such a way as to warrant deregistration.

4. Volunteers who withdraw from WEP shall be deregistered without penalty.

5. Volunteers who are found to have refused to participate after receiving a Notice of Intended Deregistration, or who have requested a hearing on the matter and have received an adverse decision, shall be deregistered as exempt.

6. Persons who volunteer but for whom no suitable employment or training is available shall be deregistered as exempt.

R. Severability. The provisions of this rule shall be severable and if any phrase, clause, sentence or provision is declared illegal or of no effect, the validity of the remainder of this rule and the applicability thereof to any person or circumstances shall not be affected thereby.

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ARO08637

12 MCAR S 2.064 Surveillance and utilization review program.

A. Introduction.

1. This rule governs procedures to be used by the Surveillance and Utilization Review (SUR) Section, Minnesota Department of Public Welfare in the identification and investigation of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts by a provider or recipient of health care in the Minnesota Medical Assistance, General Assistance Medical Care and/or Catastrophic Health Expense Protection Programs.

2. The provisions of this rule are to be read in conjunction with Titles XVIII and XIX of the Federal Social Security Act; Title 42 of the Code of Federal Regulations; Minnesota Statutes, chapters 62E, 256, 256B, 256D and 609; Minnesota Laws of 1980, chapter 349; and other rules of the Minnesota Department of Public Welfare.

3. The Minnesota Department of Public Welfare, as the state agency responsible for the administration of the Minnesota Medical Assistance, General Assistance Medical Care and Catastrophic Health Expense Protection programs, will issue instructional bulletins, manual materials and forms to assist others in complying with this rule.

4. The provisions of this rule are binding on all county welfare boards (hereinafter referred to as local welfare agencies) in the State of Minnesota administering the programs, on all providers of health care participating in the programs, on all recipients under the programs, and on the state agency.

B. Definitions. For the purposes of this rule, the following terms shall be defined as indicated.

1. "Abuse." A pattern of practice by a provider, or a pattern of health care utilization by a recipient which is inconsistent with sound fiscal, business, or medical practices, and results in unnecessary costs to the programs, or in reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Abuse is characterized by, but not limited to, the presence of one of the following conditions:

a. The repeated submission of claims by a provider from which required material data is missing or incorrect. Examples include but are not limited to: incorrect or missing procedure or diagnosis codes, incorrect mathematical entries, incorrect third party liability information, incorrect use of procedure code modifiers.

b. The repeated submission of claims by a provider presenting procedure codes which overstate the level or amount

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of health care provided.

c. The repeated submission of claims by a provider for health care which is not reimbursable under the programs, or the repeated submission of duplicate claims.

d. Failure of a provider to develop and maintain patient care records which document the nature, extent, and evidence of the medical necessity of health care provided.

e. Failure of a provider to use generally accepted accounting principles, or other accounting methods which relate entries on the medical or health care record to corresponding entries on the billing invoice, unless otherwise indicated by federal or state law or rule.

f. The repeated submission of claims by a provider for health care which is not medically necessary, or which is of an unacceptable quality.

g. The repeated submission of claims by a provider for health care which exceeds that requested or agreed to by the recipient or his responsible relative or guardian or that otherwise required by federal or state law or rule; services, prescriptions or devices deemed unnecessary or excessive under the generally accepted practice of providers of such services, prescriptions or devices is abusive.

h. The recipient permitting the use of his/her medical identification card by any unauthorized individual for the purpose of obtaining health care through any of the programs.

i. Obtaining unneeded equipment, supplies or pharmaceuticals by a recipient for the purpose of resale or the disposal of equipment, supplies or pharmaceuticals obtained with program monies without authorization of the local welfare agency.

j. Obtaining duplicate services by a recipient, from a multiple number of providers, for the same health care condition excluding confirmation for diagnosis, evaluation or assessment.

2. "Commissioner." The Commissioner of Public Welfare or his designee.

3. "Health care." Services, equipment, or supplies provided by any individual, organization or entity that participates in the Medical Assistance, General Assistance Medical Care and/or Catastrophic Health Expense Protection programs.

4. "Health care record." Written or diagrammed documentation of the nature, extent and evidence of the medical necessity of health care provided to the program recipients by a provider other than a medical doctor and billed to the programs.

5. "Medicaid Management Information System." (MMIS) A

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centralized automated processing and payment system certified by the United States Department of Health and Human Services and implemented in Minnesota to administer the Title XIX program.

6. "Medical record." Written documentation of the nature, extent and evidence of the medical necessity of health care provided to program recipients by or under the authority of a medical doctor and billed to the programs.

7. "Medically necessary." Health care which is rendered pursuant to the provider's authority under state law and within the scope of his/her license, if any, and is:

a. Provided in response to life threatening conditions, or

b. Provided in response to pain, or

c. Provided to treat injuries, illness, or infections, or

d. Provided in compliance with the provisions of 12 MCAR SS 2.047, 2.058 or 2.060 regarding services reimbursable under the programs.

8. "Pattern." An identifiable series of events or activities.

9. "Programs." The Minnesota Medical Assistance program, the General Assistance Medical Care program and/or Catastrophic Health Expense Protection program.

10. "Provider." An individual, organization, or entity that has entered into an agreement with the state agency to be reimbursed by Minnesota Medical Assistance, General Assistance Medical Care and/or Catastrophic Health Expense Protection programs for health care provided to a recipient.

11. "Recipient." An individual who has established eligibility to receive health care paid by Minnesota Medical Assistance, General Assistance Medical Care and/or Catastrophic Health Expense Protection programs.

12. "Records." Medical, health care and financial records pertaining to health care provided program recipients and billed to the programs.

13. "State agency." The Minnesota Department of Public Welfare.

14. "Surveillance and Utilization Review." (SUR) The section of the Department of Public Welfare responsible for the identification and investigation of suspected fraud and abuse by providers and recipients participating in the programs. For the purpose of this rule, this definition specifically excludes the utilization control activity of the SUR section.

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15. "Suspending participation." Making a provider ineligible for reimbursement by the programs for a stated period of time.

16. "Suspension of payments." Stoppage of any or all program payments for services billed by a provider pending resolution of the matter in dispute between the provider and the state agency.

17. "Terminating participation." Making a provider ineligible for reimbursement by the programs.

18. "Utilization control." The activity within the state agency responsible for the ongoing evaluation of the necessity for and the quality and timeliness of services provided in long term care facilities not under the responsibility of a Professional Standards Review Organization.

19. "Withholding of payments." A reduction or adjustment of the amounts paid to a provider for purposes of offsetting overpayments previously made to the provider, or of recovering payments made to a provider for services not documented in the recipient's medical or health care record.

C. Records.

1. Medical and health care records.

a. Medical and health care records must be developed and maintained as a condition for reimbursement by the programs. Program funds paid for health care not documented in the medical and health care record shall be subject to monetary recovery.

b. Medical and health care records shall be legible throughout to at least the individuals providing care.

c. Medical and health care records shall contain the following information:

(1) Each page of the record shall name or otherwise identify the patient.

(2) Each entry in the record shall be signed and dated by the individual providing health care. Record entries for health care provided by an individual under the supervision of an individual licensed provider, and which is billed directly to the programs by the provider, shall be countersigned by the provider. Institutional providers shall not be required to countersign record entries for health care provided in the facility by an individual provider; however, the institutional providers shall be responsible for monitoring the provision of such health care.

(3) Diagnoses, assessments or evaluations.

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(4) The patient case history and results of oral or physical examination.

(5) The plan of treatment or patient care plan shall be entered in the physical record or shall be otherwise available on-site.

(6) Quantities and dosages of any prescribed drugs ordered and/or administered shall be entered in the record.

(7) The results of all diagnostic tests and examinations.

(8) The record shall indicate the patient's progress, response to treatment, any change in treatment, and any change in diagnosis.

(9) Copies of consultation reports relating to a particular recipient.

(10) Dates of hospitalization relating to service provided by a particular provider.

(11) A copy of the summary of surgical procedures billed to the programs by the provider.

d. The requirements of C.1.c. of this rule shall not apply to pharmacies, laboratories, ambulance services and medical transportation providers, or suppliers of medical equipment and nondurable supplies. For the purpose of this rule provider groups mentioned in this section shall develop and maintain the following records:

(1) Pharmacies.

(a) Prescriptions or equivalent computer record.

(b) This rule shall not require the development and maintenance of a recipient drug profile; however, if available, the state agency shall be authorized to review such a record.

(2) Laboratories.

(a) Documentation of provider orders for laboratory tests or procedures.

(b) Documentation of test results.

(3) Ambulance service and medical transportation providers.

(a) Documentation of physician authorization for non-emergency medical transportation.

(b) Trip tickets.

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(c) Documentation of durable and nondurable supplies expended on a recipient.

(4) Suppliers of medical equipment and nondurable supplies.

(a) Prescriptions.

(b) Documentation of physician orders related to the provision of equipment and supplies.

2. Financial records.

a. Financial records pertaining to the provider's costs (if the provider is reimbursed on a cost basis) and charges for health care provided to program recipients shall be developed and maintained.

b. Financial records for all providers, other than nursing homes and board and care homes certified by the Minnesota Department of Health, shall include:

(1) Purchase invoices.

(2) All accounting records including, but not limited to, payroll ledgers, cancelled checks, and bank deposit slips.

(3) All contracts for supplies and services which relate to the provider's costs and charges for health care billed to the programs.

(4) Evidence of the provider's usual and customary charges and written evidence of charges to non-recipient patients without violating non-recipient patient rights to confidentiality.

(5) Evidence of claims for reimbursement, payments, settlements, or denials resulting from claims submitted to other third party payers of health care. For the purposes of this rule, third parties shall include other governmental programs, insurance companies, no-fault auto insurers and other payers of health care who may be financially responsible for services rendered a recipient.

c. Financial records for nursing homes and board and care homes certified by the Minnesota Department of Health, shall include:

(1) All records identified in C.2.b. of this rule.

(2) Records of deposits and expenditures for patient personal needs allowance accounts.

3. For the purposes of this rule, as set forth in A.1., providers shall grant the state agency access during regular

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business hours to examine medical, health care and financial records related to health care billed to the programs. Access to a recipient's personal medical and health care record shall be for the purpose of investigating whether or not a provider has submitted a claim for reimbursement, a cost report or a rate application which may be false in whole or in part or whether or not the health care was medically necessary. The SUR section shall notify the provider at least 24 hours before gaining access to such records. Upon the request of the provider, the SUR section shall present a copy of the recipient's written authorization to examine personal medical records unless the provider already has received written authorization from the recipient. A provider's refusal to grant the state agency access to examine records when authorized shall be grounds for sanction.

4. The state agency, at its own expense, is authorized to photocopy or otherwise duplicate any medical or financial record which it is authorized to examine. Photocopying shall be limited to the provider's premises unless removal is specifically permitted by the provider.

5. Providers shall retain all records for at least five (5) years. Records may be microfilmed after the third year.

6. In the event of a change of ownership of a facility or practice the seller, unless otherwise provided by law or by written agreement, shall be responsible for maintaining and preserving all records generated prior to the date of sale. Responsibility for making records available for inspection after the date of sale is on the seller and the seller must take reasonable steps by contract or otherwise to maintain a right of access to those records which is necessary to substantiate his billings, cost reports, or rate applications.

7. In the event a provider withdraws or is terminated from the programs, all records developed during participation in the programs, and not subject to the provisions of item 6 of this section, shall be retained by the provider for a period of five (5) years and shall be available for review by the state agency. Providers must retain records for at least 5 years after the date of billing.

8. A recipient's consent to the state agency's review of his or her medical or health care records shall be presumed competent if given in conjunction with an application for coverage under the programs. This presumption shall be rebuttable, and shall exist regardless of whether the application was signed by a recipient or a guardian.

D. Provider Surveillance and Utilization Review.

1. Identification of suspected fraud and abuse.

a. SUR shall be responsible for the detection and identification of suspected fraud, theft, abuse, presentment of

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false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts by providers who have billed the programs for health care rendered to a recipient.

b. For the purposes of this rule, SUR shall be authorized to utilize information from sources which shall include, but not be limited to:

(1) Computer reports generated by MMIS, using claim data to develop profiles on the provision and utilization of health care reimbursed by the programs. The profiles compare data on a peer group basis, and identify providers and recipients who appear exceptional when compared to group norms.

(2) Units of local, state and federal government.

(3) Other third-party payers including health insurance carriers.

(4) Professional standards review organizations.

(5) Citizens, including recipients.

(6) Providers, professional associations, and health care professionals.

c. In assessing questions of abuse or medical necessity, SUR shall consult with a review organization as defined in Minnesota Statutes, section 145.61 or other provider advisory committees as appointed by the Commissioner.

2. Investigation of suspected fraud or abuse.

a. SUR shall be responsible for the investigation of suspected fraud and abuse identified pursuant to D.1. of this rule. An investigation shall be conducted for the purposes of determining one or more of the following:

(1) Whether the suspected aberrant activity of a provider is the result of a legitimate condition of practice.

(2) Whether suspected fraud and abuse exists and can be documented.

(3) Whether sufficient evidence can be developed to support administrative, civil or criminal action as to such fraud and abuse.

b. A SUR investigation may include, but is not limited to:

(1) Examination of records pursuant to C. of this rule.

(2) Interviews of providers, their associates and

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employees.

(3) Interviews of program recipients.

(4) Verification of the professional credentials of providers, their associates and employees.

(5) Examination of any equipment, stock, materials or other items used in or for the treatment of program recipients.

(6) Examination of prescriptions written for program recipients.

(7) Determination of whether the health care provided was medically necessary.

c. Following the completion of an investigation SUR shall take one or more of the following actions:

(1) Determine that no further action is warranted and so notify the provider.

(2) Impose administrative sanctions against a provider in accordance with D.3. of this rule.

(3) Seek monetary recovery from a provider as set forth in D.3. of this rule.

(4) Refer the case in writing to the Attorney General for possible civil or criminal legal action.

3. Monetary recovery and sanctions. The commissioner shall be authorized to seek monetary recovery or impose administrative sanctions to protect the public welfare and the interests of the program. Monetary recovery and sanctions implemented by the commissioner shall be based upon documentation of fraud and abuse as set forth in D.1. and D.2. of this rule.

a. Grounds for monetary recovery and sanctions.

(1) The commissioner may seek monetary recovery against providers for any of the following:

(a) Fraud, theft, or abuse in connection with health care services billed to the programs.

(b) Presentment of false or duplicate claims, or claims for services not medically necessary.

(c) False statement of material facts for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

(2) The commissioner may impose administrative

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sanctions against providers for any of the following:

(a) Fraud, theft, or abuse in connection with health care services billed to the program.

(b) A pattern of presentment of false or duplicate claims or claims for services not medically necessary.

(c) A pattern of making false statement of material facts for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

(d) Refusal to grant the state agency access to records pursuant to C.3. of this rule.

(3) The commissioner shall suspend or terminate any provider who has been suspended or terminated from participation in the Medicare program because of fraud or abuse in connection with the Title XVIII of the Social Security Act.

b. The commissioner shall make monetary recovery from providers of monies erroneously paid due to violations described in D.3.a.(1) of this rule by the following means:

(1) Permitting voluntary repayment by the provider of monies erroneously paid, either in lump sum payment or installment payments.

(2) Withholding of payments.

(3) Debiting from program payments, monies determined to have been erroneously paid.

(4) Using any legal process to collect such monies.

c. For the purpose of D.3.b. of this rule, the commissioner shall be authorized to make monetary recovery from providers of monies erroneously paid, based upon extrapolation from systematic random samples of claims submitted by a provider and paid by the programs.

(1) The decision to use sampling and extrapolation in calculating a monetary recovery shall be at the discretion of the Director of the SUR Section. The following criteria shall apply in determining whether the sampling technique will be used:

(a) The claims to be sampled represent services to 50 or more recipients; or

(b) There are more than 1,000 claims to be sampled; or

(c) The claims to be sampled constitute charges to the Department of more than $2,000.

(2) The following factors shall apply in determining

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recovery by sampling and extrapolation:

(a) Samples shall be selected such that every claim to be sampled has an equal and independent chance of being chosen for the sample;

(b) Samples shall only be selected from claims within a time period which coincides with the duration of the violations for which recovery will be made;

(c) The sampling method, to include sample size, sample selection and extrapolation from the results of the sample, shall be in accordance with statistical procedures published in the following texts: L. Kish, Survey Sampling, John Wiley and Sons, New York (1965), or W. Cochran, Sampling Techniques, John Wiley and Sons, New York 3rd Ed. (1977).

(d) Samples shall be selected at the 95 percent confidence level, such that, the overall monetary recovery amount determined by extrapolation from the sample recovery amount will be within five percent of the amount which would be recovered by a complete audit, 95 percent of the time. The department will recover the extrapolated amount less the five percent factor.

(3) The department shall notify the provider of its intent to use sampling and extrapolation. The notice shall state:

(a) the nature of claims to be sampled;

(b) the sample size;

(c) the sample selection method; and

(d) the formulas and calculators to be used in extrapolation.

(4) The monetary recovery proposed by the department, based upon the use of sampling and extrapolation is rebuttable. The provider may present, at a conference with the SUR director, material to rebut the sample size and design, the facts and conclusions drawn from each sample used, and the calculations used to extrapolate the sample findings to all services furnished for the period of time reviewed. The costs of gathering and presenting the information will be met by the provider. Alternatively, the provider, at his expense, may conduct a complete audit and use the results to rebut the Department's findings.

(5) If the department does not accept the provider's rebuttal, the provider may appeal under procedures cited at F. of this rule.

d. The commissioner may impose any of the following sanctions for the conduct described in D.3.a.(2) of this rule:

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(1) Referral to the appropriate state regulatory agency.

(2) Referral to the appropriate peer review mechanism.

(3) Transfer to a provider agreement of limited duration not to exceed 12 months.

(4) Transfer to a provider agreement which stipulates specific conditions of participation.

(5) Suspending or terminating participation.

e. Notice to providers.

(1) The state agency shall notify providers in writing of any recovery of money or sanction it intends to impose.

(2) The notice shall state:

(a) The factual basis for alleging discrepancies or violations;

(b) The dollar value to such discrepancies or violations;

(c) How such dollar value was computed;

(d) What actions the state agency intends to take;

(e) The provider's right to dispute the state agency's factual allegations and to provide evidence to support the provider's position; and

(f) The provider's right to appeal the state agency's proposed action pursuant to F. of this rule.

(3) The effective date of the proposed monetary recovery or sanction shall be at least 20 calendar days following receipt of certified mail notifying the provider of the proposed action. If the provider appeals pursuant to F. of this rule, the action shall not be implemented until the commissioner's order is issued following the hearing on appeal, provided that the suspending or withholding of payment shall be effective on the date the notice is received, if in the commissioner's opinion such action is necessary to protect the public welfare and interests of the program. However, the commissioner shall not order a prehearing suspension or withholding of payments to a nursing home or board and care home. Implementation of a proposed action following the hearing on appeal may be postponed if in the opinion of the commissioner the delayed action is necessary to protect the welfare or interests of program recipients.

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f. The decision as to the sanction to be imposed against a provider, pursuant to subsection D.3.a.(2) of this rule, shall be at the discretion of the commissioner. The following factors shall be considered in determining the sanctions to be imposed:

(1) Nature and extent of offenses or violations;

(2) History of prior violations;

(3) Provider's willingness to obey program rules; and

(4) Actions taken or recommended by other state regulatory agencies.

g. Suspension or termination from participation shall preclude a provider from submitting any claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association for any health care provided under the programs, except for health care provided prior to the suspension or termination.

h. No clinic, group, corporation, or other association which is a provider of services shall submit any claim for payment for any health care provided by an individual provider within such organization who has been suspended or terminated from participation in the programs, except for health care provided prior to the suspension or termination. The state agency shall seek monetary recovery of such claims. Knowing submission of such claims shall be a ground for administrative sanction.

i. When a provider has been sanctioned in accordance with subsection D.3.c. of this rule, after all appeals have been exhausted or the time in which to file an appeal has elapsed, the state agency shall notify the appropriate professional society, board of registration or licensure, and federal or state agencies of the findings made, sanctions imposed, appeals made and the results of any subsequent appeal.

4. Nothing in this rule shall prevent the commissioner from simultaneously seeking monetary recovery and imposing sanction against a provider.

5. Nothing in this rule shall prohibit SUR from conducting routine audits of providers in order to monitor compliance with program requirements.

6. The commissioner is authorized to suspend or withhold payments to a provider prior to a hearing, as provided in Part D.3.e.(3), if:

a. There is a substantial likelihood of prevailing in an action pursuant to D.3. of this rule, or

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b. There is a substantial likelihood that the provider's pattern of practice which prompted a SUR investigation, will continue in the future, or

c. There is reasonable cause to doubt a provider's financial ability to refund any amounts determined to be due the program.

7. To the extent that federal law or regulation mandates sanctions against providers or recipients which conflict with provisions of this rule, such federal law or regulation shall prevail.

E. Recipient Surveillance and Utilization Review.

1. Identification of suspected fraud and abuse.

a. SUR shall be responsible for the detection and investigation of suspected fraud, theft or abuse by recipients of the programs.

b. For the purpose of this rule, SUR shall be authorized to utilize at least the sources of information identified in D.1.b. of this rule.

c. In assessing the question of medical necessity, SUR shall consult with a review organization as defined in Minn. Stat. S 145.61 or other provider advisory committees as appointed by the Commissioner.

2. Investigation of suspected fraud and abuse.

a. SUR shall be responsible for the investigation of suspected fraud and abuse identified pursuant to E.1. of this rule. A SUR investigation shall be conducted for the purpose of determining:

(1) Whether suspected fraud, theft, or abuse exists and can be documented.

(2) Whether sufficient evidence can be developed to support restricting recipient participation in the programs in accordance with E.3. of this rule.

(3) Whether sufficient evidence exists to support the imposition of other sanctions in accordance with E.3. of this rule.

3. Sanctions.

a. Grounds for sanctions. SUR may impose administrative sanctions against program recipients for any of the following:

(1) Altering or duplicating the medical identification card in any manner.

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(2) Permitting the use of his or her medical identification card by any unauthorized individual for the purpose of obtaining health care through the programs.

(3) Using a medical identification card that belongs to another person.

(4) Using the medical identification card to assist any unauthorized individual in obtaining health care for which the programs are billed.

(5) Duplicating or altering prescriptions.

(6) Knowingly misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, or drugs.

(7) Knowingly furnishing incorrect eligibility status or information to a provider.

(8) Knowingly furnishing false information to a provider in connection with health care previously rendered which the recipient has obtained and for which the programs have been billed.

(9) Knowingly obtaining health care in excess of established program limitations, or knowingly obtaining health care which is clearly not medically necessary.

(10) Knowingly obtaining duplicate services from a multiple number of providers for the same health care condition, excluding confirmation of diagnosis.

(11) Otherwise obtaining health care by false pretenses.

b. Sanctions against program recipients. SUR may impose any of the following sanctions for the conduct described in E.3.a. of this rule:

(1) Referring the recipient for appropriate health counseling in order to correct inappropriate or dangerous utilization of health care.

(2) Restricting the recipient's participation in a program to receiving health care from a provider whom the recipient has had the opportunity to select. The restriction shall be for a specified period of time and all changes in the designation of a provider during the restriction period shall be approved by the state agency. Reimbursement for non-emergency health care shall be limited to the designated provider.

(3) Recovery from recipients, to the extent permitted by law all amounts incorrectly paid by the programs.

(4) Terminating participation for that period during

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which a potential recipient refuses to sign a consent for release of records.

(5) Referring the recipient to the Attorney General for possible criminal or civil legal action.

c. Notice to recipients.

(1) The state agency shall cause the recipients to be notified in writing of any sanction it intends to impose.

(2) The notice shall state:

(a) The factual basis for alleging discrepancies or violations;

(b) The dollar value to such discrepancies or violations;

(c) How such dollar amount was computed;

(d) What actions the state agency intends to take;

(e) The recipient's right to dispute the state agency's factual allegations; and

(f) The recipient's right to appeal the state agency's proposed action pursuant to F. of this rule.

d. Emergency health care provided a restricted recipient by any provider shall be eligible for reimbursement by the programs if the claim for reimbursement is accompanied by a full explanation of the emergency circumstances.

e. The programs shall pay for specialized health care provided a restricted recipient if a copy of the written referral by the recipient's chosen provider is sent to the SUR section.

f. The fact that a recipient is restricted shall be clearly indicated on the medical card.

F. Appeal.

1. A provider may appeal the state agency's proposed administrative sanction, proposed suspension or withholding of payment, or demand for monetary recovery against a provider pursuant to the provisions of Minn. Stat. S 15.0418 pertaining to contested cases. An appeal shall be considered timely if written notice of appeal is received by the commissioner with 20 days of the date notice is received pursuant to D.3.e. of this rule.

2. A recipient may appeal any sanction proposed by the state agency pursuant to the provisions of Minn. Stat. S 256.045.

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3. Nothing in this rule shall prevent a provider or recipient, upon receipt of a notice of intended sanction, from meeting with the commissioner to informally discuss the matter in dispute, so long as an appeal has not been commenced.

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12 MCAR S 2.065 Preadmission screening for persons entering long term care facilities and alternative care grant services.

A. Responsibility for the program. The county agency responsible for administering the medical assistance program in each participating county shall be responsible for complying with requirements of the preadmission screening program.

B. Program scope. In counties participating in the program, screening teams shall review and make recommendations for nursing home applicants who are eligible for medical assistance and those who will be eligible within 90 days of admission to a nursing home. If an applicant or recipient's county of financial responsibility is included in the screening program, such applicant or recipient must be screened by the county of financial responsibility for admission to any nursing home. The procedures and criteria used by the screening team shall be in accordance with D.-H. Participating counties shall be eligible for the alternative care grant program described in H.

C. Notification about program.

1. Notice to eligible persons. The county agency responsible for the screening program shall refer to a screening team all persons eligible for the screening as described in B. When possible, medical assistance recipients shall be notified of the screening requirement through a direct mailing by the local welfare agency. At the time of the referral, with the consent of the applicant, the local welfare agency shall notify a responsible party or appropriate relative that the person has been referred, and the pre-admission screening is a condition of medical assistance coverage.

2. Public notice. The county agency responsible for the screening program shall provide public notification of the screening requirement. The methods of public notification shall include publication in available appropriate newsletters, display and dissemination of information leaflets in a readable form and in accessible locations, and promotion through other local media sources. The public notification shall include information on how to contact the screening team, implications of the screening team's recommendations, and the individuals' rights to appeal the screening team's recommendations.

3. Notice to officials and health care professionals. The Department of Public Welfare shall provide formal notification about the screening program to county commissioners, local health and welfare agencies, state hospitals, nursing homes, and physicians. The department shall assist participating counties in providing information sessions and materials to further explain the program.

D. Resource material for screening programs.

1. Screening tool. The department shall recommend a

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screening tool to be used as a guide in conducting the screening interview. The screening tool recommended by the department shall obtain consistent categories of information and ensure that persons are receiving uniform screening. The assessment tool used by the county screening teams shall require information related to the following criteria:

a. present medical conditions;

b. present unmet needs;

c. informal and formal service available or being provided to the person;

d. the recipient's preferences;

e. persons consulted in the screening process;

f. observations of the screening team during the onsite visit;

g. assessment of functional capacity; and

h. a preliminary service care plan.

The state agency shall allow counties flexibility in using the recommended tool or a comparable one which includes the information related to the criteria in a.-h. and has been approved by the state agency.

2. Technical assistance. Department staff shall be available to provide technical assistance in conducting the screenings, including special training sessions.

3. Directory of services. The county agency shall develop a resource directory of available institutional and noninstitutional services to be used by the screening team in determining how well an applicant's needs can be met by existing community services.

E. Screening requirements.

1. Screening team. Minnesota Statutes, section 256B.091, subdivision 2, shall govern the composition of the screening team. The screening team must include a public health nurse from the local public health nursing service, a social worker from the local community welfare agency, a physician available for consultation when necessary, and the individual's physician if the physician chooses to participate. The screening team shall utilize the individual's attending physicians' assessment forms if available.

2. Screening procedures. The screening team shall notify the individual's attending physician that the screening is a condition of medical assistance and that the physician has the right to participate in the screening procedure. The screening

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team shall begin the screening process within five working days after receiving the request, and it shall issue a recommendation within ten working days after receiving the request. The screening team shall notify the applicant or appropriate relative or responsible party of the decision. The team shall also notify the referring physician, the referring local welfare department if the applicant is a medical assistance recipient, and the nursing home if placement is recommended.

3. Rescreening procedures. Reconsideration of a previously denied application shall be given when there has been a change in circumstances. The application shall be resubmitted to the screening team with a written explanation of the change in circumstances. Time requirements for initial applications shall apply.

F. Criteria for screening team recommendations.

1. Nursing home admission. The screening team shall recommend admission to a nursing home when it is determined that the individual requires care or services which are not available to the recipient outside of the nursing home and cannot be provided through the alternative care grants program. In assessing the individual's need for service, the screening team may use reliable information gathered by others.

2. Use of community services. The screening team shall not recommend admission to a nursing home when it is determined that the individual can remain in the community and that care and services are available to the individual in his or her own community.

3. Choice of care. The recipient or his or her representative shall be informed of all feasible alternatives and allowed to choose among them where the cost of home and community-based services are not expected to exceed the cost of the appropriate level of nursing home care. This choice shall be recorded and maintained in the individual's plan of care.

G. Plan of care required. A recommendation for the applicant to remain in the community shall be accompanied by a plan of care including referral to service providers and assignment of responsibility for implementing the plan.

1. Development of the plan. The plan of care shall be developed by the screening team in consultation with the individual, the treating physician, and appropriate family members or responsible parties. The resource directory described in D.3. shall be used in determining what services are available.

2. Services provided in the plan of care. Where the plan of care includes services that are not available at that time through other public assistance sources, the services shall be provided through an alternative care grant described in H.

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3. Responsibility for the plan of care. The plan of care shall include the name of the person responsible for ensuring compliance, the method of monitoring the recipient's acceptance of and adjustment to the services provided under the plan, the date for reevaluation, and any temporary measures that might be required immediately in order to ensure the safety of the person. When needed services become unavailable, the assigned person shall be responsible for recommending a reevaluation by the screening team.

4. Cost-effective alternatives. The plan of care shall include documentation that the most cost-effective alternatives available have been offered to the individual.

H. Alternative care grant.

1. Use of grant. The grant shall be used to provide services to medical assistance recipients who have been screened and found appropriate for home or community care. Services that may be provided through this grant are day care, case management, homemaker, home health aide, personal care, respite care, foster care, and others for which federal participation is provided under the Social Security Act, section 1915, as added by Public Law 97-35, as amended through December 31, 1981. The grant shall supplement but not supplant services available through other public assistance or service programs. The grant shall not be used to establish new programs for which public money is available through other sources.

2. Service provision. The services shall be provided by a licensed health care provider; a home health service eligible for reimbursement under 42 United States Code, Subchapters XVIII or XIX, as amended through December 31, 1981, and Code of Federal Regulations, title 42, sections 405.1201-405.1230 (1981); or by persons employed by, or under contract to, the county board or the local welfare agency.

3. Reimbursement of services. Services shall be reimbursed at a level no greater than that which is allowed under 42 United States Code, Subchapters XIX and XX, as amended through December 31, 1981, and Code of Federal Regulations, title 42, sections 405.201-405.252 (1981), unless lower rates are negotiated with providers at a level sufficient to insure the availability of such services in the community.

4. Assurances. The county shall provide the Commissioner of Public Welfare with assurances that the alternative care grant is used for purposes specified in Minnesota Statutes, section 256B.091, subdivision 8 and in Public Law 97-35, Section 2176 relating to community-based services.

I. Reimbursement of nursing home costs.

1. Notification of admission of unscreened applicants. When an individual covered by the mandatory screening requirement is admitted to a nursing home on an emergency or

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nonemergency basis and has not obtained the required preadmission screening, the nursing home shall notify the screening team within two working days. If the admitting facility fails to contact the screening team within the prescribed period, the facility shall not be reimbursed for any costs incurred until the decision is made and the recipient and the nursing home are notified. Patient days resulting from that stay must be counted in the facility's patient day statistics for the purposes of rate calculation under 12 MCAR S 2.049.

2. Screening team review. When an unscreened applicant has been admitted to the nursing home, the screening team shall make a decision on the case within five working days of being contacted by the nursing home. If the person prefers to return to the community, medical assistance shall cover the costs only for the period through the date the screening team notified the nursing home of this decision and until a plan for alternative care can be implemented.

3. Persons not screened. Nursing home applicants who have not been screened and are not medical assistance recipients shall be asked by the nursing home if they have sufficient funds to cover 90 days of nursing home care or whether they will be applying for medical assistance within that time period. If, based on the information given and recorded, the nursing home determines that the person is not subject to the screening requirement the applicant may be admitted without screening. The nursing home shall maintain documentation of the basis for this decision in the patient's file. If the patient's statement concerning proposed eligibility is inaccurate, the health care facility shall not be denied reimbursement because of the inaccuracy of this statement.

J. Reimbursement for screening costs.

1. Persons eligible for medical assistance. The Department of Public Welfare shall reimburse the county agency for the preadmission screening required for persons who are eligible for medical assistance and those who will be eligible for medical assistance within 90 days of admission to a nursing home. Reimbursement shall be in a manner agreed upon by both parties.

2. Persons not receiving assistance. The Department of Public Welfare shall reimburse the county agency for all or a portion of the cost of screening for a person whose costs are not reimbursed under 1. The percentage rate of reimbursement by the department shall be determined according to the schedule in Exhibit 12 MCAR S 2.065 J.2.-1., except that the maximum amount of reimbursement from the department for a screening shall not exceed the maximum reimbursement available to a county agency for the cost of a screening reimbursed under 1. The county agency may assess the person who is screened for the part of the screening cost not reimbursed by the department.

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Exhibit 12 MCAR S 2.065 J.2.-1.

Annual Gross Income per Individual	Screening Fee Reimbursement for Applicants not Eligible for Medical Assistance
under - 13,000	100 %
13,001 - 13,500	90
13,501 - 14,000	80
14,001 - 14,500	70
14,501 - 15,000	60
15,001 - 15,500	50
15,501 - 16,000	40
16,001 - 16,500	30
16,501 - 17,000	20
17,001 - 17,500	10
17,501 - and over	0

K. Right to appeal.

1. Appeal procedures. Persons who are recipients of or applying for medical assistance have the right to a fair hearing pursuant to Minnesota Statutes, section 256.045 if they are not informed of and allowed to choose among alternatives available to them as set forth in F.3., or if the plan of care is not satisfactory. The hearing shall be conducted in accordance with appeal procedures set forth in Minnesota Statutes, section 256.045. If it appears at the hearing that circumstances are different than they were at the time the plan of care was established, the referee may refer the case back to the screening team for reconsideration.

2. Appeal by the physician. When the treating physician disagrees with the outcome of the screening, the physician shall notify the screening team in order to initiate an appeal on behalf of the individual. The appeal may be withdrawn with the consent of the individual and the treating physician.

L. County reports. The county agency shall submit a report to the Department of Public Welfare according to a schedule agreed upon by the department and the county agency. The report shall be submitted on forms provided by the commissioner and include the number of persons screened, results of each screening, and the rationale for each screening recommendation. The county agency shall retain the plan of care for persons who are to remain in the community and shall make it available to the department on request. The county agency shall also provide information as requested by the commissioner for ongoing evaluation of the program.

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12 MCAR S 2.079 Rules governing all vending stands and business enterprises of the services for the blind.

A. Legal authority and scope of rules. Pursuant to Minnesota Statutes, sections 15.0412, subdivision 3, and 248.07, subdivision 11, the following rules are hereby issued by the Commissioner of Public Welfare to govern all vending stands and business enterprises established by the Services for the Blind, Department of Public Welfare, for which the Department of Public Welfare is responsible. Licenses to blind persons will be issued in accordance with these rules and applicable statutes by the commissioner or his designee, hereinafter to be known as the licensing agency.

B. Issuance and conditions of licenses.

1. Selection of stand operators. The selection of stand operators will be made on an objective basis, including a thorough evaluation of the following: experience, training, former vocations, education, and other factors that relate to job requirements. Preference will be given to blind persons who are in need of employment. The following specific requirements will also be adhered to. Blind persons selected as operators will:

a. Be determined, after examination by a physician skilled in diseases of the eye or by an optometrist, whichever such person shall select, to have

(1) Not more than 20/200 central visual acuity in the better eye with correcting lenses, or

(2) An equally disabling loss of the visual field as evidenced by a limitation to the field of vision in the better eye to such a degree that its evident diameter subtends an angle of no greater than 20 degrees,

b. Be citizens of the United States,

c. Be certified as qualified for the operation of a vending stand by the rehabilitation staff of the Services for the Blind, Department of Public Welfare.

2. License period and license termination.

a. Each license will be issued for an indefinite period but subject to termination by written notice for good cause shown, including but not limited to:

(1) Failure to operate in accordance with this rule, the agreement with the operator, or the terms and conditions of the licensing agency's permit to operate in the building or property;

(2) Improvement of vision so that the operator no

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longer meets the definition of blindness as stated in part B.1.a. of this rule;

(3) Extended illness with medically documented diagnosis of prolonged incapacity of the operator to operate the vending stand in a manner consistent with the needs of the location or other available locations in the program;

(4) Withdrawal of the operator from the program upon the operator's written notification to the licensing agency.

b. The licensing agency shall promptly notify by certified mail or personal service any vending stand operator whose license is proposed to be revoked. This notification shall state the grounds for such action and shall inform the operator of the right to appeal the action. The operator will be afforded an opportunity for a fair hearing before termination of the license as described in Section I. of this rule.

3. Operator agreements.

a. Each licensed operator will sign an agreement for the operation of an assigned vending stand, and will sign a new agreement each time the operator moves or transfers to another vending stand.

b. The operator's agreement to operate a vending stand may be revoked or temporarily suspended in those instances where the operation, integrity, or reputation of the program may be damaged. The licensing agency shall promptly notify by certified mail or personal service any vending stand operator whose agreement is suspended or revoked. The notification shall state the grounds for such action and shall inform the operator of the right to appeal the action, as described in section I. of this rule. The action to suspend or revoke an agreement does not automatically mean the termination of the operator's license. Notice of intent to terminate the operator's license shall require a separate notice, as described in part B.2.b. of this rule.

C. Furnishing equipment and initial stocks. The licensing agency is responsible:

1. For furnishing each vending stand or business enterprise with adequate, suitable equipment and maintenance, repair, and replacement of such equipment.

2. For furnishing each vending stand or business enterprise with adequate initial stocks of merchandise and supplies. Subsequent purchase of merchandise shall be made by the operator out of current receipts. Merchandise shall be replaced as sold, maintaining the inventory at the minimum of the original inventory.

D. Right to, title to, and interest in the vending stand equipment and stocks. The right to, title to, and interest in

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the vending stand equipment used in the program is vested in the state of Minnesota. Operators will be required to acquire ownership of merchandise and supplies through reimbursing the licensing agency for such expenditures, by monthly payments extended over a three-year period. Upon approval of the licensing agency additional time may be granted in hardship cases, the purpose of which is to assure that no individual be denied the opportunity to become an operator because of the operator's inability to purchase the initial stock. Upon termination of the operator's license, the licensing agency will purchase, at the prevailing wholesale price, all saleable merchandise and, at an amortized price, all supplies remaining in the stand, assuming there is no delinquency in the operator's accounts with the licensing agency. No fixtures or equipment shall be added, altered, or removed from the stand except at the direction of the licensing agency. The operator will exercise all possible care in the use of fixtures and equipment, making no alterations, changes, or additions.

E. Funds set aside from vending stand proceeds.

1. The licensing agency will set aside or cause to be set aside from the monthly net proceeds of the operation of vending stands the following amounts:

a. On the 1st $100 or portion thereof, 2%

b. On the 2nd $100 or portion thereof, 4%

c. On the 3rd $100 or portion thereof, 6%

d. On the 4th $100 or portion thereof, 8%

e. On the 5th $100 or portion thereof, 10%

f. On the 6th $100 or portion thereof, 12%

g. On the 7th $100 or portion thereof, 14%

and any amounts over $700 16%

"Net proceeds," as used herein, means the monthly cash receipts including any vending machine or other income, less merchandise purchases, general expenses, and pay roll (excluding set-aside charges).

2. This rate supersedes any previous rate heretofore established by any agreements or policies of the licensing agency. The operator shall pay these set-aside funds monthly to the licensing agency. These set-aside funds shall be used only to the extent necessary and may be used for the sole purpose of:

a. Maintenance and replacement of equipment;

b. The purchase of new equipment; and

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c. The management services that are specified in state law.

3. The operator management committee, as defined in part H.3. of this rule, will participate with the licensing agency in the establishment of a set-aside schedule covering each of the purposes for which the set-aside funds are intended to be used, and will be reviewed annually to determine the need for change based upon the previous year's expenditures. The schedule shall be designed to prevent, so far as is practicable, a greater charge for any purpose than is reasonably required, with the allowances for the retention of reasonable reserves necessary to assure that each such purpose can be provided on a continuing basis. Changes, when necessary, shall be by amendment to this rule.

F. Distribution and use of income from vending machines on federal property.

1. Vending machine income from vending machines on federal property which has been disbursed to the licensing agency by a property managing department, agency, or instrumentality of the United States shall accrue to each blind operator operating a vending stand on such federal property in an amount not to exceed the average net income of the total number of blind operators within the state program, as determined each fiscal year on the basis of each prior year's operation, except that vending machine income shall not accrue to any blind operator in any amount exceeding the average net income of the total number of blind operators in the United States.

2. No blind operator shall receive less vending machine income than the operator was receiving during the calendar year prior to January 1, 1974, as a direct result of any limitation imposed on such income under this ceiling.

3. No limitation shall be imposed on income from vending machines combined to create a vending stand when such stand is maintained, serviced, or operated by a blind operator. The licensing agency will retain vending machine income disbursed by a property managing department, agency or instrumentality of the United States in excess of the amounts eligible to accrue to blind operators.

4. The licensing agency will disburse vending machine income to blind operators on at least a quarterly basis.

5. Vending machine income retained by the licensing agency will be used for the establishment and maintenance of retirement or pension plans, for health insurance contributions, and for the provision of paid sick leave and vacation time for blind operators, if it is so determined by a majority vote of the licensed operators, after each operator has been furnished information on all matters relevant to such purposes. Any vending machine income not necessary for such purposes shall be

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used for one or more of the following: maintenance and replacement of equipment; purchase of new equipment; or management services. Any set-aside charged to blind operators shall be reduced pro rata in an amount equal to the total of such remaining vending machine income.

G. Policies governing the duties, supervision, transfer, and participation of operators.

1. Each operator shall be entitled to the net proceeds of the operation of the vending stand he/she operates, less the amount set-aside by the licensing agency.

2. Each operator shall agree to:

a. Perform faithfully and to the best of the operator's ability the necessary duties in connection with the operation of a vending stand in accordance with the licensing agency's rules, the terms of the licensing agency's permit to operate in the building or property, and the agreement with the operator;

b. Cooperate with official and duly authorized representatives of the licensing agency in connection with their official program responsibilities;

c. Operate the vending stand in accordance with all applicable health laws and regulations;

d. Furnish monthly reports to the licensing agency by the tenth of the following month, listing daily sales, other income, purchases, other expenditures, and personal withdrawals, and attaching all invoices properly receipted. Inventory of merchandise will be included when requested;

e. Make all purchases of merchandise on a strictly cash basis unless exception is permitted in writing by the licensing agency; and

f. Make no credit sales.

3. The licensing agency assumes responsibility for providing to the vending stand operators such supervision, assistance and training as may be necessary to insure the operation of each vending stand in the most productive and efficient manner possible. This supervision, assistance and training must be performed in accordance with the following policies in addition to other provisions of this rule.

a. In entering agreements for new or vacated stands, preference on the basis of seniority of experience of operating stands under the control of the licensing agency shall be given to capable operators who are deemed competent to handle the enterprise under consideration. The application of such preference will not prohibit the licensing agency from selecting an operator from the community in which the stand is located.

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Seniority shall be determined on the basis of continuous service in the stand program while under contract with the licensing agency. In the case of broken service, previous service shall be considered only when termination was due to no fault of the operator. Termination for medical reasons may be considered as a leave of absence when so requested by the operator and approved by the licensing agency at the time of termination.

b. When it has been determined that a relief operator or an assistant or assistants must be employed, the licensing agency shall first make attempts to locate a handicapped individual before approving the employment of a non-handicapped person. The wages paid for any help, including bookkeeping, must be in reasonable proportion to work performed and must be approved by the licensing agency.

c. The licensing agency shall approve the items and the selling prices at which those items may be sold, which comprise the merchandise inventory at each vending stand.

d. The operator must obtain the approval of the licensing agency before changing vendors with whom the operator does business in connection with the vending stand.

e. The operator will purchase liability insurance for the vending stand. The agency will purchase liability insurance for a vending stand only when, in the opinion of the licensing agency, it is deemed essential that the agency purchase this insurance.

H. Election, organization, and functions of the operator management committee.

1. The licensing agency and the elections sub-committee of the operator management committee will conduct an annual election for representatives to the operator management committee.

2. The committee will consist of one representative from each of the program districts (at present six) and two representatives at large.

a. Nominations will be solicited in each district for that district and state-wide for at-large representatives.

b. Elections will be by licensed operators in each district for their district and state-wide for at-large representatives.

c. Each term will be two years, with a limit of two successive terms.

d. The committee shall elect its own chairman and other officers. The chairman shall appoint sub-committees as necessary.

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e. The full committee will meet a minimum of twice a year. Meetings may be called by notice of either the licensing agency or the chairman of the committee. Sub-committees will meet as necessary to carry on their functions.

f. The committee shall establish by-laws for the further rules, functioning and guidance of the committee.

3. The operator management committee's purpose and function is to:

a. Participate with the licensing agency in major administrative decisions and policy and program development;

b. Receive grievances of vending stand operators and serve as their advocates;

c. Participate with the licensing agency in the administration of the transfer and promotion system for vending stand operators;

d. Participate with the licensing agency in developing training and retraining programs; and

e. Sponsor, with the assistance of the licensing agency, meetings and instructional conferences for vending stand operators.

I. Review of agency decisions. Operators shall be informed in writing at the time they are licensed of their right to and the procedures to be followed in obtaining an administrative review or a fair hearing regarding an agency decision.

1. An opportunity for an informal administrative review will be afforded to each operator dissatisfied with any action arising from the operation or administration of the vending stand program. The following procedures will be followed in granting operators an informal administrative review:

a. An operator or the operator's designee (who need not be an attorney) may request in writing, within 15 working days of the occurrence of the action, administrative review of the licensing agency action. This review will be made only by a member or members of the administrative staff of the agency who have not in any way participated in the agency action in question.

b. The administrative review will be held during regular agency working hours, at a district or local office location. An administrative review will be conducted within 30 working days of receipt by the licensing agency of such a written request.

c. Documentation as to written requests for administrative review and actions and decisions resulting therefrom shall be maintained as part of the official record of

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the administrative review process.

d. When an informal administrative review does not resolve a dispute to the satisfaction of a blind operator, the blind operator may request that the licensing agency provide a fair hearing.

2. An opportunity for a fair hearing conducted pursuant to Minnesota Statutes, sections 15.0418 to 15.0422 will be afforded to each operator dissatisfied with any action arising from the operation or administration of the vending stand program. The following procedures will be followed in granting operators a fair hearing.

a. If an operator requests a fair hearing, such a request must be made either within 15 working days after an adverse decision based on an administrative review or, in the absence of an administrative review, within 15 working days of the occurrence of the action with which the operator is dissatisfied.

b. An operator or the operator's designee must request a fair hearing in writing. This request must be transmitted to the administrator of the licensing agency personally or by certified mail, return receipt requested. The request must specify the action being appealed and state in detail the basis for the appeal.

c. The hearing shall be held at a time and place convenient and accessible to the operator requesting a fair hearing. A hearing held during regular agency working hours and located at the state agency central office will be deemed among the convenient times and places. Upon receipt of the request, the licensing agency shall immediately request a hearing date from the state Office of Administrative Hearings, and then notify the operator of the time and place for the hearing. The operator shall be provided a copy of the hearing procedures and rules.

d. After receipt of the report of the hearing examiner the state administrator (or, in the case of license revocation, the Commissioner of Public Welfare) shall issue a proposed decision. The proposed decision shall state that the decision shall become final 15 days after its issuance unless, before that date, the operator requests a review by a three-person appeal committee according to Minnesota Statutes, section 248.07, subdivision 15(3). The appeal committee's recommendation will be made to the administrator of the licensing agency or the commissioner who shall issue a final decision modifying or affirming the proposed decision.

3. If an operator is dissatisfied with the decision rendered after a full evidentiary hearing, the operator may request that an arbitration panel be convened by filing a complaint with the Secretary of the Department of Education, as authorized by federal regulations at 45 Code of Federal

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Regulations, section 1369.13 (1979).

J. Access to program and financial information. Each operator shall be provided access to all program and financial data of the licensing agency relevant to the operation of the vending stand program, including quarterly and annual financial reports. Insofar as is practicable such data shall be made available in braille or recorded tape. At the request of an operator, the licensing agency will arrange a convenient time to assist in the interpretation of such data.

K. Explanation to operator of the operator's responsibilities and privileges. The licensing agency rules, the agreement with the operator, and any applicable regulations of the authority having charge of the property on which the vending stand or business enterprise is located shall be read and explained to each operator. A copy of the agreement and this rule will be furnished to each operator. The agreement between the licensing agency and the operator, consistent with the provisions of this rule and signed by the operator, will be the operator's attestation that the agreement and this rule have been read to the operator and that the operator agrees to abide by them.

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§ 2.080 Standards for residential facilities and services for the physically handicapped.

Minn. Stat., §§ 245.78 through 245.82, establishes the authority of the Commissioner of Public Welfare to set rules governing the operation of residential facilities and services for the physically handicapped. The Commissioner of Public Welfare hereby promulgates the following rule to establish standards for residential facilities and services for the physically handicapped.

A. General objectives.

1. At least these essential aims shall be incorporated in the general philosophy and subsequent policies of the facility.

a. To promote the greatest degree of independence possible for each resident.

b. To enhance the ability of each resident to cope with his environment.

c. To maximize and foster the human qualities of each resident.

d. To provide a homelike atmosphere to the greatest possible extent, in which the resident is recognized as an individual whose personal interests are maintained and developed and whose personal dignity is respected and safeguarded.

2. The residential facility program shall attempt to elicit and maintain behavior that is as culturally normative as possible, taking into account local and subcultural differences.

3. The residential facility should be located within and conveniently accessible to the population served, so as to have access to necessary generic community services.

4. The residential facility and the surrounding community should be encouraged to share their services and resources on a reciprocal basis.

5. Residents should be integrated to the greatest possible extent with the general population. To this end, generic and specialized community services, rather than facility services, should be used extensively or, if possible, completely.

B. Definitions.

1. "Physically handicapped" encompasses those orthopedic, incoordinative, sight, and hearing disabilities that culminate in the significant reduction of mobility, flexibility, coordination, or perceptiveness and that, singly or in combination, interfere with the individual's ability to live and function independently; that are not the result of the normal aging process; and that are considered to be chronic conditions.

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2. "Active community service" pertains to any human service provider (including but not limited to individuals, agencies, organizations, or institutions offering health, educational, financial, psychological, social, or vocational services) that is independent of and located apart from the residential facility in the community and plans to or is presently providing service to the resident.

3. "Common living areas" refers to all portions of the residential facility designated for the shared usage of its residents.

4. "Developmental/rehabilitative services" include those services that are designed to promote the resident's gradual and synchronized progression toward differentiation, complexity, and ultimate integration of structure, function, and behavior and those that are designed to attain maximum reduction of disability and restoration of the resident to his best possible functional level.

5. "In-residence medical services" means that organized program of care and services provided within the confines of the residential facility pertaining to medical care that are performed by or at the direction of a physician on behalf of residents by physicians, dentists, nurses, and other professional and technical personnel.

6. "Mobility categories" denotes the following four classifications of ease and independence with which a person can move from one place to another.

a. Ambulatory—ability to walk independently and at least negotiate any barriers such as ramps, doors, stairs, corridors, etc., as may be necessary to get in and out of the facility.

b. Mobile—ability to move from place to place with the use of devices such as walkers, crutches, wheelchairs, wheeled platforms, etc.

c. Nonambulatory—inability to walk independently.

d. Nonmobile—inability to independently move from place to place.

7. "Operator" means the person or persons, whether or not owners, who manage the residential facility and are responsible for the general program of the facility and the individual programs of the residents.

8. "Program" means the planned and purposeful set of conditions and events established by or through the residential facility that covers all or a portion of the major areas of the resident's life.

9. "Resident" means any individual who resides in or receives service from a residential facility, including current and former residents as well as those persons being considered for residence.

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10. "Residential facility" refers to any institution, building, agency, or place offering some element of congregate care or service in which an individual lives or dwells on a regular basis and that he at least uses for sleeping; for maintaining his personal clothing, papers, and other personal possessions; and as his designated mailing address.

11. "Resident living area" means that building or distinct portion thereof that contains sleeping, living, or recreation, and, in some instances, dining and kitchen, areas.

C. Facility classification. Residential facilities will be classified on the basis of the level-of-care and service needs of their residents.

Level I

1. Will include all residential facilities serving five or more physically handicapped persons in the various mobility categories who can live independently in the community with modification of certain architectural barriers and who:

a. Are capable of performing substantially all of their own personal-care functions.

b. Are capable of using regular public and/or private transportation.

c. Are 16 years of age or older.

2. These shall be interpreted as the minimum criteria to be applied to any physically handicapped resident in a Level I facility.

Level II

1. Will include all residential facilities serving five or more physically handicapped persons in the various mobility categories who have some limitations on their ability to live independently in the community even with the modification of certain architectural barriers and who:

a. Are in need of assistance in varying degrees with personal-care functions.

b. Have service needs that exclude continuing in-residence medical care.

c. Are either children or adults.

2. These shall be interpreted as the minimum criteria to be applied to any physically handicapped resident in a Level II facility.

Level III

1. Will include all residential facilities serving five or more physically

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handicapped persons in the various mobility categories whose ability to live independently in the community is severely circumscribed even with the modification of certain architectural barriers and who:

a. Are in need of some form of continuing in-residence medical service, irrespective of other services needed.

b. Are in need of assistance with a substantial portion of personal-care functions.

c. Are either children or adults.

2. These shall be interpreted as the minimum criteria to be applied to any physically handicapped resident in a Level III facility.

D. Admission, transfer, and discharge. The facility's admission, transfer, and discharge policies and procedures shall:

1. Provide for participation by the resident and/or parent, guardian, or his designated representative in all such decisions.

2. Include an initial and periodic assessment of all relevant physical, emotional, social, cognitive, vocational, and other significant factors by facility staff and the appropriate active community service representatives.

3. Prohibit discrimination in all such considerations on the basis of race, color, religion, nationality, or sex where it is the general policy of the facility to serve persons of both sexes.

4. Insure that adequate information about the facility and its program is disseminated to all interested and involved parties.

5. Base all such decisions on the individual program needs of the present or prospective resident and their compatibility with the facility's capacity to formally arrange or directly provide program resources and the facility's physical and spacial constraints.

E. Developmental and rehabilitative services. As determined by the resident's abilities and individual program needs, the residential facility shall:

1. Provide directly or otherwise formally arrange developmental and rehabilitative services in order to strengthen and sustain the resident's capacity to function independently.

2. Insure that developmental and rehabilitative services are sufficient in variety and scope to satisfy each resident's needs and are of a quality comparable to those services provided in the wider community.

3. Arrange for developmental and rehabilitative services, including a periodic review, on the basis of an individual service plan developed by facility staff and appropriate active community-service representatives.

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F. Resident-staff policies and procedures. The manner in which staff members provide service and care to the residents is vital to the effectiveness of the facility's program. In this respect, the facility's resident-staff policies and procedures shall:

1. Establish the care and development of the residents as the primary responsibility of its staff.

2. Provide for a fair, impartial, and humane governing and management process that protects the interests of the residents singly and as a group while taking into account resident views on those matters affecting them.

3. Insure that staff members participate in the development of and have access to resident program plans and recommendations.

4. Seek to create and maintain a warm, personal, supportive environment that is conducive to the well-being of the resident and that promotes maximum independent functioning.

G. Records. Records are to be maintained by the facility for residents, employees, and administrative operations and shall:

1. Contain sufficient and accurate information for and be accessible to the appropriate and authorized persons to plan, implement, review, and evaluate the care and services to individual residents as well as the broader programs offered through or arranged by the facility.

2. Provide adequate legal protection of the rights of the residents, the facility, and its staff through correct documentation of the various activities.

3. Be considered confidential and subject to proper consent procedures for all but those facility staff members and active community-service representatives who are actually involved in and require such information for the provision of care and services to residents.

H. Administrative organization. Policies and procedures pertaining to the facility's administrative organization shall:

1. Specify its philosophy, purpose, and goals, making them available to all interested parties.

2. Define its organizational structure.

3. Have available documentary evidence of its source of operating authority.

4. Provide for the sound management of all facets of the facility's operations for which a qualified person designated as director is responsible.

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5. Insure that the facility's operations are organized and managed in a manner appropriate to the program needs of the residents.

I. Staffing and personnel. The facility's personnel policies and practices shall:

1. Insure that a sufficient number of adequately trained and qualified staff members who are administratively responsible to persons of appropriate program training and experience are on duty during each 24-hour period to provide suitable care and service to the residents in a manner consistent with the facility's stated program objectives.

2. Delineate staff responsibilities to cover emergency situations.

3. Provide for an initial and periodic assessment of the health status of staff members.

4. Establish and maintain job descriptions for all personnel.

5. Promote the development and upgrading of staff by making available opportunities for in-service training.

6. Provide for the periodic, at least annual, evaluation of each employee.

J. Organization of resident-living areas. The placement and grouping of residents within the context of the spacial confines of the facility are prominent considerations for the effective use of care and services. To this extent the facility policies and procedures pertaining to the organization of resident-living areas shall:

1. Seek to create and maintain an environment that promotes the development of meaningful interpersonal relationships among residents and between residents and staff.

2. Maintain resident-living areas separate from other program areas in the facility.

3. Establish and follow criteria for placement of residents within the facility that will promote the growth and development of all those together in residence.

4. Not exclude persons from residence that the facility is otherwise equipped to serve solely on the basis of the facility's internal placement criteria.

K. Resident-living services. Resident-living services (including, but not limited to, food, laundry, housekeeping, and plant-maintenance services) shall:

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1. Approximate the patterns of a family home from the standpoint of scheduling, frequency, and manner of provision of such services.

2. Be provided in accordance with the customs of the resident population and its developmental levels.

3. Be provided in a manner that assures the maintenance of a high level of health, safety, and sanitation within the facility that complies with all such applicable federal, state, and local regulations.

L. Design and equipage of living areas. The design, construction, and furnishing of resident-living areas shall:

1. Be consistent with the developmental levels and programatic needs of the resident.

2. Simulate the arrangements of a family home.

3. Provide for adequate space and equipment to carry out the facility's expressed functions and activities.

4. Assure continued compliance with all applicable state and local fire, safety, sanitation, building, and zoning regulations.

M. Removal and reduction of architectural barriers. The facility's policies and procedures to remove and reduce architectural barriers shall:

1. Seek to minimize physical, social, and psychological isolation of the residents.

2. Provide for the residents' accessibility to living, recreational, and other program areas within the facility, as well as such resources in the community.

3. Provide for and protect the health and safety of the residents.

N. Licensing procedures. In order that the licensing agency can discharge its duties in a prompt, efficient and effective manner, residential facility owners and/or operators shall:

1. Conform with those procedures established by that agency pertaining to license issuance, renewal, and revocation.

2. Supply supportive information as may be required by the licensing agency.

3. Permit on-site inspections as required by the licensing agency to ascertain initial and continued compliance with licensing conditions.

4. Comply with all specific conditions attached to individual licenses.

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5. Make full payment of the designated license fees prior to issuance or renewal of a license.

6. Be entitled to proper notice and hearing as provided for in Minn. Stat., ch. 15, pertaining to revocation and refusal to issue or reissue a license.

O. Licensing exceptions. If, in the licensing procedure or enforcement of these standards, the Commissioner finds that to require a facility or service to comply strictly with one or more provisions of these standards will result in undue hardship, and if the facility or service is in substantial compliance with the intent and purpose of these standards, an exception may be granted for a specified period of time.

P. Refusal or revocation of license. Failure to comply with these standards shall be cause for refusal or revocation of license.

Effective Date–November 20, 1972.

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§ 2.151 Health care facility reports.

A. Authority and objectives.

1. This rule is enacted pursuant to 1973 Laws of Minn., ch. 688, § 8, in order to provide a system for the financial reporting of all facilities licensed under provisions of Minn. Stat., §§ 144.50 to 144.58.

B. Required reports.

1. All facilities (except those filing reports pursuant to 12 MCAR § 2.049 or § 2.052 licensed under the provisions of Minn. Stat. §§ 144.50 to 144.58 must file the following information with the Commissioner of the Department of Public Welfare within 90 days of the end of the facility's normal fiscal year:

a. an annual statement of income and expenditures,

b. a complete statement of all fees and all charges,

c. the names of all persons other than mortgage companies owning any interest in the facility including stockholders with an ownership interest of ten percent or more of the facility.

Effective Date—February 4, 1974.

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006349

12 MCAR S 2.160 Administration of Minnesota public social services.

A. Introduction.

1. This rule governs the administration of publicly funded social services in Minnesota as identified in A.6.t. of this rule. The authority for the administration of social services is found in Minnesota Statutes, chapter 256, and other applicable state laws. Authority is also found in Public Law 93-647, as implemented by Code of Federal Regulations, title 45, part 228. The delivery of public social services in Minnesota is state supervised and locally administered. The authority for this method of delivery is given in Minnesota Statutes, chapters 256E, 393 and 402.

2. The commissioner of public welfare may issue bulletins and manual material to local social service agencies and other service providers to clarify the provisions of this rule and may prescribe forms to be used in the administration of social services.

3. Social services shall be administered in a manner to ensure the individual and civil rights of applicants and clients. Information regarding individuals shall not be disclosed, except as provided under applicable state law and/or official departmental rules and regulations.

4. This rule is binding on all county boards of commissioners and human services boards and their respective agencies (hereinafter referred to as local social services agencies) in the state of Minnesota administering and providing social services, the state agency or other service providers under contract to local social services agencies or the state agency and applicants and clients of social services.

5. Sections A. through G. of this rule apply to county boards of commissioners and those human service boards which assume the responsibility for social services that would be provided by county boards of commissioners. Section H. applies to social services funded through Title XX of the Social Security Act of 1935, as amended.

6. Definitions.

a. Applicant means an individual who has directly, or through someone acting in his behalf, made application for social services.

b. Application means a request for social services on forms prescribed by the state agency. The application shall contain sufficient information about the applicant to enable the local social services agency to make an eligibility decision. As part of the application process, the applicant shall be informed of his rights and responsibilities as outlined by the

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state agency.

c. Approved vendor means providers of social services which are licensed, approved as meeting state licensing standards, or where licensing is not required, meet standards or criteria established by the state agency or local social services agency.

d. Categories of individuals means grouping of persons on the basis of common characteristics such as recipient status (Aid to Families with Dependent Children, Supplemental Security Income, Minnesota Supplemental Aid), income level, age and physical or mental condition.

e. Comprehensive Annual Services Program Plan (CASP Plan) means the state social services plan, which is a compilation of all the local social services plans, and which meets the state plan requirements of Title XX of the Social Security Act.

f. Declaration method means acceptance of an individual's statements regarding the source and amount of his household monthly gross income, and the income maintenance status of any member of the household.

g. Documentation means written evidence, in addition to signed application and income declaration forms, of income maintenance status or household monthly gross income.

h. Federal financial participation (FFP) means federal moneys available through Title XX of the Social Security Act to be used in payment for social services.

i. Fees means moneys billed and/or collected for the services provided.

j. Geographic area means locally identified political subdivision of the state covered by a social services plan.

k. Gross income means income, prior to any deductions, received from wages or salary; net income from self-employment; net farm income; Social Security payments; dividends, interest, rent received, or royalties; general assistance payments; pensions and annuities; unemployment compensation; worker's compensation; alimony; child support; veteran's pensions; or any combination of the above sources of income.

l. Host county contract means contractual agreement between a purchase of service vendor and the local social services agency (the host county) where the vendor is located. All other social services agencies wishing to purchase from the vendor are bound by the terms of the host county contract.

m. Income eligible client means an individual needing and receiving social services whose income level is the basis for allowing the agency to claim federal financial participation

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under Title XX.

n. Income maintenance status means an individual whose eligibility for Title XX federal financial participation in services received is based on his receipt of Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), or Minnesota Supplemental Aid (MSA).

o. Local social services agency (also known as local agency) means local agency under the authority of the county board of commissioners or human services board which is responsible for social services.

p. Mandatory services means services required by agency rule, state law or federal regulation, to be made available by the county board of commissioners or human services board.

q. Optional services means services available at the discretion of the county board of commissioners or human service board.

r. Priority services means services the state agency strongly recommends be made available by the local social services agencies, but which are available at the discretion of the county board of commissioners or human services board.

s. Provider means agency or individual delivering services.

t. Social services means those services which are included in the Minnesota comprehensive annual services program plan. Such services include, but are not limited to: adoption, chore, counseling, developmental achievement for adults and children, day care for adults and children, educational assistance, employability, family planning, foster care for adults and children, health, home delivered and congregate meals, homemaking, housing, information and referral, legal, money management, protection for adults and children, residential treatment, social and recreational, and transportation. Social services do not include income maintenance programs, mental health center programs established pursuant to Minnesota Statutes, sections 245.61 to 245.69, health department programs or CETA programs unless there happens to exist a Title XX purchase of service contract between the county board of commissioners and those other programs.

u. Source document means a written statement such as a paycheck stub or birth certificate used to verify income, age, etc.

v. State administrative plan means a federal approved statewide plan for the administration of the Title XX program. The state administrative plan establishes the requirements in section H.2. of this rule.

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w. State agency means Minnesota Department of Public Welfare.

x. Vendor means agency or individual from whom services are purchased.

B. State and local social services planning.

1. The comprehensive annual services program plan year shall be October 1 through September 30.

2. On or before a date stipulated by the state agency, each local social services agency shall submit to the state agency a plan for service delivery and a budget to support that plan. The plan and budget shall be in accordance with the local social services plan guidelines and budget forms prescribed by the state agency.

3. The political entity covered by a local social services plan shall be known as the geographic area. The following criteria shall be followed in establishing geographic areas:

a. A county may designate itself as a geographic area.

b. No political subdivision smaller than a county shall be designated as a geographic area.

c. A political subdivision larger than one county may be designated a geographic area if one of the following conditions is met:

(1) Counties have combined for administrative purposes under a joint powers agreement, executed pursuant to Minnesota Statutes, section 393.01, subdivision 7.

(2) Counties have combined under provision of the Human Services Act, or

(3) Contiguous counties within the same governor's economic region or two or more regions have elected by board action to submit a multicounty plan that provides the same services to the same eligibility groups in all counties in that geographic area.

(4) There is a state contract for a service, and that service is available statewide.

4. Services provided may differ among geographic areas, except for mandatory services, which must be available on a statewide basis.

5. Priority and optional services included in geographic area plans shall be available to all persons in eligible categories specified in the plan.

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6. On or before July 1 of each year, the state agency shall publish a proposed comprehensive annual services program plan for the delivery of public social services. A copy of the proposed plan shall be available from the state or local social services agencies at no cost to any individual on request.

a. There shall be a 45-day period, beginning July 1, for public review and comment on the proposed plan.

b. Public meetings may be held throughout the state to answer questions and receive public comment on the proposed annual plan.

7. On or before October 1 of each year, the state agency shall publish the final comprehensive annual services program plan. On request, a copy of the final plan shall be available from the state or local social services agencies at no cost to any individual.

8. The comprehensive annual services program plan may be amended by the state agency on its own initiative or at the request of a local social services agency with state agency approval.

a. The proposed amendment shall be published in all geographic areas affected by the amendment, and there shall be a 30-day public review and comment period on the proposed amendment.

b. The final amendment shall be published in all geographic areas affected by the amendment and shall not be effective earlier than the date of publication.

C. Local agency duties and responsibilities.

1. The local social services agency shall provide social services as required by law and the local social services plan. These services may be provided directly by the agency, purchased, or arranged for at no cost to the local social services agency.

a. Mandatory services shall be provided in accordance with the individual service plan to all persons who need them as determined by the local social services agency.

b. Priority and optional services shall be provided to persons requesting them if a need for them is determined by the local social services agency in accordance with the individual service plan. The local social services agency's obligation to provide priority and optional services need not exceed the cost estimate for each service specified in the annual local social services plan provided, however, such services shall continue to be provided until the local social services agency formally amends the local social services plan to exclude the service(s).

2. The following services or components of services are

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mandatory under federal or state law and shall be provided by the local social services agency to all persons in each geographic area provided need for such service is determined by the local social services agency.

a. Adoption services.

(1) Adoptive home studies on court referred adoption petitions.

(2) Adoptive home studies for applicants wishing to adopt minority or handicapped children.

(3) Placement and follow-up for all children placed under agency auspices.

b. Developmental achievement services.

c. Day care services for children receiving aid to families with dependent children (AFDC) whose parents are employed or in training for employment.

d. Family planning services, education, or counseling for individuals receiving aid to families with dependent children.

e. Foster care services for children.

f. Health related services required under the Minnesota Hospitalization and Commitment Act for individuals needing institutional treatment; community alternatives to institutional care for mental illness, chemical dependency or mental retardation; and management of individualized service plans on release from state institutions.

g. Protective services for adults including mental retardation guardianship and conservatorship services.

h. Protective services for children including mental retardation guardianship and conservatorship services.

i. Residential treatment services.

(1) For emotionally disturbed children in licensed residential treatment centers or group homes.

(2) For mentally retarded children and adults.

j. Employability services for individuals receiving aid to families with dependent children.

3. The following services, or components of services, are priority services, not made mandatory by federal or state law, but which have been funded by the state in the past or which have been provided in the past. That is, priority services are based upon historical practice. Priority services are available

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at the discretion of the county board of commissioners or human services board. The state agency strongly recommends these services be made available by local social services agencies.

a. Chore services for individuals receiving supplemental security income.

b. Day care services for children of working parents in income eligible categories.

c. Family plannning services.

(1) Education for counseling for individuals in the income eligible categories.

(2) Health related services and supplies for individuals in the income eligible categories.

d. Health related services other than those required by the Minnesota Hospitalization and Commitment Act as defined in the comprehensive annual services program plan.

e. Home delivered and congregate meals.

(1) For individuals receiving supplemental security income.

(2) For individuals who are in the income eligible categories.

f. Homemaking services including, but not limited to, attendant care.

(1) For all adults.

(2) For children during the temporary absence of the parent responsible for their care.

g. Information and referral services.

h. Money management services.

i. Protective services for adults other than subacute detoxification services and mental retardation guardianship services.

j. Residential treatment services.

(1) Primary treatment for individuals who are chemically dependent.

(2) Residential treatment for individuals who are mentally ill.

(3) Halfway house for individuals who are chemically dependent or mentally ill.

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k. Transportation services for individuals receiving supplemental security income.

l. Employability services.

(1) For supplemental security income-Minnesota supplemental aid recipients.

(2) For low-income persons who are income eligible.

4. The following services, or components of services, shall be made available at the option of the local social services agency. These optional services have past records of delivery or state funding that have not been as significant as the provision of priority services found in section C.3. of this rule.

a. Day care for children for families on a fee basis who are not in the income eligible categories.

b. Day care for adults.

c. Education assistance.

d. Foster care for adults.

e. Home delivered and congregate meals.

(1) For individuals receiving aid to families with dependent children.

(2) For individuals on a fee basis who are not in the income eligible categories.

f. Housing services.

g. Legal services.

h. Social and recreational services.

i. Transportation services other than supplemental security income.

j. Counseling services for families and individuals.

D. Client information for social services.

1. Information gathered on clients shall be used for the provision of services and the management of the program and shall be limited to the information necessary for these purposes.

2. Clients shall be informed that information on them is collected, used, stored and disseminated.

3. Information regarding clients shall be collected, used, stored, and disseminated only in accordance with state and

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federal law.

4. Officials directly related to the provision of service and administration of the program shall have access to client information. These officials may include those of the agency to which the client applies, those of the agency providing service, federal and state auditors, evaluators, and researchers with the authorization of the commissioner of public welfare.

E. Application.

1. Each individual wishing to apply for social services shall be given the opportunity to do so without delay.

a. Applications shall not be required for information and referral services.

b. At local agency option, applications may be required for determining group eligibility. However, whether or not applications are required, the local social services agency shall obtain sufficient information to document the basis for the group eligibility decision.

Exception: Clients requesting family planning services, whether based on group eligibility or individual eligibility, shall make written application in order to document that the request is voluntary.

2. Except as provided for in E.1. above, each application shall be completed, signed, and dated by the applicant or by a responsible individual acting on behalf of the applicant on an application form prescribed by the state agency. If for reason of age, incompetence, noncooperation or any other valid reason the applicant cannot sign the application, the following may sign in descending order of priority:

a. Legal guardian of the applicant.

b. Relative of the applicant.

c. Friend of the applicant.

d. Agency representative.

3. Before an applicant's signature is requested on any forms, each applicant shall be given a complete and comprehensive written statement of his rights and responsibilities on the form prescribed by the state agency. For those individuals who cannot make use of/or understand the written statement for any reason, the agency representative shall read out loud or interpret (if foreign language interpreting capability is available) and explain the written statement to the individual or to a responsible person acting on behalf of the individual. The agency representative also shall respond to any questions the applicant or his representative may have. For deaf and hard of hearing individuals who rely on

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visual language reception as their primary mode of communication, the local agency shall have access to interpreting services (sign language) so that the applicant may receive the same quality of direct services as provided "hearing" clients.

4. Each applicant or his representative shall declare his income on a form prescribed by the state agency, and shall sign and date the form. This form need not be completed if:

a. The applicant will only receive services without regard to income; or

b. The agency does not intend to claim Title XX federal financial participation (FFP) for the services to be provided; or

c. The applicant will only receive services on the basis of group eligibility.

5. The agency shall act promptly on the application. The agency shall not take longer than 30 days to make an eligibility decision and the agency shall not take longer than 15 days after the eligibility decision to notify the applicant in writing that his application has been approved or denied. The notification date and reason for denial or approval shall be entered in the case record. If the application is denied, the individual shall be notified in writing of the reason for denial and of his right to appeal to the state agency.

6. If application is approved, the local social services agency shall provide the social services with reasonable promptness. Reasonable promptness means:

a. Within 15 calendar days after the applicant has been notified of his eligibility; or

b. At an appropriate later date which has been mutually agreed upon by the local social services agency and the applicant.

7. Applicants for and recipients of social services shall have the right to a fair hearing to appeal any denial, reduction, or termination of a service, or failure of the local social services agency to act upon a request for service with reasonable promptness.

a. The following are examples of appealable actions:

(1) Failure to act upon an application within the prescribed time limits;

(2) Reduction of quality or quantity of social services;

(3) Denial of a request for a specific social

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service;

(4) Termination of social services;

(5) Disagreement with the social services plan developed between the recipient and the agency. An appeal shall also be authorized relative to any matter which is appealable based on state law or rule or federal law or regulation as they currently exist, or as they may exist based on subsequent amendments.

b. The local social services agency shall give the social services recipient timely, advance notice of any proposed agency action which may adversely affect the recipient. This notice shall be in writing and shall inform the recipient of the right to appeal the action, the right to be represented by an attorney or other interested party at the hearing, and the conditions under which social services may be continued. Furthermore, the letter shall cite the specific rule upon which the reduction or termination of services is based. The local social services agency shall mail the notice to the recipient at least ten days before the action becomes effective. However, when the local social services agency learns that social services should be discontinued, reduced or terminated because of probable fraud of the recipient, and, where possible, such facts have been verified through collateral sources, notice of agency action shall be considered timely if mailed at least five days before the action becomes effective.

F. Client's right to accept or reject services. The applicant, if legally competent, shall have free choice to accept or reject an agency assessment of a need for social services or an offer of social services. A refusal to accept social services shall not affect payment of financial assistance under income maintenance programs except in the work incentive program. The local social services agency is not relieved of its statutory responsibility to provide protective services by the refusal of such services by any person who needs such services or acts on behalf of anyone who needs social services. In these instances when a statutorily required service is rejected, the person or his caretaker or guardian shall be given a clear explanation of the possible consequences of that choice.

G. Client social services plan.

1. Whether services are provided directly by the local social services agency or through a contract with another provider, there shall be a plan mutually agreed upon by the agency and the service recipient (or his representative) for the provision of services for each family or individual receiving services.

2. The client social services plan shall:

a. Be developed with the person receiving service. If the client is unable to participate in developing the plan, the

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plan shall be developed with the person responsible for the client.

b. Identify the needs for service (reasons for agency involvement); the specific services to be provided; the service provider; and the objectives to be achieved.

c. Specify the frequency (weekly, every other week, monthly, etc.) and purpose of contacts between worker and client.

d. State the anticipated time necessary to accomplish the identified objectives.

e. Specify mutually agreed upon times for review of the plan, to assess progress and revise, as necessary. The plan shall be reviewed at least annually.

H. Title XX of the Social Security Act.

1. Goals: Federal financial participation under Title XX of the Social Security Act shall be available to the extent federal funds are allotted for eligible individuals and services which are specified in the local social services plan. Social services shall be provided to achieve the following goals:

a. Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;

b. Achieving or maintaining self-sufficiency, including reduction or prevention of dependency;

c. Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests;

d. Preserving, rehabilitating, or reuniting families;

e. Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; or

f. Securing referral or admission for institutional care when other forms of care are not appropriate or providing services to individuals in institutions.

2. State administrative plan requirements:

a. The Minnesota Department of Public Welfare shall be the designated state agency for Title XX.

b. State and local funds shall be included in meeting the cost of the program.

c. Personnel administration shall be governed by rules of the state merit system or respective county civil service system.

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d. The use and disclosure of information on applicants and clients shall be collected, used, stored and disseminated only in accordance with state and federal law.

e. There shall be no requirements as to duration of residency or citizenship in respect to eligibility for Title XX federal financial participation in costs of services provided.

f. Standards for institutions and foster homes shall be established by state licensing rules.

g. Standards for child day care services shall be established by state licensing rules.

h. A system of fair hearings shall be established under which an applicant may appeal denial, reduction, or termination of service.

i. The state administrative plan shall be amended when necessary.

j. Amendments to the state administrative plan shall be submitted to the Department of Health, Education, and Welfare by the State Department of Public Welfare.

k. Records shall be maintained and reports made to the federal agency as required by federal regulations.

l. The aggregate state expenditures for social services shall not be reduced below the aggregate expenditures for the fiscal year ending June 30, 1973.

3. Eligible categories: Title XX shall be available for all mandatory, priority and optional services provided to eligible categories of individuals and families, when these services and categories are included in the local social services plan. Eligible categories of individuals are as follows:

a. Income maintenance eligible categories:

(1) Current recipients of aid to families with dependent children (AFDC).

(2) All individuals, not in the aid to families with dependent children grant, including stepfathers, but excluding foster parents, who are adult caretakers of children receiving aid to families with dependent children.

(3) Recipients of supplemental security income (SSI) or Minnesota supplemental aid (MSA).

b. Income eligible categories:

(1) Individuals and families eligible without a fee.

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(2) Individuals and families eligible with a fee.

(3) Individuals and families whose eligibility is determined on a group basis as specified in section H.5. of this rule.

c. Eligible without regard to income:

(1) Individuals receiving information and referral services.

(2) Individuals receiving services directed toward the goal of protection as specified in section H.5. of this rule. (For cross-reference, see 45 Code of Federal Regulations, section 228.65.)

(3) Minors who voluntarily request family planning services as specified in section H.6. of this rule.

4. Group eligibility. With state agency approval, local social services agencies have the option to include in the geographic area plan group determination of eligibility for social services as provided in and subject to federal regulations for Title XX.

5. Services directed toward the goal of preventing or remedying neglect, abuse, or exploitation without regard to income

a. Adults.

(1) Title XX funds shall be available for services provided to adults who are unable to protect their own interests because of the actions or inactions of themselves or others which may result in injury, neglect, maltreatment, or exploitation. These adults shall include, but not be limited to, battered women.

(2) The local social services agency shall document by entering into the case record for each adult the circumstances which lead the agency to believe the adult is subject to or in risk of being abused, neglected or exploited. A social services plan shall be developed that is directed toward protecting the adult or assisting the adult in protecting his interests.

(3) No later than six months after the case has been opened, and every six months thereafter while the case remains open, the local social services agency shall reevaluate and document the continued need for services for preventing or remedying neglect, abuse, or exploitation of the adult. The appropriateness of the social services plan shall be reassessed at the same time.

(4) Federal financial participation shall be available without regard to income for the following services

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and activities for adults in need of protection:

(a) Identification of adults who are in need of protection.

(b) Provisions for the receipt and response to reports.

(c) Substantiation of the allegations.

(d) Counseling services with the adult or others responsible or interested in the adult's welfare when provided by the local social services agency.

(e) Assistance in arranging alternative living arrangements, medical care, legal services, and other services in the community.

(f) Assistance in arranging for guardianship, conservatorship, and commitment, or for providing advocacy, including legal services to assure the adult of rights and entitlements.

(g) Emergency homemaking services not to exceed 30 cumulative days in any 12-month period.

(h) Money management services.

(5) Eligibility for other social services in the comprehensive annual services program plan which are directed to this goal shall be established on the basis of income maintenance status, income status, or group eligibility.

b. Children.

(1) Title XX funds shall be available to prevent or remedy child neglect, abuse or exploitation. Title XX funds shall also be available for runaways harmed or threatened with harm by virtue of their status as runaways.

(2) The local social services agency shall document by entering into the case record for each child, that the child is harmed or threatened with harm. Such harm shall be identified as nonaccidental physical or mental injury, sexual abuse as defined in Minnesota Statutes, section 626.556, or negligent treatment or maltreatment, including the failure to provide adequate food, clothing, or shelter. Harm or threatened harm to a runaway shall also be documented.

(3) No later than six months after the case has been opened and every six months thereafter while the case remains open, the local social services agency shall reevaluate and document the continued need for services to prevent or remedy neglect, abuse or exploitation of a child. The appropriateness of the social services plan shall be reassessed at the same time.

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(4) Federal financial participation shall be available without regard to income for the following services and activities for children in need of protection.

(a) Identification and social/medical diagnosis of such a child or condition.

(b) Provision for the receipt and response to reports.

(c) Substantiation of the allegations.

(d) Counseling services for families and individuals when provided by the local social services agency.

(e) Emergency shelter not to exceed 30 days in any six-month period which may be consecutive or may accumulate over more than one stay.

(f) Arranging for the provision of other services, when essential to the protection of the child.

(g) Legal representation or advocacy for the child.

(h) All appropriate social services in the comprehensive annual services program plan which are necessary to protect runaways harmed or threatened with harm.

(i) Emergency homemaking services not to exceed 30 cumulative days in any 12-month period.

(j) Money management services.

(5) Eligibility for other social services in the comprehensive annual services program plan which are directed to this goal shall be established on the basis of income maintenance status, income status, or group eligibility.

6. Family planning services.

a. Title XX federal financial participation shall be available for family planning services provided at the option of the local social services agency to minors (under age 18) who voluntarily request such services.

b. When a minor requests family planning services, he shall be informed that his parents need not be contacted in order for him to receive services. The local social services agency shall contact the minor's parents regarding his receipt of family planning services only with the written consent of the minor.

7. Household:

a. The following individuals living in the same

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domicile shall be considered a household for purposes of determining eligibility for Title XX funding:

(1) Spouses.

(2) Parents and their dependent children under age 18.

b. Household members (parents and their children under age 18) temporarily absent from the household in settings such as residential treatment, foster care, and school shall be considered members of the household.

c. The following individuals shall be considered a one-person household for purposes of determining eligibility for Title XX:

(1) An adult living alone.

(2) An adult living with individuals other than a spouse or dependent children.

(3) A child living with a relative other than a parent or legal guardian.

(4) An emancipated minor. For purposes of determining Title XX eligibility, an emancipated minor is an individual under the age of 18:

(a) Who has married; or

(b) Who is living apart from his parents and managing his own financial affairs; or

(c) Who is seeking one or more of the following Title XX services -- family planning, health services, residential treatment for chemical dependency, or counseling related to pregnancy, venereal disease or chemical dependency -- and has:

(i) Borne a child; or

(ii) Wishes to determine the presence of or treat pregnancy, venereal disease, or chemical dependency.

(5) A child whose parental rights are terminated.

(6) A child living in adoptive placement prior to finalization of the adoption.

(7) A child who is not living with his parents or legal guardian and who is seeking confidential services (social services related to determining or treating pregnancy, venereal disease, alcohol and other drug abuse as provided for in Minnesota Statutes, section 144.343).

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(8) A minor child regardless of living arrangement who receives family planning services as specified in H.6. of this rule.

(9) A child who is not living with his parents but whose parents are under a juvenile court order to contribute to his support as a result of a finding of dependency, neglect, or delinquency.

8. Determination of eligibility for Title XX federal financial participation.

a. Different methods of determining eligibility for Title XX funds may be implemented for different services, categories of individuals, and geographic areas.

b. Through official county board of commissioners/human services board action, each geographic area shall establish methods of determining eligibility.

c. At a minimum, such method shall be the declaration method, with the exception that when a local social services agency has reason to believe a client is giving false information, the agency may then require the client to document the information.

d. When the documentation method is used:

(1) Federal financial participation shall be available only to meet the cost of services provided to clients whose income maintenance status or household monthly gross income has been documented.

(2) Adequate documentation shall include written evidence of income maintenance status or household monthly gross income in addition to the signed application and income declaration forms. This written evidence shall include either:

(a) A copy of a source document filed in the case record; or

(b) A written statement by the worker which specifies the content of the source document.

(3) Failure on the part of an applicant to cooperate in documenting income shall be acceptable grounds for delay beyond 30 days in processing an application or denial of eligibility for Title XX federal financial participation in services requested.

(4) Contact with other individuals or agencies shall be made only with the prior written permission of the applicant and shall be made only when there is no other way to document income.

(5) If an applicant declares that income is received

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as cash without a receipt, the local social services agency shall request the client to secure a receipt from the employer.

(6) If documentation cannot be obtained in any other manner, the local agency shall contact the employer, after gaining the written permission of the applicant. If a purchase of service contract permits the vendor to document eligibility and if contact with a third party is necessary, the vendor shall inform the applicant that the applicant has the right to have the local social services agency, rather than the vendor, make the contact.

e. Applicant declaration of household size shall be accepted without documenting evidence, unless there is reason to question the declaration, in which case birth certificates or other documentation is required.

f. Time period for determination of eligibility for Title XX federal financial participation:

(1) Income maintenance status shall be based on the month of application for services or the month prior to application for services.

(2) Household monthly gross income shall be based on either:

(a) Prospective monthly gross income for the month in which application for services is made; or

(b) An average monthly amount estimated over any six (6) consecutive month period in which the month of application is included.

g. An individual shall remain eligible for a maximum of six months from the date eligibility was initially determined. Eligibility may be redetermined at any time by the local social services agency.

Exception: Eligibility shall be redetermined annually for individuals whose household monthly gross income is derived exclusively from pensions, Social Security, or Supplemental Security Income, or a combination of these.

9. Social services fee.

a. When Title XX federal financial participation is claimed for service provided to individuals and families who are income eligible without a fee, no social services fee shall be charged to the client.

b. When a local social services agency wishes to claim federal financial participation for services provided to individuals and households who are income eligible with a fee, a social services fee shall be charged according to the statewide fee schedule in the comprehensive annual services program plan.

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c. Local social services agencies shall make a reasonable effort to collect fees charged. Evidence of a reasonable effort shall exist if the local social services agency documents that at least 90 percent of the fees imposed have been collected. If this test cannot be documented, then a reasonable effort shall exist if the following conditions are met and documented:

(1) A bill is rendered or notice given to the client at the time of eligibility determination of the fee amounts and dates due; and

(2) At least three collection notices are given in person or by mail to the client, at approximately 30-day intervals; and a client's Title XX eligibility has been terminated if the fee remains delinquent after three collection notices have been given. A client's Title XX eligibility cannot be regained until a plan of payment has been agreed upon and implemented by the client and the agency.

d. The fee charged shall be the amount indicated on the appropriate fee schedule, in the comprehensive annual services program plan, except that no fee shall exceed the actual cost of all the services in the service plan.

(1) Fees for residential services for emotionally disturbed, mentally retarded, and epileptic children shall be consistent with Minnesota cost of care laws and rules.

(2) When services are being provided in addition to residential services for emotionally disturbed, mentally retarded and epileptic children, two fees shall be computed and imposed, one for residential services and one for all other services received.

10. Purchase of service contracting.

a. General provisions.

(1) The local social services agency shall deliver social services subject to federal financial participation under Title XX by direct delivery, by purchase, or by arranging the services at no cost to the agency.

(2) As an alternative to providing such services directly and if not available without cost to the agency, the local social services agency may purchase services from public, nonprofit or proprietary agencies, or from individuals who have been designated as approved vendors.

(3) Services purchased with the intention of claiming federal financial participation must be listed in the comprehensive annual services program plan.

(4) At the option of the local social services agency, these same policies and procedures may be utilized for

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purchased services not subject to federal financial participation.

b. Administrative requirements:

(1) The local social services agency shall:

(a) Claim federal financial participation only for services purchased through a written contract. Every purchase of service contract shall be completed, signed and approved by the county board of commissioners or human services board prior to the provision of services.

(b) Be responsible for client eligibility for purchased services; however, the local agency may make provision in the contract for the provider to make a determination of eligibility.

(c) Be responsible for the development of a client service plan based on the needs of the individual and the ability of the provider to meet those needs.

(d) Be responsible for monitoring purchased services and evaluating contract performance.

(e) Purchase only from approved vendors.

(2) Case record requirements for direct services shall apply to purchased services.

(3) The local social services agency shall maintain an administrative file for each contract which contains:

(a) A copy of the signed and completed contract.

(b) Copies of correspondence between the provider and the local agency.

(c) Evidence that the determination of reimbursement eligibility and authorization of approval of client social services plan have been made.

(d) Copies of monitoring and evaluation reports.

(e) Copies of correspondence between the local agency and the state agency related to the contract.

(f) Copies of fair hearings, complaints, grievances, and inquiries related to contract performance.

(g) Financial, statistical, and social services reports specified in the contract.

c. Host county contracting.

(1) The local social services agency of the county

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in which an approved provider is located shall negotiate and administer host county purchase of service contracts on behalf of any other local social services agency wishing to purchase services, provided, however, that if a local social services agency (host county) does not want to comply with this provision because it is being required to administer (for another local social services agency) a host county purchase of service contract 1) with a provider who has not complied with the conditions of past or present contracts, or 2) with a provider whose previous contract with the host county was terminated for failure to provide adequate service, the host county local social services agency may refuse to enter into such a contract.

(2) All local social services agencies shall abide by the terms of the host county contract.

(3) The host county shall assume responsibility for monitoring and evaluation of the contract.

(4) The host county shall make available, on the request of other local social services agencies, copies of the host county contract.

(5) The following exceptions apply:

(a) The host county need not enter a contract unless there is at least one other local agency wishing to purchase from the provider; and

(b) Each local social services agency within the area served by a community mental health board authorized by Minnesota Statutes, sections 245.61 to 245.69 may contract directly with the board; however, if a local social services agency outside of the geographic area served by the board wishes to purchase services, the host county policy applies.

d. Technical assistance. The local social services agency shall provide technical assistance and information to potential providers, draft contracts for purposes of negotiation, and assist providers in matters of recordkeeping, statistical reporting, and determination of rates of payment.

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§ 2.161 Interstate placement of children for foster care.

A. Introduction.

1. This rule governs the placement of children into or out of the State of Minnesota for the purpose of foster care.

2. Definitions.

a. Child: A person who is under the age of eighteen.

b. Placing children in foster care or placement: Placing children in any of the following residential facilities—foster family home, work home, free home, group home, residential treatment center.

c. Commissioner: Minnesota Commissioner of Public Welfare.

B. Placement provisions.

1. Placement of children to and from states which are parties of the Interstate Compact on the Placement of Children shall be made in accordance with the current terms of the Compact.

2. Placements to and from non-Compact states.

a. When a child enters or leaves the State of Minnesota for placement in foster care, the following policies are to be used when the move involves non-Compact states.

(1) The Commissioner's consent must be obtained for children entering or leaving the state for the purpose of placement in foster care, except for placements made by certain relatives and guardians under conditions prescribed in statute.

(2) Those seeking to place a child must demonstrate:

(a) That they have legal authority to do so.

(b) That the move is in the best interest of the child.

(c) That the move is necessary to provide the optimum placement opportunity for the child.

(3) Those seeking to place a child shall furnish the Commissioner such supporting or additional information, consents or guarantees as the Commissioner may deem necessary to protect the child.

b. Prior to the Commissioner's consent for a child to leave the state for the purpose of foster care, the following information and agreements must be furnished the Commissioner:

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(1) Identifying information on the child and parents, and

(2) The name, address and relationship of the individual in the receiving state responsible for the child's care, and

(3) The authority of the agency or individual to make such placements, and

(4) Written authorization for the out-of-state placement by the court of jurisdiction, or written authorization from the child's parent or guardian.

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12 MCAR S 2.163 Child day care sliding fee.

A. Introduction.

1. Pursuant to Minnesota Statutes, sections 245.83 to 245.87, this rule governs the administration of the experimental child day care sliding fee program for reducing, according to a sliding fee schedule, the costs of child care for eligible families whose income ranges from 60 to 70 percent of the state median income.

2. Definitions.

a. Child day care service: The less than 24-hour a day service which provides care for children as a substitute for or supplement to parental care for a planned period of time.

b. Eligible child day care provider: A family day care home, group family day care home or group day care center holding a current and valid license issued by the commissioner, or exempt from licensure by the commissioner, or an in-home attendant certified by the commissioner.

c. Commissioner: Minnesota Commissioner of Public Welfare.

d. County: The board of county commissioners.

e. State advisory council: The Minnesota Child Care and Development Advisory Council, appointed by the commissioner for the purpose of advising the commissioner on child day care issues.

f. Administering agency: The agency designated by the county to administer the child day care sliding fee program, which may be the county welfare department or any public or nonpublic agency.

g. Title XX: The title of the Social Security Act known as "Grants to States for Services," established by Public Law 93-647, as amended.

h. Comprehensive annual services program plan (CASP Plan): The state social services plan, which is a compilation of all the local social services plans, and which meets the state plan requirements of Title XX of the Social Security Act.

i. Family: Parents and their dependent children under age 18 years including children temporarily absent from the household in settings such as schools, foster care, and residential treatment facilities.

j. Area: Either the governor's economic development region eleven or the governor's economic development regions one through ten.

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k. Program year: The state fiscal year, July 1 through June 30.

l. Program costs: The provider charge plus the administrative costs.

m. Net program costs: The provider charge plus the administrative costs minus the parent fee.

B. Eligibility for grant.

1. Applicant: Pursuant to Minnesota Statutes, chapters 393 and 402, the applicant for a grant shall be a county or group of counties. The applicant may designate any public or nonpublic agency to administer the program.

2. Title XX child day care services: To qualify for the sliding fee program the county shall offer fully subsidized child day care services to eligible persons with incomes below 60 percent of the state median income as set forth in the CASP Plan.

3. Local share match: The county shall provide a local share match equal to five percent of the program cost during the first grant year and 15 percent of such cost during the second grant year. For purposes of determining the local match, administrative costs shall be considered to be the provider charge times seven percent. The local match shall not include the amount of minimum fee payments made by families but may include in-kind materials and services, furnished by the county, required for the administration of the program.

4. Because of the experimental nature of the program no county will be allowed to enter for the second year only.

C. Application for grant.

1. All counties shall select one of the following options regarding the experimental child day care sliding fee program:

a. Decide not to participate and notify the commissioner of its reasons for the decision.

b. Participate using only state sliding fee funds and the required local match, serving families with an income of 60 to 70 percent of the state median income.

c. Participate using state sliding fee funds, the required local match, and Title XX funds, serving families with an income of 60 to 70 percent of the state median income.

d. Participate using state sliding fee funds and the required local match to serve families with an income of 60 to 70 percent of the state median income and use Title XX and/or other funds to serve families with an income of 70 to 115 percent of the state median income.

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2. The application procedures for grants are as follows:

a. The county shall make application on forms provided by the commissioner.

b. A county may propose an alternate fee schedule if it meets the following criteria:

(1) Use of the state sliding fee schedule would impose a hardship on families already participating in a sliding fee program (e.g., raising their fees substantially);

(2) The county can demonstrate how the use of their proposed fee schedule would reduce the incidence of lower income families remaining or becoming welfare recipients, increase the incentive for economic independence and provide other benefits;

(3) The county program serves a large enough population to demonstrate the impact of the program; and

(4) The fee charged does not exceed the fee allowed in the state fee schedule. Participating counties may only use one fee schedule for all eligible fee paying income groups receiving child day care services.

c. The county shall submit two copies of the application to the commissioner by the deadlines established by the commissioner.

d. The commissioner shall submit a copy of each application to the state advisory council for their review and comment.

e. The commissioner shall inform the county of the approval or denial of the application within 30 days of the submission deadline.

D. Award of grant.

1. The commissioner shall award grants to counties which meet the eligibility requirements and for which applications have been approved, subject to the limits described below:

a. Thirty-five percent of the appropriation shall be awarded the first program year and 65 percent of the appropriation shall be awarded the second program year.

b. Area limits: Fifty percent of the funds as determined in a. above shall be distributed to each area.

c. County limits within an area. The amount, based on b. above, to be granted a county within an area, shall be equal to the sum of the following:

(1) Fifty percent of the area distribution times a ratio consisting of the number of working-parent families with a

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child under six years of age in the county against the total number of working-parent families with a child under six years of age in all counties in the area; and

(2) Fifty percent of the area distribution times a ratio consisting of the number of children receiving AFDC grants in the county against the total number of children receiving AFDC grants in all counties in the area.

d. Not withstanding other provisions of this rule, grant awards shall not exceed 95 percent of the net program costs during the county's first grant year nor 85 percent of the net program costs during the county's second grant year.

2. The commissioner shall reallocate unused first year funds after December 31, 1979, and shall reallocate unused second year funds after December 31, 1980, on the basis of need without regard to the limits described in D.1. above.

E. Family application.

1. The administering agency shall inform parents on an on-going basis, through the news media and child day care providers, of the availability of child day care sliding fee assistance as well as the procedures for applying for such assistance.

2. The application procedures for assistance shall be:

a. Application for assistance shall be on forms prescribed by the commissioner.

b. The administering agency shall make information about the program and application requirements available to all persons requesting this information.

c. Assistance in making application shall be available from the administering agency upon request.

d. The county shall use its current Title XX practice in verifying sources and amounts of income and reasons for needing child day care services.

e. The administering agency shall inform each applicant of the approval or denial of his/her application within 30 days of receipt of a completed application in writing.

f. Eligibility for assistance will be from the date of application.

3. The administering agency shall redetermine eligibility at least every six months.

4. The administering agency shall inform each applicant of the availability of all types of child day care services, the limits on available assistance, the reporting procedures and

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periods, and other policies or actions which have a direct affect on the applicant.

F. Family eligibility for assistance.

1. Income. The family's income shall be above the maximum allowable for Title XX fully subsidized child care services but less than 70 percent of the state median income as set forth in the current CASP Plan. Income shall be defined, as in the Title XX program, to mean all monthly income before deductions received by all family members age 14 or over.

2. Reasons for needing care. Families eligible for assistance are those needing child day care services for the following reasons only: employment, school attendance, or other circumstances related to employment and school attendance.

3. Age. Only children 14 years of age or younger may be eligible for assistance.

4. Residence. Application shall be made in the family's county of residence.

G. Family fee payment schedule.

1. The commissioner shall establish a monthly family fee schedule based upon income and family size.

2. In setting the fee schedule, the following computations shall be made for family sizes two to ten:

a. The federal, state and Social Security taxes are computed at the 60 percent, 70 percent, 80 percent, 90 percent, 100 percent, 110 percent, and 115 percent of the state median income levels (Federal Income Tax Table, Family size 2-Table D - Unmarried Head of Household Family size 3 to 10, Table B-Married filing Joint Return and the Minnesota Income Tax Table - tax computed on gross income). The computation of the state and federal taxes includes a child care credit. (The child care credit is determined by using 20 percent of the estimated annual cost of child care as directed in the income tax tables. Estimated annual cost of child care by family size: 2-$840, 3-$936, 4-$1,080, 5-$1,200, 6-$1,380, 7-$1,500, 8-$1,860, 10-$1,980).

b. The federal, state and Social Security taxes are added together at each income level.

c. The difference in the tax total between the 60 percent income level and the tax total of each subsequent income level is determined.

d. The difference in the gross annual income at the 60 percent income level and the gross annual income for each subsequent income level is determined.

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e. The difference in the taxes at each income level is subtracted from the difference in income at each level.

f. The net income at the 70 percent level is multiplied by 75 percent to determine the annual child care fee. The net income at the subsequent income levels is multiplied by 55 percent to determine the annual child care fee.

g. At each income level, the annual child care fee is divided by 12 to determine the monthly child care fee. (For a family of six, at the 70 percent income level the fee calculated is $125. Since this is a higher fee than at the 70 percent income level for a family of seven-$117, the fee is reduced to $110 to produce for a continual increase in the fee schedule as the family size increases).

h. The fee for income increments between each income level computed is determined by evenly dividing the difference in the fee between the income levels by the number of income increments between the levels. For family size two to ten, there are ten income increments between 61-71 percent of the state median income with each increment representing a one percent increase in income and between 71-80 percent, 81-90 percent, 91-100 percent, and 101-110 percent, there are four income increments with each representing a 2.5 percent increase in income. Between 111 and 115 percent there are two income increments with each representing a 2.5 percent increase in income. More increments are allowed between the 61-70 percent income level as the primary users of the sliding fee program will be dealing with this income range.

3. The total fee payment for a family shall not exceed 75 percent of the income determined available in G.2.e. above.

4. Only a single fee shall be charged regardless of the number of services a family receives. The fee charged shall be the highest fee.

5. When the county makes payments to providers for child day care costs, eligible families shall be responsible for reimbursing the county in monthly payments the amount of which shall be determined in accordance with the fee schedule described in section G.

6. The commissioner shall publish a fee schedule, coordinated with the state CASP Plan.

H. Provision of service.

1. The commissioner shall determine the median service charge for each type of child day care service for each of the governor's economic regions.

2. The county shall not make payment for that part of any child day care service charge in excess of 125 percent of the median charge for that service.

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3. The county may limit the number of families to whom assistance is provided because of insufficient grant funds. However, counties using Title XX funds must amend their CASP Plan.

I. Payment of assistance.

1. The administering agency shall make payment in either of the following ways:

a. An eligible family may be reimbursed for expenses incurred up to the limits specified in H. above.

b. The child day care provider may be reimbursed for charges up to the limits described in H. above.

2. The administering agency shall inform the family and/or child day care provider, who will receive payment as well as how and when it will be received.

3. The administering agency shall make payments at least monthly.

4. The administering agency shall inform the family of the method in which its monthly family fee payment was computed.

J. Evaluation.

1. The commissioner shall collect data and evaluate the program for the purpose of demonstrating the effectiveness of the program in preventing and reducing the dependence of participants on public assistance and in providing other benefits.

2. The administering agency shall collect data and prepare periodic reports as required by the commissioner.

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Repealed 7 SR 1376
3-28-83

§ 2.170 Services to unmarried parents.

A. Introduction.

1. This rule governs the provision of services to unmarried parents by local social service agencies.

2. The purpose of this program is to assist parents who are not married to each other to make responsible plans for themselves and their children, and to ensure that children born to unmarried parents have the same opportunities for physical and emotional growth and development as do children whose parents are married to each other.

3. Definition.

a. Local Social Service Agency: Local agency under the authority of the county welfare or human service board which is responsible for social services.

B. Public information.

1. The local social service agency shall develop programs and methods to inform potential clients of the services that are available to them.

C. Provision of services.

1. In addition to state statutory requirements governing services to unmarried parents, the local social service agency shall:

a. Offer assistance in planning to every unmarried father who requests service from the agency.

b. Provide social services to assist unmarried parents to establish paternity for the child who is born to them.

(Cite 1 S.R. 491)
Effective Date: October 17, 1976.

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§ 2.171 Children under state guardianship - dependent/neglected.

A. Introduction.

1. This rule identifies and governs the administration of local social service agency responsibilities for children under state guardianship as dependent or neglected pursuant to Minn. Statute 260.11 et seq., and the delegation to local social service agencies of the authority to grant consents.

2. The purpose of state guardianship is to carry out the responsibility to act and care for a child committed to the guardianship of the Commissioner of Public Welfare as dependent or neglected.

B. Definitions.

1. Local Social Service Agency: Local agency under the authority of the County Welfare Board or Human Service Board responsible for social services.

C. General responsibilities.

1. The local social service agency having financial responsibility shall provide financial assistance and assure provision of social services, including protection, planning and decision-making either directly or indirectly through other agencies.

2. The local social service agency having financial responsibility shall notify the Commissioner of Public Welfare within 30 days after commitment of a child to state guardianship.

3. The local social service agency having financial responsibility shall prepare and carry out a plan for the care and supervision of the child through its own agency or an agency that agrees to supervise the child.

a. The client social service plan (see 12 MCAR § 2.160) shall be developed with the child and reviewed with the child at least annually.

b. The plan shall meet the emotional, health, educational, vocational and spiritual needs of the child, and preserve, where feasible, the racial and familial identity of the child.

c. The plan shall establish a permanent family relationship for the child through the selection of a family committed to providing a home until the child reaches majority.

d. Any plan which permits a child to assume responsibility to meet his own needs without agency guidance shall not preclude agency responsibility to be aware of the child's needs and provide for them if necessary.

e. The goals, plans and objectives for children under the supervision

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of private agencies shall be made only with the agreement of the local social service agency having financial responsibility.

4. When a child moves from the county of the local social service agency having financial responsibility, the local social service agency of the county where the child will reside shall be notified in writing with a request to supervise the child. The supervising local social service agency shall provide services, and issue consents on behalf of the child and provide reports requested by the local social service agency having financial responsibility.

5. The local social service agency having financial responsibility shall notify in writing, with a request to supervise, each succeeding local social service agency when the child moves from one geographical area of supervision to another.

6. The local social service agency having financial responsibility shall assure the appointment of a guardian ad litem in the appropriate court to represent the child under state guardianship:

a. When the child has a legal claim against another party;

b. When the child has an interest in an existing legal action;

c. When an action has been instituted against the child by another;

and in all other instances when the best interest of the child requires legal counsel.

D. Consents.

1. The following consents are delegated to local social service agencies:

a. Autopsy.

b. Baptism.

c. Petition for change of name.

d. Publicity about the child.

e. Application for driver's license.

f. Enlistment in the armed services, peace corps or job corps.

g. Giving the body or parts of the body to science after death.

h. Admission to a state hospital or other psychiatric treatment facility to the extent permitted under law.

i. Application for marriage license.

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j. Medical treatment.

k. Psychiatric treatment.

l. Surgical treatment.

m. Abortion.

(1) To extent required by law, the local social service agency may not withhold consent.

n. Request for tuition waiver.

o. Permanent placement agreement.

p. Petition to transfer guardianship.

2. All consents not specifically delegated to local social service agencies may be issued only by the Commissioner of Public Welfare. The consents not specifically delegated include:

a. Adoption.

b. Exportation (out-of-state) for foster care or adoption.

c. Leaving the state or country for more than 90 days.

d. Giving a part of the body for therapeutic purposes for another person while the child is living.

e. Transfer from one state hospital to another state hospital.

f. Sterilization.

g. Separation of siblings after date of appointment of Commissioner of Public Welfare as guardian.

E. Disposition of the social welfare fund.

1. The local social service agency having financial responsibility may apply for and receive survivor benefits for an eligible child under state guardianship. The benefits may be applied to the maintenance and support of the child, and any excess amounts held in a social welfare fund, or the total benefits may be accumulated in the social welfare fund.

a. Upon reaching age 18, the accumulated balance in the social welfare fund is to be paid directly, at that time, to the person for whom the survivor benefits were received.

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F. State guardianship benefits up to age 21.

1. An individual who is under state guardianship at age 18 continues to be eligible for guardianship benefits up to age 21 at the request of the individual.

Effective Date December 12, 1977

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§ 2.178 Services for the deaf.

A. Introduction.

1. This rule governs the provisions of specialized services to deaf and hearing impaired individuals.

2. Services for the deaf are provided by a subdivision of the Minnesota Department of Public Welfare responsible for providing specialized social services throughout the state to deaf and hard-of-hearing individuals and their families needing or requesting such services.

3. Specialized services provided include counseling, information and referral, manual communication interpretation through the use of the language of signs, consultation and the maintenance of the Registry of the Deaf.

B. Eligibility.

1. Eligibility of deaf and hard-of-hearing residents of the state for services shall be based solely on the existence of a hearing impairment, without regard to financial status or other limiting factors.

2. The applicant shall provide medical documentation of hearing loss upon request.

(Cite 1 S.R. 575)
Effective Date: November 1, 1976.

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12 MCAR S 2.185 County board or human service board responsibilities to individuals who are or may be mentally retarded.

A. Introduction.

1. This rule is promulgated pursuant to Minnesota Statutes, sections 245.61 to 245.69, 252A.01 to 252A.21, 253A.01 to 253A.21, 256E.01 to 256E.12, 252.28, 393.07, and Minnesota Statutes, sections 245.781 to 245.812.

2. This rule governs the planning and provision of services to all individuals who are or may be mentally retarded. In addition, provisions of Minnesota Statutes, sections 252A.01 to 252A.21, Mental Retardation Protection Act, are applicable to those mentally retarded persons under guardianship or conservatorship of the commissioner. All financial resources available to agencies affected by this rule for the mentally retarded shall be expended in accordance with this rule. This rule shall not be construed as requiring expenditures of money that is not made available to the county board from all available resources for mental retardation services.

3. The purpose of this rule is to establish minimum service standards for county boards and human service boards in the provision of case management and the planning, coordination and development of services for all individuals who are or may be mentally retarded.

4. Definitions.

a. Case management: The provision of direct services to and with the involvement of the client, which includes diagnosis, assessment of client needs and development of an individual service plan, implementation of the individual service plan, evaluation and payment for services when the individual, or parent of a child under 18 years of age, is unable or not required to pay. When the client is a ward of the commissioner, the provisions of Minnesota Statutes, sections 252A.01 to 252A.21 are also applicable.

b. Client: A child or adult who is or may be mentally retarded and in need of services as provided in this rule.

c. Commissioner: The commissioner of public welfare and includes any duly authorized representative of the commissioner.

d. Community mental health board: The local board established under Minnesota Statutes, section 245.66 and authorized by the county board to facilitate and implement mental retardation programs and services. If no such board is established by the county board, then the county board itself shall assume the responsibilities of a community mental health

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board.

e. Community social services: Those services as authorized under Minnesota Statutes, section 256E.03, subdivision 2.

f. County board: That body of duly elected officials responsible for the governance of its county under the authority of Minnesota Statutes, sections 375.01 to 375.55. Where a human services board has been established under Minnesota Statutes, sections 402.02 to 402.10, it shall be considered to be the county board, for purposes of this rule.

g. Day facility: Out-of-home setting licensed to provide training in self-care, remedial, developmental, or social skills, on a regular basis for periods of less than 24 hours per day.

h. Individual program plan: A detailed plan of the service provider setting forth both short-term and long-term goals with detailed methods for achieving movement toward the individual service plan of the local social service agency.

i. Individual service plan: An analysis by the local social service agency of services needed by the client, including identification of the type of residential placement, if needed, and the general type of program required by the client to meet the assessed needs within a specified period of time.

j. Local social service agency: A local agency designated and authorized by the county board or the human service board, to be responsible for providing social services.

k. Mentally retarded person: A mentally retarded person refers to any person who has been diagnosed as having significantly subaverage intellectual functioning existing concurrently with demonstrated deficits in adaptive behavior and manifested during the developmental period.

(1) Intellectual functioning shall be assessed by one or more of the professionally recognized standardized tests developed for that purpose: significantly subaverage refers to performance which is approximately two or more standard deviations from the mean or average of the tests.

(2) Adaptive behavior shall be determined through the use of published scales, or by a combination of pertinent test data, professional observations, and the utilization of all available sources of information regarding the person's behavior which indicates the effectiveness or degree with which the individual meets the standards of personal independence and social responsibilities expected of his/her age and peer cultural group.

l. Need determination: The determination by the

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commissioner of need, location and program of public and private residential and day care facilities and services for mentally retarded children and adults, Minnesota Statutes, section 252.28, subdivision 1.

m. Person who may be mentally retarded:

(1) A child under 18 years of age whose behavior demonstrates significant deficits in adaptive behavior concurrently with subaverage intellectual functioning, who is in the process of diagnosis, or for various reasons, a diagnosis of whom cannot be determined or for who a diagnosis may not be advisable because of age.

(2) An adult 18 years of age or older who has not been diagnosed as mentally retarded during the developmental period of his/her life, and who, for reasons of accident or physical trauma (excluding such conditions as mental illness, chemical abuse, senility, and debilitating diseases such as muscular dystrophy and multiple sclerosis), has been diagnosed as having significantly subaverage intellectual functioning existing concurrently with demonstrated deficits in adaptive behavior such as to require supervision and protection for his welfare.

n. Program: A formal continuum of care that is a culturally relevant and coordinated combination of services, with clear goals and measurable objectives. A program is directed toward meeting the needs of one specified disability group and the individuals within that group, allowing for ready movement of clients among appropriate services.

o. Residential facility: A setting out of the client's home licensed to provide care, food, lodging, and provide training in self-care, remedial, developmental or social skills.

(1) Private facility: Profit and nonprofit licensed facilities for mentally retarded clients.

(2) Public facility: Licensed state hospitals (also known as institutions) for mentally retarded clients.

p. Service: A specific, identifiable, goal-related activity designed to carry out a program.

q. State agency: Minnesota Department of Public Welfare.

B. The following standards shall be applicable in the planning and provision of services to individuals who are mentally retarded.

1. To provide the client with a normal existence. If this is not possible, to provide the person with the alternative which is least restrictive. This includes making available to

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the client patterns and conditions of everyday life that are as close as possible to the norms and patterns of the mainstream of society.

2. To provide the client with an individual service plan which is designed to acquire new and progressively difficult skills. Such plan must take into consideration the presentation of learning and developmental experience appropriate to client adaptive behavior levels, physical condition and degenerative status.

3. The individual service plan must be based on a comprehensive assessment of needs, and annual evaluations to determine appropriateness and effectiveness of the individual service plan.

a. Providing assistance and appropriate support services to enable the client to live in the person's home.

b. Providing a community-based private residential facility with appropriate services when the person must leave home for a specified purpose and period of time.

c. Providing placement in a public residential facility when the person cannot be served at home or in the community for a specified purpose and period of time.

d. When placement is made in a public residential facility because a vacancy in a community residential facility does not exist, the county planning body (D.2.) shall be informed of such need.

C. Responsibilities of the county board for case management services to mentally retarded individuals. These responsibilities may be delegated to the local social service agency pursuant to Minnesota Statutes, section 256E.08, subdivisions 2 and 4. Since it is a universal practice for the county board to delegate these responsibilities to the local social service agency, section C. will refer to "local social service agency" in place of "county board."

1. Diagnosis of mental retardation.

a. The local social service agency has the primary responsibility for insuring prompt diagnosis of mental retardation, utilizing professionally qualified staff, and professional information and assistance from other sources, to secure diagnostic information.

b. The local social service agency shall determine whether the individual is or may be mentally retarded. Such determination may be appealed to the commissioner, pursuant to Minnesota Statutes, section 256.045 as a social service appeal.

c. The following is required for diagnosis of mental retardation:

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(1) Determination of intellectual functioning through tests administered by a psychologist who is qualified in the diagnosis and treatment of mental retardation.

(2) Determination of adaptive behavior on the basis of available information regarding the person's everyday behavior.

(3) Medical examination prepared under the direction of a licensed physician including, but not limited to sight, hearing, seizure problems, and physical disabilities.

(4) Report by a social worker experienced in working with mentally retarded persons on the client's social history and adjustment.

d. Diagnostic review shall be completed when significant changes in behavior of functional levels occur, and at intervals not exceeding two years' duration. Exception to this requirement may be made when adults who have been in a service plan for a period of ten or more years, and the original diagnosis has been twice conformed. In such cases if there has been no significant change in behavior or functional level, diagnositic review shall be completed at intervals not exceeding four years' duration.

2. Assessment of client needs and development of individual service plan.

a. The local social service agency shall assist any person needing help who is or may be mentally retarded by assessing that person's needs and subsequently planning to meet those needs with the cooperation and involvement of the client, parents, relatives or guardian.

b. The following information, in addition to the diagnostic information, shall be considered in determining the individual service plan. If any of this information does not exist, that fact shall be documented in the individual service plan:

(1) Family history.

(2) Medical, prenatal, and birth history.

(3) Early development history.

(4) School reports indicating behavior and functional levels.

(5) Psychiatric evaluation, if indicated by the other reports.

(6) Vocational evaluation reports.

(7) Observations and interviews about family and the

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environment.

c. The local social service agency shall, in cooperation with the client and parents and/or guardian, develop an individual service plan which shall include:

(1) The Minnesota developmental programming system, or other instrument of comparable validity and reliability, shall be used to provide a standardized behavioral assessment prior to development of an individual service plan.

(2) Services to be provided shall be specifically individualized to meet the client's needs. Developmental achievement center services shall be provided when determined appropriate in the individual service plan.

(3) Provision for implementation of the individual service plan and arrangement for appropriate services.

(4) Provision for ensuring the delivery of service as provided in the individual service plan.

(5) Evaluation, with the assistance of qualified individuals, of the client's progress as described in the client's individual service plan.

(6) Payment for services when the eligible client or parent of a child-client under 18 years of age, is unable or not required to pay.

3. The individual service plan shall be designed to provide services to the client in the client's home, and to strengthen family relationships, capabilities and responsibilities when placement in a day or residential facility is necessary. Such placement shall be made by the local social service agency in order to carry out the individual service plan.

a. When placement in a day or residential facility is necessary, the local social service agency shall be responsible for planning with the client, the family or representative of the family, the residential or day facility resources, and the public school, if the client is of school age.

b. Arrangements for placement in a public or private day or residential facility shall be made by the local social service agency. When in the facility, the client continues to be the client of the local social service agency.

c. Acceptance by the public or private facility shall be based on the goals and objectives of the individual service plan of the local social service agency, as agreed upon with the client, parent, and/or guardian and as indicated by subsequent assessment and review. Acceptance shall constitute agreement that the public or private facility can carry out the goals and objectives of the individual service plan within a specified period of time.

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d. When a client is accepted in a day or residential facility, the facility staff shall be responsible, within 30 days of admission, for the development of an individual program plan based on the individual service plan of the local social service agency. The local social service agency shall participate in the development of the facility's individual program plan and take the lead in coordinating such planning when the client is receiving services from more than one provider.

e. Out of home placement of clients or persons in the process of diagnosis, is restricted to facilities licensed under applicable state agency rules or their successor. Exception can be made (1) in the case of certification of need for hospitalization or need for a skilled nursing facility for skilled nursing care on a 24-hour per day basis, or (2) when the individual service plan calls for placement in a licensed or certified foster home for four or fewer residents.

f. When the local social service agency places a client in a private residential facility located outside of that county, formal arrangements, noted in the individual service plan, must be made with the host county social service agency to carry out certain services. Primary responsibility, however, remains with the agency of social service responsibility, as specified in Minnesota Statutes, section 256E.08, subdivision 7.

g. Counseling shall be provided or arranged by the local social service agency to the individual, his parents or guardian as needed. The local social service agency may request assistance of the community mental health board.

h. Clients shall be informed that appeal may be made to the commissioner pursuant to Minnesota Statutes, section 256.045 as a social service appeal.

D. Responsibilities of the county board for services to mentally retarded. These responsibilities may be delegated to a community mental health board pursuant to Minnesota Statutes, sections 256E.08, subdivision 4, and 245.61 to 245.69, and chapter 402.

1. The county board shall ensure opportunity for citizen participation, including representatives of users of services, in accordance with Minnesota Statutes, section 256E.09, subdivision 2, in the planning of service delivery. The county board shall also insure opportunity for the involvement of local social service agencies, local developmental disabilities councils, public and private residential and day care facilities and other service providers and advocacy organization in the coordination of service delivery.

2. The county board shall employ a professionally qualified person who has at least a bachelor's degree and experience in a field related to the treatment and care of persons who are mentally retarded. This person shall coordinate

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service delivery to mentally retarded individuals in the county and develop a service plan.

a. The county board shall take the lead in planning and development of services not available through service providers, public and private agencies, educational and judicial agencies.

b. The county board shall identify the social services available in and outside of the county for its mental retardation population, including those provided by private individuals or agencies, local public agencies and public facilities.

c. The county board shall identify in priority of need order the social services that are not available to its mental retardation population.

d. The county board shall provide or arrange for social services needed, as specified in the county social services plan, within the means available from all sources, as provided by the county board.

3. The county board shall provide psychological and psychiatric diagnostic evaluation, client and parental counseling and assistance in care planning for persons who are or may be mentally retarded as requested by the client or the local social service agencies in the county served by the board.

4. Need determination responsibilities of the county board.

a. The county board shall obtain need assessment data and other available information concerning needs of the mental retardation population in the county.

(1) The county board shall provide such data and information to parties interested in developing a facility or service for mentally retarded clients.

(2) Applications for need determination for a proposed facility or service to be located in the county shall be prepared by the applicant and reviewed by the county board.

(3) Applications shall include, but are not limited to, the following:

(a) Applicant's name, address, telephone number; proposed location of the facility or service; number, sex and age range of clients to be served; description of proposed facility or service.

(b) Functional level of clients to be served; description of physical, sensory, behavioral conditions.

(c) Program plan; developmental, education,

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vocational services that will be available outside of the facility (if residential).

(d) Sources of clients; numbers of clients to be served from named facilities such as state hospital, general intermediate care facility, skilled nursing facility, intermediate care facility for mentally retarded, foster home, natural home.

(e) Name(s) of other counties to be served by applicant; if so, the applicant shall submit evidence to the board that those counties will make referrals.

b. The county board, after consideration of the standards for provision of services (part B, this rule), shall submit a letter of recommendation to the commissioner concerning local need, location and program for proposed facilities and services subject to license under Minnesota Statutes, section 252.28. The letter shall include need data and other information relevant to need for the proposed facility or service, and the applicant's information concerning the proposal.

c. The commissioner shall make final determination of need, location and program.

(1) After receiving the required information, the commissioner shall consider the facts, and recommendation of the county board, and other considerations, which shall be:

(a) To protect mentally retarded persons from violations of their human and civil rights.

(b) To assure that such persons receive the full range of needed social, financial, residential and habilitative service to which they are lawfully entitled.

(c) To assure that the location of the facility will not substantially contribute to excessive concentration of community residential facilities within any town, municipality or county of the state.

(d) To assure that clients of public residential facilities who are in need of a small, home-like facility near their family will be admitted to the facility.

(e) To assure that standards for provision of services are carried out, the size of the facility must relate to the needs of the clients for services. The following criteria shall apply:

i. No facility for more than eight persons shall be approved unless it can be clearly shown that the needs of the residents will be better served in a larger facility and only if the size of the living units (including bedrooms, living rooms, dining room, and kitchen) are for no more than six persons. Meals would not necessarily have to be prepared in

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each living unit, but kitchen facilities should be available for each living unit.

ii. The ability of the residents to use community medical, psychological, therapeutic and support services.

iii. The number of residents whose physical, sensory or other disability justifies the employment of special staff by the facility.

(f) To assure that the facility and program plan cost projections are within fiscal limitations, and meet standards of effective program management.

(2) Within 30 days of receipt of the applicant information and recommendation of the county board, the applicant and county board shall be notified of the commissioner's decision. The notice of the commissioner's decision shall contain notice of the right to appeal that decision, pursuant to section D.4.c.(4) below. If approved the licensing division of the state agency shall then act upon a license application, and the applicant may seek certification under Title XIX and other funding resources from the state agency.

(3) If a licensed facility requests an increase or decrease in licensed capacity, or change in program of any facility or service, that may require change in staffing or remodeling, the facility shall apply to the commissioner directly. No change shall be granted until the county board has an opportunity to comment. The commissioner shall notify the county board of such a request by sending a copy of the request to the county board. The county shall have 30 days to comment. The commissioner shall use the same criteria as is specified for original applications.

(4) Determination of need may be appealed in accordance with provisions of Minnesota Statutes, chapter 15. Notice of appeal must be served upon the commissioner within 30 days of receipt of notification of the commissioner's decision.

E. Service categories.

1. The following service categories, in alphabetical order, shall constitute the range of direct and indirect services needed for a service delivery system in an identified geographical area of the state of Minnesota for its mentally retarded population. These service categories shall be identified to assure delivery as needed, on the basis of individualized program plans.

a. Activity program for adults: Activities which emphasize occupational and social goals which assist adults to become as self-dependent as possible and to make constructive use of leisure time. They are comprehensive and coordinated

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sets of activities providing personal care and other services to adult mentally retarded persons in or out of their own homes during a portion of the 24-hour day. Services may include a variety of creative, social, physical and learning activities based upon an appropriate assessment of need.

b. Assessment services: The systematic determination of pertinent physical, psychological, vocational, educational, cultural, social, economic, legal, environmental and other factors of the mentally retarded person and his/her family; to determine the extent to which the disability limits can be expected to limit the person's daily living and work activity; to determine how and to what extent the disabling conditions may be expected to be minimized by services; to determine the nature and scope of services to be provided; to select service objectives which are commensurate with an individual service plan of action. It is to be followed at whatever intervals are needed by periodic reassessment; services are to be provided whenever necessary in the life of the individual. Assessment services are directed toward the effects of the disability and toward maximizing life functions in the face of remaining conditions.

c. Basic developmental services: Activities emphasizing maturation and supplementing the services provided by parents or parent surrogates.

They are comprehensive and coordinated sets of developmental learning activities conducted in or outside the home during a portion of the day. These services include a variety of creative, social, physical, and learning activities selected in accordance with an appropriate assessment. The focus is upon the developmental schedule itself (individual program plan) and upon the acquisition of skills in self-care. This service should continue on a sustaining basis for these who would otherwise suffer loss of functional level.

d. Case management (service management): An expert person who provides coordination of all the case activities on behalf of the clients of the local social service agency. The case manager is held responsible for mobilizing the resources needed, including especially those not provided directly by his/her own agency. It is a persuasive, rather than an administrative role. Case management is provided by a professionally qualified individual (typically not a volunteer) who has a limited but assigned number of clients.

e. Client information and referral service: Public information about services and procedures in obtaining them. This service may provide referral activity directly or may inform an inquirer. This client information and referral service may be on a face-to-face basis or may be available by telephone.

f. Community services: Mentally retarded people are ordinarily expected to make use of the same community services

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that are used by people who are not retarded. These services are not detailed because they are not specialized on behalf of the mentally retarded population.

g. Counseling: A face-to-face relationship with the mentally retarded individual and/or parent, siblings or other relatives in order to help the individual understand and accept his/her capabilities and limitations, and to carry through on a program of adjustment and self-improvement. This requires knowledge of human behavior and the use of special interviewing skills to achieve specified goals mutually accepted by counselor and client (or parent/guardian). Counseling is an episodic activity carried out when the need arises. Its focus is upon the solution of specific problems.

h. Diagnostic services: Coordinated services including, but not limited to, psychological services, social services, medical and other services necessary to identify the presence of a disability, its causes and its complications. Diagnosis is a current assessment of the client's condition and shall be a guiding factor in the development of the individual service plan. Diagnostic review is to be made whenever necessary in the life of the mentally retarded person, according to C.1.d. of this rule.

i. Domiciliary (residential) care: Out-of-home living quarters, supervision and personal care to persons needing such care and services. Domiciliary care services differ from special living arrangements by its higher degree of supervision and the greater amount of personal care needed, as compared to special living arrangements.

j. Family support services: Those services which enable the family as a unit to meet the family-related needs of the mentally retarded persons. Family support services may include any of the other defined services. It is distinguished in that it is given to the family in their homes.

k. Follow along: A monitoring relationship by the local social service agency on a life-long basis with retarded persons and their families, if needed. It is to assure that changes in need, progression to new levels of adaptive competence, and the problems arising from crises are recognized and appropriately met.

l. Job placement services: The process of securing employment. Competitive employment is employment offered under ordinary conditions and in competition with ordinary employees. Job placement services needed by mentally retarded persons are generally those of securing and adjusting to a job, with no implication that this is limited to a single time or period in the life of the persons.

m. Professional information and referral service: An up-to-date and complete listing of all appropriate resources which can be made available and accessible to professional

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persons serving mentally retarded persons and their families so that they can be referred to the most appropriate and readily available resources. This kind of information and referral services is ordinarily not used by the client.

n. Protective services: Social, legal and other appropriate services which assist individuals who are unable to manage their own affairs or to protect themselves from neglect, exploitation or hazardous situations without assistance from others and to help them exercise their rights as citizens. Protective services may be an adjunct to parent responsibility, or they may be exercised in the absence of the responsible parent. Protective services should be selective in scope and should be limited to those aspects of life function in which a need is demonstrated. (See Minnesota Statutes, sections 252A.01 to 252A.21, Mental Retardation Protection Act.)

o. Recreation services: Planned and supervised leisure-time activities designed to help meet specific individual needs in self-expression, social interaction, athletic endeavors and entertainment; to develop skills and interests leading to enjoyable and constructive use of leisure time; and to improve his/her well-being. The service may include assistance to the individual in his/her use and access of normal community recreation activities.

p. Service delivery system coordination: Responsibility within a given community for the provision of the full range of services. This is a planning and resource-mobilizing function rather than a direct service to clients. It is concerned with the structure and the availability of services rather than with the solution of personal problems. It must be provided in connection with a multi-service area of authority. Information and referral services shall be provided in conjunction with service coordination, and the two are typically interrelated.

q. Sheltered employment: A structured service providing partial self-support through the employment of the retarded worker under conditions which allow for low production rate, need for special work supervision, inability to handle a full range of job duties, or need for special job engineering and adaptive equipment.

r. Special education: A structured learning experience, based upon appropriate assessment and through the use of a broad curriculum of practical academic subjects primarily designed to develop the ability to learn and to acquire useful knowledge and basic skills in its earliest stages. In its later stages, it grades all the way through the equivalent of a secondary education and appropriately interacts with the occupational service system, such as work adjustment. Special education is legally required of the public school district acting either as direct provider or as purchaser of the service.

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s. Special living arrangements: Living arrangements for persons who need some degree of supervision. Special living arrangements should provide at least counseling and leisure-time activities in addition to living arrangements. The service is for disabled persons who can leave their place of residence for work, recreation or other reasons.

t. Treatment services: Interventions which halt, control or reverse those processes which cause, aggravate or complicate disability. Interventions may include treatment, such as surgical procedures, dietary controls, cosmetic therapy, chemotherapy, speech therapy or physical therapy, directed toward basic personal goals, dentistry, and medical treatments as indicated by the needs of the individual being served. Specialized medical and dental care are included.

u. Training services: Planned and systematic sequence of instruction in formal and informal activities based upon appropriate assessment and designed to develop skills in performing activities of daily living, including self-help, motor skills, and communications; to enhance emotional, personal, and social development; to provide experience conducive to the acquisition of positive self-concepts and desire to learn; and to provide experiences basic for future productive activity. Emphasis is upon those skills needed to function as a member of the community. This service is not restricted to any particular age and can be offered at any appropriate time in the life of the individual who is mentally retarded.

v. Transportation services: Necessary travel and related costs in connection with transporting retarded persons to and from places in which they receive services. Transportation also includes taking services to the homebound, delivery of raw materials, and finished products from homebound industries when needed. The use of public transportation is included.

w. Vocational evaluation: Assessment of worker characteristics, through the use of unreal or simulated work tasks. The purpose is to assess occupational strengths and weaknesses, and potential for vocational development. It also includes prevocational evaluation and work evaluation. This requires the use of a rehabilitation facility or similar controlled experimental setting.

x. Volunteer services: Volunteer activities by individuals, service organizations and advocacy groups, provide a variety of services on a group or one-to-one basis that supplements and augments services provided to mentally retarded persons. This may also include participation in advisory committees, advocacy activities and other forms of personal support to individuals. Such services are not to supplant staff services, and are ordinarily provided by unpaid persons and groups.

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y. Work activity: It is for those whose productivity is such that they cannot meet the demands of sheltered employment. For people who need a work setting as part of their program in order to foster a sense of self-worth through work while earning a below minimum wage, it legally enables a wage to be paid. Work activity, in addition, includes a variety of creative, social, physical and learning activities. Work activity may be provided only in facilities having a federal wage and hour certificate for this purpose. It differs from activity programs for adults in that there is a significant productive element: it differs from sheltered employment in that it allows a wage of up to one-fourth the standard minimum.

z. Work adjustment: Learning activities typically involving real or simulated work tasks and situations. It is intended to assist a person to develop basic skills, attitudes, motivation, and work habits of the kind needed in competitive employment, sheltered employment or work activity. It develops social skills needed to function in a work environment. Its focus is upon basic employability rather than upon the skills of a specific occupation.

F. General. The provisions of this rule shall be severable. If any clause, sentence, or provision is declared illegal or of no effect, the validity of the remainder of this rule and its applicability shall not be affected.

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§ 2.195 Senior companion program.

A. Applicability and purpose.

1. Authority. This rule is enacted pursuant to the statutory authority vested in the Minnesota Board on Aging pursuant to Laws of 1976, ch. 323, establishing a senior companion program to engage the services of low income persons aged 60 or over to provide supportive person to person assistance in health, education, welfare and related fields primarily to handicapped adults and elderly people living in their own homes.

2. Purpose. The purpose of the senior companion program (SCP) is to provide meaningful part-time volunteer opportunities for low-income older persons to render supportive person-to-person services to adults with special or exceptional needs in health, education, welfare and related fields. The services are intended primarily for persons in their own homes, but those in group homes, nursing homes, or other public or private nonprofit institutions or agencies, providing care for handicapped adults or elderly persons may also be served.

B. Definitions.

1. Board on aging—a board established pursuant to Minn. Stat. §§ 256.957 and 256.976, previously titled and known as the Governor's Citizens Council on Aging.

2. Memo of understanding—a written agreement between sponsor and person to be served, appropriate caretaker, or an authorized official of a volunteer station that specifies working relationships, channels of communication, and means of cooperation between the parties to the agreement.

3. Persons to be served—the handicapped and older people who receive the supportive person to person assistance of the volunteer Senior Companions.

4. Project advisory council—the Council established pursuant to this rule to advise and assist the sponsors on matters of planning, community participation and financial support.

5. Project sponsor—the agency or organization awarded the grant and the authority to administer the Senior Companion Program in a specified area pursuant to this rule.

6. Volunteers—as used herein, a person who proffers his or her time and efforts in supportive person-to-person services as a Senior Companion (SC) Volunteers for an agreed upon stipend.

7. Volunteer station—a private home, public or private nonprofit agency, institution or organization, or proprietary health care organization or facility, in which or through which persons to be served by senior companion services are found, or made accessible to these services.

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C. Sponsor.

1. To become the sponsor of an SC project for a community, an organization shall submit a grant application, consistent in form and content with these rules, to the Board on Aging for funds to develop and operate an SC project. In order to receive a grant, it is required that the potential sponsor shall:

a. Be a public or private nonprofit agency or organization with the authority to accept and administer such grants.

b. Agree to administer the project in accordance with state legislation and rules, policies and procedures, and the conditions of the grant award set forth by the Board on Aging.

c. Accept full responsibility in the community for the development, implementation, management, and funding of the project.

d. Not be a volunteer station.

e. Provide written assurances that the project will be conducted in consultation with, or with the participation of, an area agency on aging, the regional coordinating agent of the Board.

2. Applications to provide senior companion services to individuals in their homes shall have priority over applications to provide services to those in group homes, or institutions.

D. SCP advisory council.

1. A project advisory council shall be established by the sponsor to meet regularly in order to advise and assist the sponsor on matters concerning planning, community participation, and financial support, and project policies and operational issues.

E. Service area.

1. An SC project shall have an exclusive, geographically defined, service area from which senior companion volunteers are recruited and in which they serve. The service area will be identified in the approved project plan and may not be redefined without the prior written approval of the Board on Aging.

F. Volunteer stations.

1. Volunteer stations shall be within the project's geographical service area as defined in the approved grant application.

2. Each facility serving as a volunteer station, shall be licensed or otherwise certified by the appropriate state or local licensing authority.

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3. A volunteer station shall not request or receive any compensation for services of Senior Companions supervised by it.

4. A volunteer station shall not be a project sponsor.

5. Assignment of senior companions to private homes will be made only with concurrence of the project director and after a memo of understanding has been obtained from the person to be served or an appropriate caretaker.

G. Eligibility of senior companions.

1. To be eligible for enrollment as a volunteer, senior companions shall:

a. Be 60 years of age or over.

b. Have an annual income at or below the applicable income eligibility level as established by the Board.

c. No longer be in the regular work force.

d. Have a physical examination and report adjudging them fit for duty.

2. In computing combined annual income of married couples prior to enrolling them both as senior companions, one senior companion stipend must be included in the determination of maximum annual income.

3. There are no enrollment barriers for senior companions relating to experience, education, race, sex, creed, national origin, or political affiliation.

4. After enrollment as a senior companion, no person shall be terminated as a result of change in eligibility requirements, nor as a result of a change in his income, marital status, or number of dependents.

H. Service schedule.

1. Senior companions shall be compensated for no more than 20 hours a week, in accordance with the schedule of the persons being served, as approved in the grant application. Exceptions to the service schedule authorized by the grant award may be made by the sponsor for unusual situations but only with the concurrence of the Board on Aging in the form of a project amendment. Twenty hours a week may not be exceeded.

2. Personnel policies for the senior companion's insurance, vacation, sick leave, holiday, etc., shall be consistent with those of the sponsor and be developed in consultation with the project advisory council.

3. Time required for transportation between the senior companion's home and the volunteer station shall not be considered a part of the service

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schedule. When persons are served in their own homes, transportation time between two or more such assignments is considered part of the service schedule.

I. Adults served.

1. Senior companions may provide frequent supportive person-to-person services on a regular schedule to adults with exceptional needs, especially older persons living in their own homes, in nursing homes and in other institutions. Persons to be served include, but are not limited to, adults receiving home health care and nursing care and those with developmental disabilities.

2. Volunteer stations, with concurrence of project staff, select the adults in need of individual attention and project staff, with concurrence of the volunteer station, assigns senior companions to the adults.

3. Statewide and in each project, at least 50 percent of the persons served by senior companions shall be age 60 or older.

J. Responsibilities of the Board on Aging.

1. Pursuant to the intent of the Senior Companion Act and these rules, the Board on Aging shall, from time to time, develop and promulgate interpretive guidelines and forms for the administration of uniform and equitable procedures in setting or revising:

a. The level of maximum annual income for determination of eligibility of senior companions, consistent with changing costs of living and the levels prescribed for other federal and state programs using volunteer stipends.

b. Service areas for SCP projects consistent with the availability of funds and coordination with other federal and state programs for older and handicapped people.

c. Levels of stipend, insurance protection, travel expense, or other expenditures that must vary with costs and that are not otherwise prescribed in law or these rules.

d. The provision of technical assistance by the state and area agencies on aging to senior companion projects.

K. Cost sharing.

1. The state will fund up to 90 percent of an approved project budget. Ten percent or more of the total approved budget shall be provided locally by or through the sponsor in the form of cash or in-kind contributions. Actual local expenditures must reach at least the percentage of non-state support identified in the acceptance of the grant award. Sponsors will be encouraged to increase non-state support of the project beyond minimum requirements.

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L. Grant awards, suspension, termination.

1. Grant awards made by the Board on Aging:

a. Shall be for one year or less.

b. Shall not be used to match other state funds.

c. Shall not be used to replace any staff members of the grantee.

2. Grant applications must specify the geographic area to be served, the number of persons and the kinds of disabilities expected to be served, and the numbers of senior companions to be used, together with the kinds of service they are expected to provide. Project expenditures must be restricted to the persons and services specified for that area.

3. The Board on Aging may suspend further payments to a sponsor or terminate payments under a grant when there is a material failure to comply with its terms and conditions. However, no grant may be terminated without reasonable notice to the sponsor and an opportunity for a full and fair hearing. Suspension, except in emergency situations, as well as the denial of an application for refunding (continuation grant), will only take place after the sponsor has been given reasonable notice and an opportunity to show cause why such an action should not be taken.

4. A record keeping system shall be established by each project to allow for collection and storage of information on senior companions, their assignments, volunteer stations and other necessary information, including senior companion and project costs.

A semi-annual report shall be filed with the board on aging.

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12 MCAR S 2.200 Adoption.

A. Introduction.

1. Goal of the Minnesota adoption program: To ensure for each child, who is free to be legally adopted in the state, a suitable adoptive home and agency services supportive of his integration into the new family.

2. Definitions.

a. Adoptive home: A home approved by an authorized child-placing agency for the purpose of placing a child for adoption.

b. Authorized child-placing agency: The local social service agency or any agency licensed to place children by the commissioner or by a comparable authority in the state or country in which the agency exists.

c. Child: An individual under 18 years of age.

d. Foster family home: A family home licensed to provide 24-hour-a-day care to children who are unrelated to the family.

e. Genetic parent: An individual who is referred to as the child's natural parent, who is named in the child's original birth certificate as a parent, whose claim to genetic parenthood is unchallenged, or whose genetic parenthood is established by a court of competent jurisdiction.

f. Independent placement: A proposed or actual nonagency placement of a child by a natural parent or unlicensed third party with persons not related to the child within the third degree.

g. Infant: A child under the age of 15 months.

h. Licensed child-placing agency: An agency authorized by the commissioner to place children for foster care or adoption.

i. Local social service agency: The local agency under the authority of the county welfare board or human service board responsible for arranging and providing social services to individuals.

j. Placing agency: The Minnesota licensed child placing agency which has guardianship of a child from a Minnesota court or the local social service agency which has financial responsibility for a ward of the commissioner of public welfare. The placing agency retains adoptive planning responsibility for the child even though another agency is supervising.

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k. Post-placement services: Social services provided to the child and the adoptive parents from the time of placement until legal adoption.

l. Post-adoption services: Social services provided after legal adoption to the adoptive parents, genetic parents or adopted individuals.

m. Relative: An individual who is related to a child within the third degree according to the Civil Table of Consanguinity by blood, marriage or adoption as a parent, stepparent, brother, sister, grandparent, great grandparent, aunt, uncle, niece or nephew.

n. State adoption exchange: The central adoptive home and child registration service operated by the Minnesota Department of Public Welfare's adoption unit for use by authorized child-placing agencies.

o. State agency: The commissioner of public welfare or the Minnesota Department of Public Welfare.

p. Subsidized adoption: An adoption in which an agreement provides that financial payments shall be made to the adoptive parent(s), subsequent guardian or conservator because of special needs of a child who is certified as eligible for subsidy.

q. Suitability study: The pre-adoptive counseling and subsequent evaluation made by the authorized child-placing agency to determine whether or not the proposed adoptive home can adequately parent and meet the social, educational and health needs of a particular child.

B. Legally freeing the child for adoption.

1. The child shall be legally freed for adoption by either a termination of parental rights pursuant to the Juvenile Court Act, or by a voluntary surrender to the commissioner or to a licensed child-placing agency pursuant to statute.

a. Before a valid agency adoptive placement may occur, court termination of the parent's rights or a voluntary relinquishment to a child-placing agency must be obtained from any individual recognized by state law as having parental rights.

2. All written consents to adoption, executed in a manner prescribed by law, shall be filed with the court prior to the hearing on the adoption petition.

3. All surrenders and consents to adoption (except those given by the commissioner, his agent or a licensed child-placing agency) shall be executed before two competent witnesses and an agency representative, and shall be filed in court prior to the date of the hearing. However, consents to an adoption by the child's parent when that parent is either a co-petitioner in the

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adoption proceedings or does not have custody of the child need not be executed before an agency representative, but only before two competent witnesses. Consents obtained in another state may be executed according to either Minnesota law or applicable laws of the other state.

a. Both the consentor's and the agency representative's signature must each be duly notarized.

b. The two witnesses shall be 18 years of age or older and of sound mind, and neither shall be the subscribing notary public.

c. The agency representative shall be a person qualified to counsel the consenting party on adoption matters.

4. Affidavits submitted by individuals who allege or deny parenthood which contain a consent to adoption must be executed according to the requirements set forth in section 3., supra.

C. Services for children freed for adoption.

1. State adoption exchange. To ensure each child's placement in an adoptive home preferably away from his area of prior residence, the state adoption exchange shall be used by all local social service agencies in accordance with prevailing procedures established by the commissioner. This provision shall not apply to the licensed child placing agencies, Hennepin, Ramsey, or St. Louis counties, whose use of the exchange is optional.

a. The local social service agency shall, without undue delay, seek an adoptive home which will meet the child's special needs. Special needs include sibling ties, racial or religious heritages, and health, social, and educational needs.

b. The local social service agency shall make reasonable efforts to provide and preserve the child's heritage by placing the child:

(1) In an adoptive home of similar background; or

(2) In an adoptive home which is knowledgeable and appreciative of the child's heritage.

2. The child's foster home. The local social service agency may consider the foster home in which the child is currently living as a potential adoptive resource for the child.

a. In such cases, at least one of the following criteria shall apply:

(1) The child has special needs (physical and mental health, education or social) which the foster family will be able to adequately meet.

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(2) The child is older than an infant, has lived at least 12 consecutive months in the foster home, and is an integrated member of the foster family.

(3) The foster family will be able to accept the child and his background and help the child understand his adoption.

(4) The foster family is either the best adoptive resource for the child or is at least comparable to available resources.

b. Except in Hennepin, Ramsey and St. Louis counties, a joint decision between the state agency's adoption unit and the local social service agency as to whether the foster home would be a suitable adoptive home for the child shall be made. The decision shall be based upon:

(1) The local social service agency's written statement and recommendation to the state agency identifying applicable criteria; and

(2) The state agency's written response either approving or disapproving the recommendation.

c. Where a licensed child-placing agency, which is supervising a child under state guardianship, wishes to consider the foster home as the adoptive resource for the child, it shall obtain approval from the local social service agency which has financial responsibility.

3. Child placement. The following policies shall govern the local social service agency's child-placing activities:

a. Preplacement activities:

(1) The social worker assigned to the adoptive home shall, prior to the child being placed in the adoptive home, visit the child in his foster home. This preplacement visit may only be waived if the child is under six months of age and is without special needs.

(2) The child's social worker shall provide the adoptive parents with a written genetic and health history of the child in which all identifying information on the child's relatives has been omitted. The history is to be written in a manner which is understandable and meaningful to the adoptive family.

(3) An adoptive family shall spend at least two days in the child's community becoming acquainted with the child prior to the transfer of physical custody from the agency to them. This provision may be waived, in the discretion of the agency, where extraordinary circumstances dictate prompt placement.

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4. Subsidized adoptions: This section provides standards for determining a child's eligibility for subsidy and the criteria for establishing the terms of the subsidy agreement. Subsidized adoption is based upon the needs of the child who is certified as eligible for subsidy and is available through the commissioner of public welfare for a child under legal guardianship of the commissioner or licensed child placing agency. The commissioner may review and verify the facts upon which the child's eligibility is based.

a. The placing agency shall document in the child's case record all facts upon which the agency certifies the child as eligible for subsidy.

b. The placing agency may determine that subsidy is needed for children placed as sibling groups, children who are entitled to placement with a family of similar ethnic background (i.e., American Indian, Black, Hispanic, Asian), and children with special needs, for whom adoptive homes are not readily available. Special needs include medical, dental and surgical expenses, psychiatric and psychological expenses, maintenance costs, and other costs necessary for the child's care and well-being.

c. The placing agency shall certify the child as eligible for subsidy when the following criteria are met:

(1) The child is a Minnesota resident and a ward of the commissioner or licensed child placing agency.

(2) The agency shall make an early determination on the availability of a home without subsidy, preferably within two months of the child becoming legally available for adoption.

(3) A child shall be eligible for subsidized adoption by his/her foster parents if the following criteria are met and documented:

(a) The child's foster parents desire to adopt the child; and

(b) The agency determines the adoption is in the best interest of the child, according to the criteria established in C.2., of this rule; and

(c) The child's circumstances or characteristics make it difficult for the agency to provide the child a home without a subsidy, or

(4) The placing agency has made reasonable efforts without success to place the child without subsidy. Such efforts include the following:

(a) The agency shall register the child on the state adoption exchange to obtain adoptive home referrals.

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(b) The agency shall contact Hennepin, Ramsey, St. Louis counties and Minnesota-based licensed child placing agencies to seek potential adoptive homes.

(c) The agency may use photo listing services, adoption exchange services, newsletters or other special efforts to secure a home.

(5) When the child is placed into a prospective adoptive home without a subsidy but the need for subsidy becomes evident prior to legal adoption, the placing agency shall apply the criteria in C.4.c.(1) and (3) to determine the child's eligibility for subsidy.

(6) The placing agency shall certify to the commissioner, in writing under its director's or designee's signature, the child's eligibility for subsidy. The statement shall include the conditions or circumstances upon which the child's eligibility is based.

d. When determining the amount of subsidy, the placing agency shall consider the financial resources, social security and veterans benefits, health insurance coverage, medical assistance programs, and other resources available or which may be available to the child.

(1) Maintenance: Maintenance payments shall be provided as necessary to ensure the adoption of a child. The placing agency shall refer to DPW Rule 44, 12 MCAR S 2.044, to determine the amount of a child's monthly maintenance needs for food, clothing, allowances, supplies and transportation. The total monthly maintenance payments may be less than, equal to or more than the basic rate. Amounts greater than the basic rate shall be set according to the difficulty of care standards and the need for the greater amount shall be documented.

(2) Medical: The placing agency shall determine the medical, dental, surgical, psychiatric, and psychological expenses, and other related costs necessary for the child's care and well-being. In determining the costs, the placing agency shall identify the child's circumstances or conditions that require subsidy. The placing agency shall:

(a) Document the kind and amount of health insurance or other medical financial resources available to meet the needs of the child.

(b) Document the actual or estimated expenses for medical, dental, surgical, psychiatric, psychological or other related needs of the child which are not covered by health insurance and/or other alternative financial or medical resources.

(3) Special costs: The placing agency shall determine whether other costs not included in (1) and (2) of this section are necessary for the child's care and well-being.

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The placing agency shall specify the child's needs and document the actual or estimated expenses required to meet that need.

(4) The agency record and the subsidy agreement shall include all relevant facts upon which subsidy payments are based; the amount and frequency of payments. If the amount and frequency of payments are unknown, estimates and the basis for them shall be included.

e. The placing agency shall prepare in writing the subsidized adoption agreement clearly setting forth the responsibilities of all the parties and the terms and duration of the agreement.

(1) The agreement shall state the responsibilities of the parties as follows:

(a) The adoptive parent(s), or in the event of their death or inability to function as parent(s), the subsequent guardian or conservator, shall agree to:

(i) Submit to the commissioner a written statement each year within thirty (30) days of the anniversary date of the approved agreement to certify whether the child remains under their care and the need for subsidy continues to exist.

(ii) Notify the commissioner in writing within thirty (30) days in the event of change in status and its effect on the expenses covered by the subsidy:

(aa) Marriage of child or parent.

(bb) The child's absence from the home by court action or for any reason for a period of more than thirty (30) days.

(cc) Death of child or parent.

(dd) Legal emancipation of the child.

(iii) Notify the commissioner in writing within thirty (30) days of any change which may affect the duration or amount of the subsidy needed.

(iv) Notify the commissioner in writing within thirty (30) days of a change in address to ensure proper mailing of payments.

(v) Participate in and use health insurance and financial programs available for the child.

(vi) Notify the commissioner in writing at least thirty (30) days before a planned medical or special expense is incurred to ensure prompt payment after expense statements are submitted to the commissioner.

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(vii) Notify the commissioner in writing soon after an emergency of the anticipated cost so that the commissioner may begin to budget for that expense.

(viii) Submit expense statements to the commissioner to receive subsidy payments for incurred costs over and above agreed upon monthly payments, but within the parameters of the agreement.

(b) The placing agency shall agree to:

(i) Specify in the agreement:

(aa) The terms and duration of the subsidy as defined in C.4.d.

(bb) The effective date of the agreement which shall be the date of legal adoption. When the child's needs cannot be met by state and federal programs or other available resources prior to legal adoption, the commissioner shall establish an earlier effective date between the child's placement in the adoptive home and legal adoption.

(ii) Assist the adoptive parent(s), subsequent guardian or conservator in the review or modification of the agreement.

(iii) Assist the commissioner in the review or modification of the agreement.

(c) The commissioner shall agree to make financial payments to the adoptive parent(s), subsequent guardian or conservator, as follows:

(i) Payments regardless of the domicile or residence of the adoptive parent(s), subsequent guardian or conservator at the time of application for adoptive placement, legal decree of adoption, or thereafter.

(ii) Monthly payments for the agreed upon maintenance costs and other regular costs as specified in the agreement.

(iii) Payments based upon the expense statements received from the adoptive parent(s), subsequent guardian or conservator for the child's medical or special expenses which are within the parameters of the agreement.

(iv) Payments may be terminated at the written request of the adoptive parents, subsequent guardian or conservator.

(2) When the terms and duration of the subsidy are agreed upon by the parties, the placing agency shall:

(a) Prepare six written copies of the agreement.

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(b) Insure that all copies are signed by the adoptive parent(s) and the placing agency director or designee.

(c) Submit all copies to the state adoption unit for the commissioner's approval.

(3) Upon commissioner's approval, copies of the agreement shall be distributed to the adoptive parent(s) and placing agency. The state agency shall establish an account to reimburse the adoptive parent(s), subsequent guardian or conservator upon the effective date of the agreement or, in instances when monthly payments are made, the month beginning closest to the effective date.

(4) The subsidy agreement shall continue in accordance with its terms as long as the need for subsidy continues and the child remains the legal dependent of the adoptive parent(s), subsequent guardian or conservator.

(5) The terms of the agreement shall be reviewed and appropriately modified when significant changes in the child's status occur.

(6) The adoptive parent(s), subsequent guardian or conservator may request modification or termination of agreement at any time by a written contact with the placing agency or the commissioner.

(7) The adoptive parents, subsequent guardian or conservator have the right to appeal to the commissioner pursuant to Minnesota Statutes, section 256.045, when the commissioner denies, discontinues, or modifies the agreement. The appeal shall be initiated by a written request to the commissioner within thirty (30) days after receiving written notice of the action or decision from the commissioner or within ninety (90) days if the parent(s) show good cause why the request was not submitted within the thirty (30) day time limit.

f. Subsidy payments received according to the terms of the agreement, shall not affect eligibility for any other financial payments (i.e., social security, veterans, or other benefits) to which a person may otherwise be entitled.

g. The placing agency shall receive a reimbursement from the commissioner equal to 100 percent of the reasonable and appropriate cost of providing or purchasing adoption services for a child certified as eligible for a subsidy, including when necessary adoptive family recruitment, counseling, special training and legal fees for finalization. The criteria for reimbursement are:

(1) The child meets the certification requirements of C.4.c.

(2) The child has achieved either an adoptive placement or a legal adoption prior to the agency claim for

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reimbursement.

(3) The placing agency has determined that either partial or full cost of providing or purchasing the adoption services is not reimbursable under other state and federal financial programs.

(4) The placing agency shall submit purchase of service agreements to the commissioner for approval and for review of anticipated expenses.

(5) The placing agency shall notify the state adoption unit in writing when the agency anticipates that its expenses may exceed $3,000 for adoption services on a child certified as eligible for subsidy.

(6) The placing agency shall submit an itemized statement of expenses to the state adoption unit for reimbursement prior to June 30 of each fiscal year.

(a) The itemized expenses shall not exceed the prevailing costs for similar services to children under agency care.

(b) The commissioner shall reimburse the placing agency for 100 percent of the expenses that are not reimburseable under other state and federal programs.

h. The commissioner shall work with American Indian child adoption organizations able to be licensed as child placing agencies. American Indian children, who are protected under the Federal Indian Child Welfare Act of 1978 (25 United States Code, section 19 et seq.) and who are certified as eligible for subsidy shall, whenever possible, be served by the tribal governing body, tribal courts or a licensed Indian child placing agency.

5. Post-placement services. The local social service agency which supervises the child in his adoptive placement is to provide post-placement services.

a. The local social service agency placing the child shall be responsible for arranging and obtaining written placement and post-placement notes from the agency supervising the adoptive placement.

6. Termination of adoptive placement.

a. The local social service or licensed child-placing agency supervising the child shall notify the state agency's adoption unit within five (5) working days when the child's adoptive placement is terminated, when one of the following circumstances arise:

(1) The child is removed from the adoptive home;

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(2) The child dies; or

(3) The adoptive placement has continued for two (2) years without the formalization of the adoption;

(4) Adoption is no longer the agency's permanent plan for the child.

b. Termination of the adoptive placement by a local social service agency may be made only upon a specific finding of good cause by responsible agency personnel. Good cause exists when the placement is shown to be detrimental to the physical, mental or emotional well-being of the child or the adoptive parents. Prior to seeking the removal of the child from the home, the agency shall:

(1) Inform the adoptive parents in writing of the reasons for removal.

(2) In an emergency situation involving danger to the child's health or well-being, request the assistance of the appropriate law enforcement authorities in the immediate removal of the child from the home.

D. Services to children in independent placements.

1. When the local social service agency learns that a parent seeking to place the child desires to place the child with an identified family, the local social service agency shall provide services in evaluating this plan, unless:

a. The prospective parent is related to the child; or

b. The natural parent is receiving services with a licensed child-placing agency.

2. When the local social service agency learns that a court of competent jurisdiction has waived the agency placement requirement, whether or not the child is already in the home:

a. The local social service agency shall pursue licensing that home for foster care; and

b. The prospective parents shall notify the commissioner of the child's placement within thirty (30) days of that placement unless the commissioner was already involved in the proposed placement.

3. When the local social service agency learns that the natural parent and/or prospective parent desire to place the child through the assistance of an unlicensed intermediary, the local social service agency shall take necessary steps, including legal actions, if necessary, to prohibit such a placement from occurring.

4. When the local social service agency learns that the

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child's parent, legal guardian, prospective parents, or the unlicensed intermediary desire to transport the child into or out of Minnesota for placement, the local social service agency shall advise the party or parties that such transportation requires the prior approval and consent of the commissioner.

a. The commissioner shall not give consent to or approval of importation or exportation of the child when a proposed placement is being arranged by an unlicensed intermediary even though a court of competent jurisdiction may waive the agency placement.

b. Applications for importation or exportation of a child must be made by the natural parent or legal guardian according to the statutory provisions of both the sending and the receiving states.

5. When the local social service agency learns that a child is residing in a nonrelative home, it shall carry out the duties of the commissioner and provide all appropriate child protection services prescribed in the Public Welfare Licensing Act, child placing statutes, and the Juvenile Court Act.

a. Local social service agency actions may include, but are not limited to:

(1) Licensing current home or placing the child into a licensed foster home;

(2) Obtaining temporary legal custody;

(3) Providing services to natural parents in making appropriate permanent plans for the child;

(4) Returning the child to a responsible agency in the state of origin when child was imported into Minnesota in violation of statutes.

b. In addition, the local social service agency shall, within thirty (30) days, submit to the state agency a full written report of its investigation of the proposed or actual placement. The report shall include:

(1) Names and addresses of natural parents, child, and intended home;

(2) The names, addresses, dates and activity on all individuals involved in the independent placement plan;

(3) The circumstances surrounding the placement plan;

(4) Any promise or actual payments of money, and amounts of such payments.

c. The local social service agency shall, in writing, request the county attorney's opinion on taking legal action

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against the individuals involved in violations of child placement statutes.

d. The state agency's adoption unit shall recommend to the local social service agency any additional action required for the protection of the child.

E. Services to families applying for adoption.

1. Each local social service agency shall establish an intake policy which provides for:

a. Performance of a suitability study upon the receipt of a properly filed adoption petition;

b. Screening of applications received from potential adoptive parents for children under state guardianship and other adoptable children who have special needs;

c. Supervision of adoptive families moving into Minnesota when so requested by the prior state of residence through the state agency's adoption unit; and

d. Performance of suitability studies on prospective families when requested by the state agency's adoption unit for out-of-state adoption agencies.

2. Local social service agencies, at the minimum, shall consider the following basic standards when determining the suitability of prospective adoptive homes:

a. The applicant must be primarily motivated to meet the child's needs, emotionally mature with healthy interpersonal relationships, in good physical and mental health, and able to adequately support and parent a child in a healthy and emotionally secure environment.

b. The applicant must have the capacity to accept and incorporate into his family a child born to other parents and to assist the child in understanding his genetic background and adoption.

3. The local social service agency is responsible for determining the suitability of adoptive parents whom it has accepted for service.

a. Prospective adoptive homes which the local social service agency certifies as suitable for placement of a child shall be registered on the state adoption exchange. (This requirement is optional for Hennepin, Ramsey and St. Louis social service agencies.)

b. Prospective adoptive homes deemed unsuitable by the local agency shall be informed in writing of any such decision. Notification shall be sent after the agency has counseled with the family on the relevant facts upon which the decision was

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based.

(1) Prospective adoptive homes which the local agency determines are not suitable for an adoptive placement may be further reviewed by that agency, the county welfare or human service board, and/or the state agency's adoption unit upon the written request of the applicant. Such review shall be limited to those factors on which the local agency based its decision.

(2) Grievances arising out of adverse suitability studies are not subject to further administrative review pursuant to Minnesota Statutes, chapter 15, or section 256.045.

F. Interstate and international adoptive placements.

1. No child shall be brought into or sent out of the state of Minnesota for adoptive placement into a nonrelative's home unless one of the following conditions is met:

a. The commissioner, as state administrator of the Interstate Compact on the Placement of Children, issues written approval for the importation or exportation pursuant to the requirements of that compact; or

b. The commissioner has, in non-compact situations, issued a written consent to importation or exportation of the child, pursuant to applicable state law.

2. The commissioner shall not issue consent or approval for the movement of a child across state lines where the proposed placement plan is made by an unlicensed third party.

3. The commissioner, upon receipt of all required documentation, shall issue consent or approval for importation when:

a. The foreign country allows the child to be exported for the purpose of adoption in the United States; or

b. An authorized child-placing agency in the sending state has custody of the child and requests the importation into Minnesota; or

c. A family plans to move to Minnesota and has a child placed with them according to the laws of the other state or country.

4. The documents required for the commissioner's consent and approval are:

a. An authorized child-placing agency's written confirmation that the family is approved for adoptive placement;

b. A document which identifies the child, his birth date, birthplace, and his parentage; and

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c. Legal documents which demonstrate that the child has been properly released for adoption.

5. Local social service agencies (other than Hennepin, Ramsey and St. Louis counties) shall route correspondence directed to out of state agencies through the state agency's adoption unit.

G. Legalization of the adoptive placement.

1. The commissioner or authorized child-placing agency shall initiate the process of legalizing adoptive placements of agency-placed children by sending the petitioner, or his attorney, such information as is needed for completion of the adoption petition.

2. When an adoption petition, which fails to meet the filing requirements of Minnesota Statutes, section 259.22, subdivisions 2 and 3, is nevertheless filed in a court of competent jurisdiction, the commissioner shall recommend to the court dismissal of that petition.

3. The final report and recommendation on a petition under investigation by the commissioner or authorized child-placing agency shall be made to the court within the ninety (90) day time period.

a. The commissioner or authorized child-placing agency shall request a continuance of the court when the investigation cannot be completed in the ninety (90) day time period.

b. A copy of all requests for continuances shall be filed with the state agency's adoption unit, the servicing agency, and the petitioner's attorney.

H. Post adoption services.

1. Post adoption services shall be provided to adoptive families, adopted adults, and genetic parents at their request in a manner which strengthens the adoption contract and which is within the parameters of applicable state law and federal regulations on confidentiality and privacy of child welfare and adoption records.

2. General background information with the deletion of all identifying information such as names, specific dates, addresses and locations, shall be prepared to aid the adopted adult in understanding his genetic background and adoption.

3. Local social service agencies shall provide liaison and skilled counseling services through appropriately trained social workers to the adoptive parents, adopted adult, genetic parents, and/or siblings where there exists a mutual desire to arrange contact and there exist no known factors prohibiting such contact.

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4. Local social service agencies shall maintain a record of all such services provided in each individual's adoption record.

I. Maintenance of adoption records.

1. Content: Each child's adoption record shall contain copies of all relevant legal documents, responsibly collected genetic, medical and social history, the child's placement record, copies of all pertinent agreements or contracts, copies of all reports and recommendations to the court, and copies of all pertinent correspondence.

2. Use: Each adoption record shall constitute the permanent record upon which all court action is based, agency services are administrated and the adoptive family unit is identified and established.

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§ 2.201 Chore services.

A. Introduction.

1. This rule governs the administration and provision of chore services by local social service agencies.

2. Definition.

a. Chore services: Services such as routine housekeeping tasks, minor household repairs, shopping, lawn care and snow shoveling.

b. Local social service agency: Local agency under the authority of the county welfare board or human service board which is responsible for social services.

B. Provision of services.

1. When the local social service agency provides chore services, the following standards apply:

a. Chore services persons must be approved by the local social service agency. The services performed by the chore service person shall be in accordance with the client's social service plan.

b. Approval of the local service agency shall be obtained in all cases in which the performance of a task necessitates the handling of the client's money.

c. When the local social service agency purchases chore services from another agency, the local social service agency shall provide the functions of liaison and coordination with the vendor agency and require quality of service equal to that which it would itself provide.

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§ 2.202 Employability services.

A. Introduction. The objective of employability services is to provide individuals with the training skills and social services necessary to maximize their employability potential and to assist them in obtaining, maintaining and improving employment. Such services are needed by the underemployed, the unemployed, the unskilled individuals who have never been part of the labor force, individuals who are socially or economically disadvantaged, individuals with poor job histories, the undereducated, and persons with physical and/or mental handicaps.

1. Definitions.

a. Local Social Service Agency: The local social service agency under the authority of the County Welfare Board or Human Service Board which is responsible for social services.

b. Employability service: Arranging and providing assistance to individuals in obtaining, maintaining and improving employment through the use of vocational counseling, employability testing, college and vocational training, job finding assistance and special employment services for individuals who are handicapped because of some social, economic or mental/physical health condition.

c. Non-WIN employability program: A program of employability services, authorized and funded through Title XX of the Social Security Act, which provides Aid to Families with Dependent Children (AFDC) recipients with employability opportunities which fall beyond the scope and function of other programs, such as the Work Incentive Program (WIN) and the Division of Vocational Rehabilitation (DVR) programs.

d. Public Assistance/Vocational Rehabilitation Joint Action (PA/VR): A cooperative effort by Minnesota Division of Vocational Rehabilitation (DVR) and the Minnesota Department of Public Welfare (DPW) to provide physically, mentally and emotionally handicapped individuals with the training skills and supportive services necessary to maximize their employability potential.

e. State Agency: The Minnesota Department of Public Welfare.

f. Work Incentive Program (WIN): A program designed to provide opportunities for appropriate AFDC recipients to be placed in jobs and/or to obtain the employment and social services necessary to attain employability. Applicable state and federal legislation includes Minn. Stat. § 256.736 and Title IV-C of the Social Security Act.

(1) Mandatory WIN Registrant: An individual required to register for WIN as a condition of initial or continued receipt of AFDC.

(2) Voluntary WIN Registrant: An individual exempt from the WIN registration requirement who nevertheless volunteers to register for WIN.

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2. Resources. Local social service agencies shall be responsible for the administration and delivery of services to Aid to Families with Dependent Children (AFDC) recipients under the WIN and non-WIN (Title XX) program. State laws also mandate work relief programs for General Assistance (GA) recipients who are unable to find employment through existing employment resources. In addition, local social service agencies have an ongoing responsibility to identify and refer to the Minnesota Division of Vocational Rehabilitation (DVR) those individuals who could benefit from vocational rehabilitation services.

B. Non-WIN title XX employability program.

1. Intent and service objectives. The intent of the non-WIN employability program is to provide AFDC recipients with employability opportunities which fall beyond the scope and function of other programs, such as the Work Incentive Program and the Division of Vocational Rehabilitation programs. The objective of non-WIN social services is to provide eligible AFDC recipients with the training, skills and other social services necessary to maximize their employability potential and to assist them in obtaining, maintaining and improving employment.

2. Services. Employability services is the primary service to be provided in attaining program objectives. Additional services necessary to remove barriers to employability may include, among others, day care, health, homemaking, transportation and counseling services, and referral to other agencies (e.g., Division of Vocational Rehabilitation, CETA, etc.).

3. Non-WIN college or vocational training.

a. The three basic criteria in considering and approving classroom or vocational training are:

(1) Is it reasonable to assume that the candidate possesses sufficient motivation and potential for successful completion of the training/educational sequence?

(2) Is the training facility a reputable and accredited institution?

(3) Is the self-support plan likely to lead to employment?

b. After other resources have been exhausted, the cost of tuition, books, tools, etc., may be paid by the county social service agency.

(1) The cost of tuition shall be reviewed annually in conjunction with the self-support plans and other potential funding resources shall be explored.

(2) The local social service agency shall not agree to pay more than one academic year at a time even though the individual's self-support plan relates to a four-year college education or other vocational training ex-

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tending beyond one year. Non-WIN academic training shall be limited to a baccalaurate degree.

c. Non-WIN training/education allowance.

(1) This allowance is intended to cover expenses such as transportation, lunches, additional clothing and other incidental expenses related to training/educational activities.

(2) This allowance is a social service expenditure to be paid monthly to the recipient/trainee and is not to be considered a budgetable item in the assistance payment.

(3) Criteria governing the allowance:

(a) An individual in training 30 or more hours per week shall, upon authorization and documentation of the social worker, receive a $40 monthly allowance.

(b) An individual participating in training less than 30 hours but more than 15 hours per week shall receive $20 per month.

(c) An individual participating in training less than 15 hours per week, but who incurs transportation and other training-related expenses, will receive an allowance of $10 per month.

(d) When an individual incurs training-related expenses greater than the standard allowance, the county social service staff shall document the actual costs incurred by the individual and increase the allowance to cover all reasonable actual costs.

(e) In determining hours in training, class participation, home study, library work and other class preparation shall be included.

d. Non-WIN job seeking allowance.

(1) This allowance is available to AFDC recipients actively engaged in job-seeking activities and is intended to cover related expenses such as transportation, lunches, additional clothing and other incidental expenses.

(2) This allowance is a social service expenditure to be paid monthly to the recipient and is not to be considered a budgetable item in the assistance payment.

(3) This allowance shall accurately reflect additional costs related to job-seeking activities and is limited to $40 per month.

(a) If costs incurred during job-seeking activities exceed $40 per month, the actual costs shall be documented by county social service staff and the recipient shall be reimbursed for all reasonable costs actually incurred.

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(4) This allowance shall be available to individuals who are actively seeking employment either through participation in a job-seeking skills class or by going out on a predetermined number of job interviews (agreed to by the individual and local social service staff).

(a) A "job-seeking skills class" may include information about employers, instruction in completing job applications, information and practice in job interviewing, etc.

(b) The number of job interviews is to be established by the individual and his social worker.

4. Implementation of the non-WIN employability program.

a. Local social services staff shall work with AFDC recipients and their families in an effort to evaluate potential for employment and to encourage participation in programs which have self-support goals.

b. While local social service agencies are required to affirmatively offer and provide non-WIN (Title XX) employability services, acceptance of these services is optional and no current AFDC recipient shall incure financial sanctions for refusal of employability services.

c. Local social service agencies shall screen AFDC caseloads to identify those individuals immediately referrable for training and/or employment.

(1) The following individuals may be considered inappropriate for referral:

(a) Those individuals with illness, advanced age, (65 years or older) or incapacity (unless a DVR referral is indicated in the case of incapacity);

(b) Those individuals too far removed from work and training activities so as to make participation ineffective;

(c) Dependent Children under age 16 and those individuals 16 years of age or older who are in school on a full-time basis;

(d) Individuals needed in the home to care for children because adequate child care arrangements cannot be arranged or maintained;

(e) Individuals needed in the home on a substantially continuous basis because of the illness, incapacity or young age of another family member; and

(f) Mothers or AFDC caretakers who cannot cope with the dual role of being a homemaker and a wage-earner.

C. Work incentive program (WIN).

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1. Definitions.

a. Appraisal: An interview with a WIN registrant by WIN project staff and local social service staff to assess employability potential, determine the registrant's need for supportive services and initiate an employability plan.

b. Certification: The formal mechanism for requesting social services necessary for implementation of an individual's employability plan, as well as for authorizing 90% federal reimbursement for those services.

c. Component: An active WIN status usually requiring an individual's active and regular participation, including training, institutional training, and other Employment Services activities.

d. Employability plan: A plan for service established by the individual in conjunction with WIN project staff and local social service staff which includes a self-support goal, identification of activities required to attain such a goal, and identification of supportive social services necessary to implement the plan.

e. Separate administrative unit (SAU): Local social service agency staff responsible for providing or arranging WIN supportive social services.

f. Sixty-day counseling: Counseling and other services provided by the local SAU to certified WIN registrants who have been determined to have refused to to participate without good cause in order to encourage such individuals to return to active WIN participation.

g. WIN project staff: State employment services staff responsible for providing or arranging WIN employment and training services.

2. Service objective. The objective of WIN social services is to facilitate an individual's participation in WIN and remove any barriers to implementation of his employability plan.

3. Services. WIN social services are services necessary to remove barriers to an individual's active implementation of his employability plan.

a. The following mandated supportive services shall be available to WIN registrants in the State of Minnesota for the purpose of facilitating employability plans and self-support goals.

(1) Day care service (children): Personal care during the day (for less than 24 hours) in the child's own home or in a nurturing and protective setting to substitute for or supplement the child rearing provided by the child's parents; as well as integral but subordinate medical service.

(a) Child care must be suitable for the individual child, and the caretaker relative must be involved in the selection of the child care fa-

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cility if more than one facility is available. If only one facility is available, the caretaker relative must accept it, unless the caretaker can show that it is unsuitable for the child. Such child care arrangements shall be maintained until the caretaker relative is able to make other satisfactory arrangements. Child care arrangements must comply with standards as set forth in 45 CFR 228.42.

(2) Family planning: Services provided to enable individuals to voluntarily limit the size of their family or the space between children and to prevent or reduce the incidence of births out-of-wedlock.

(a) Family planning services shall be entirely voluntary for the registrant/participant.

(3) Counseling services for families and individuals: Utilization of a professional helping relationship to enable individuals and families to deal with and to resolve whatever intra and/or interpersonal relationship problem or stress is encountered by them.

(4) Health service (employment related): Arrange and facilitate access to and use of health resources, including mental health resources, to determine if the individual has any physical or mental limitations which would restrict or limit his or her vocational options.

(a) In all instances, this medical exam is a Medical Assistance (MA) expenditure and is not to be paid for under WIN 90/10. Reimburseable expenditures would be for social worker time involved in arranging for medical appointments, requesting medical reports, etc.

(5) Vocational rehabilitation service: Special employment services for individuals who are handicapped because of some social, economic, or mental/physical health condition including such things as surgery, psychiatric treatment, prosthetic devices, speech or hearing therapy, visual services, dental care, etc., in order to correct or substantially modify a physical or mental condition which is a handicap to employment.

(a) These vocational rehabilitation services will be provided with WIN funds only when they are not available through the Division of Vocational Rehabilitation, and when there is reasonable expectation that the same services will lead to unsubsidized employment.

b. The following supportive services may be provided with WIN funds when it is determined by the WIN sponsor and the SAU that such are necessary to the successful completion of employment plans and self-support goals.

(1) Homemaking service: Provisions of surrogate care in the absence or disability of the caretaker, providing for the personal care of ill or disabled individuals, as well as instruction on more effective methods of home management, the development and maintenance of self-care and social skills.

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(2) Housing service: Services to help individuals obtain, maintain and improve housing, and/or to modify existing housing.

(3) Legal service: Arrange and provide for assistance in resolving noncriminal legal matters and the protection of legal rights.

(4) Money management service: Arrange and provide assistance in developing effective budgets and managing indebtedness.

(5) Transportation service: Arrange and provide travel and escort to and from community resources and facilities.

4. Implementation.

a. Local SAU staff shall participate with WIN project staff in developing and implementing client-specific employability plans.

(1) Local SAU staff shall participate in appraisal interviews to develop, with the individual and WIN project staff, a tentative employability plan.

b. Local SAU staff shall certify all individuals who are assigned to a WIN component whether or not services are needed, as well as all other WIN registrants requiring services.

(1) Each unemployed father required to be registered for WIN shall be certified no later than 30 days from the receipt of AFDC benefits. If WIN project staff fail to request certification of an unemployed father within two weeks after registration, the SAU shall certify him without such a request. Should any social services be provided, the cost may not be claimed at the 90% rate until the services have been approved by the employment service agency.

(2) Each registrant receiving sixty-day counseling shall be certified.

c. After certification is completed, local SAU staff shall provide or arrange for all necessary and authorized social services during an individual's active participation in WIN or until the need for a specific service has ended.

5. Adjudication. Upon determining that a certified registrant has refused to participate in WIN without good cause, WIN project staff shall send the registrant a "Notice of Intended Deregistration". A copy of such Notice shall also be sent to the county SAU.

a. WIN project staff shall provide all such notified registrants with an opportunity for a fair hearing on the proposed deregistration. Decisions of the hearing officers shall be binding on the local social service agency. Such decisions may be appealed at the state level, and following that, to the WIN National Review Panel.

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b. Local SAU staff shall initiate sixty-day counseling on the fifth day following the expiration of the ten-day time period for requesting a fair hearing or the date of the hearing officer's adverse decision, whichever occurs later.

(1) The SAU shall provide the individual with a written explanation of the sixty-day counseling followed by a personal contact. The written explanation shall advise the individual of the effect of his continued refusal to participate in the WIN program and the potential effect upon his assistance payments.

(2) If at any time during the sixty-day counseling period the individual changes his mind and agrees to actively participate in WIN, the SAU shall communicate this to the WIN project staff and the individual shall be returned to "active participant" status. Also, training and incentive allowances shall be immediately reinstated.

(3) An individual refusing or terminating counseling at any time during the sixty-day period shall incur appropriate sanctions immediately.

(a) A registrant who fails without good cause to appear for two or more scheduled counseling sessions shall be considered to have terminated the counseling.

c. Certified registrants who complete the sixty-day counseling and agree to return to participation shall be reaccepted into WIN only upon approval of the SAU.

(1) An individual who has been offered the sixty-day counseling period, has been returned to "active participation" status, and has again been determined to have refused to participate without good cause, shall not be allowed a second determination of refusal to participate without good cause; the individual shall incur appropriate sanctions immediately.

D. Public assistance/vocational rehabilitation joint action (PA/VR).

1. Objective. The objective of services under Public assistance/vocational rehabilitation joint action (PA/VR) is to provide physically, mentally and emotionally handicapped persons with the training, skills and supportive services necessary to maximize their employability potential and to assist them in obtaining, maintaining and improving employment.

2. Referral. Local welfare agency income maintenance staff shall identify individuals appropriate for PA/VR involvement, obtain current medical information on such individuals, and refer them to both the vocational rehabilitation agency and the local social services staff.

a. Local social service staff shall follow-up on all such referrals to insure that individuals with disabling conditions who apply for public assistance (or who apply for AFDC in non-WIN counties) have been referred to the Division of Vocational Rehabilitation within 30 days of their initial contact with the local social service agency.

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b. Local social service staff shall evaluate on an ongoing basis disabled clientele not currently active with DVR who have potential for vocational rehabilitation and self-support. Where appropriate, such individuals shall be referred for vocational rehabilitation services, and necessary supportive social services shall be provided by local social service staff.

3. Services. Local social service staff shall cooperate with DVR staff in a comprehensive evaluation (medical, social, emotional, etc.) of all clientele and potentially eligible individuals and their families. On the basis of this evaluation, social services shall be provided, as needed, to facilitate the rehabilitation plan. These services shall be made available, as needed, to the individual and/or other family members who are affected by the disabling condition.

a. Services available through DVR shall include vocational adjustment counseling, books, training materials and tools, training-related expenses and other services necessary to develop the individual's employability potential.

E. Record keeping, access and retention.

1. In accordance with applicable state and federal laws and regulations, local social service agencies must maintain adequate employability service records and must assure privacy of these records to the extent required by these authorities.

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Chapter 7: Sub-Chapter I—Services.

§ 2.203 Foster care—adults.

A. Introduction.

1. This rule governs the administration and provision of foster care services to adults by the local social service agency.

2. The purpose of Adult Foster Care Services is to provide a socially, physically or mentally handicapped or isolated adult with living arrangements in a family unit in his own community as an alternative to institutional care.

3. Definitions.

Adult Foster Care Service—supervised twenty-four hour a day living arrangements for no more than four adults in a family setting with concurrent access to social services and community resources.

Local Social Service Agency—Local agency under the authority of the County Welfare Board or Human Service Board responsible for social services.

Foster Family Home—a family home approved by a local service agency which will provide twenty-four-hour-a-day care to adults who are unrelated to the family.

B. Services to adults in foster care.

1. The local social service agency shall consider for foster family care those adults who:

a. Are in need of companionship, supervision and relief from the responsibility of managing their affairs alone.

b. Are without family or friends with whom they can live.

c. Because of physical, mental or emotional impairment, need a protective home environment in order to live safely within the community.

d. Are in need of special services to remain in or return to community life.

e. As certified by medical evaluation, are not in need of the care provided by a nursing facility.

f. Are able to care for their own personal needs.

g. Are alert and stable enough to express their own wishes regarding their living arrangements and enter into planning for their needs when indicated.

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h. Are agreeable to placement.

i. Are unable to live alone because of incapacities or infirmities.

2. In addition to meeting the service plan requirements as specified in Minn. Rule 12 MCAR § 2.160, Part VI, the local social service agency shall include in the written plan for services the plan for utilizing community resources.

3. The local social service agency shall provide the foster home with a copy of the written plan pertaining to each resident.

4. The agency shall assure that provision is made for counseling services to help the client:

a. Determine if he needs a foster home.

b. In the selection of a suitable foster home.

c. Determine what assistance he may want from the agency.

d. With his adjustment to a foster home and to bring any concerns about conditions in the home to the attention of the operator.

e. Plan for disposition of belongings, if appropriate.

f. Maintain family and community ties.

g. Make use of community resources, including social and recreational opportunities.

h. Obtain regular medical evaluation and carry out any prescribed program of medical care.

i. Secure and utilize supportive services, such as transportation.

j. With any move he might make to an independent living arrangement or another facility.

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12 MCAR § 2.204 Foster care—children.

A. Introduction.

1. This rule governs the administration and provision of foster care services to children and their families by the local social service agency when the agency has placement and supervisory responsibilities.

2. The purpose of foster care services to children is to provide substitute family or group care for a child while an intensive effort is made to correct or improve the condition necessitating placement in order to reunite the family or, in the failure of this, to provide some other permanent plan.

3. Foster care services shall be provided only after services aimed at preventing the need for placement of a child in foster care have been considered, provided, or refused by the child's family.

B. Definitions.

1. Foster care service. The service which provides substitute twenty-four-hour-a-day family or group home care for a planned period of time, provides experiences and conditions which promote normal growth, and provides to the child, the child's family, and the foster parents casework services and other treatment or community services.

2. Local social service agency. Local agency under the authority of the County Welfare Board or Human Service Board or Board of County Commissioners which is responsible for social services.

3. State agency. Minnesota State Department of Public Welfare.

4. Foster family home. A family licensed under 12 MCAR § 2.001 to provide twenty-four-hour-a-day care in their home to children who are unrelated to the family.

5. Group home. A facility licensed by the Minnesota Department of Public Welfare as a group family foster home under 12 MCAR § 2.001 or as a group home under 12 MCAR § 2.008 or certified by the Department of Corrections as a group foster home or licensed or approved by an Indian tribe with the authority to do so.

6. Voluntary placement. Placement in which the local social service agency assumes responsibility for the placement of a child after the agency has determined, in conjunction with the child's parent(s) or legal guardian and the child, if possible, that such placement is in the best interest of the child and his family.

7. Legal custody. Legal custody is defined by law as the right to care, custody and control of a child and requires the removal of the child from his or her parent(s) or legal guardian for the child's welfare and/or safety. Legal custody is for a specified length of time, but not to exceed one year.

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8. Custodian. Any person who is under a legal obligation to provide care and support for a child.

9. Relative. Any of the following persons related to the child by marriage, blood or adoption: parent, grandparent, brother, sister, stepparent, stepsister, stepbrother, niece, nephew, uncle, or aunt.

C. Services to children in foster care.

1. Service delivery.

a. Placement in licensed facility. With the exception of placement in a relatives' home, the local social service agency shall place a child in a licensed foster family or group home except in emergencies when an unlicensed foster home may be selected. In these emergency cases, the agency shall assure that application for licensure is made within 30 days of the child's placement if the child is expected to remain in the home for 30 days or longer.

b. Legal basis for placement.

(1) The local social service agency shall obtain the proper authority to place a child in foster care, either through written consent of the child's parent(s) or legal guardian (voluntary placement) or with an order of the court (legal custody).

(2) Responsibilities in court ordered and voluntary placements.

(a) When legal custody is given to a local social service agency, that agency shall:

(i) avoid precipitous movement of the child without orderly pre-placement planning and preparation. When removal of the child is not emergent, the agency shall request permission of the court for time to place the child in an orderly fashion and, upon being granted this request, shall proceed to effect the placement according to the requirements of rule and statute.

(ii) provide information, evaluations and recommendations to assist the court in arriving at appropriate decisions and actions with regard to the child and the child's family;

(iii) provide the court written reports and recommendations prior to the expiration of any order giving the agency responsibility for the child;

(iv) inform the foster parents of court hearings which pertain to any foster child in their care;

(v) report to the court the placement of a child out of

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the jurisdiction of the court. Copies of such notification shall be forwarded to the child's parent(s) or legal guardian;

(vi) request the court to order any special treatment and care needed by the child if the child's parent or legal guardian fails to provide it;

(vii) obtain for its record a copy of the court's findings, decisions, disposition of the case and any other information which may aid the county in providing services to the child;

(viii) obtain the permission of the court before terminating foster care and returning the child to his or her parent(s);

(ix) obtain the written consent of the parent(s) or legal guardian and the court if a child under legal custody is to be placed in a facility outside of the state. If the parent(s) or legal guardian refuse or fail to give consent, the court's written consent is sufficient.

(b) When a child is placed in foster care by voluntary agreement between the local social service agency and the parent(s) or legal guardian, the agency shall:

(i) obtain the parent(s)' or legal guardian's written consent prior to the placement;

(ii) require the parent(s) or legal guardian to agree to provide reasonable notice before seeking return of the child from placement so that the agency may prepare for the orderly return of the child in no more than 30 days.

c. Major decisions affecting child. The local social service agency shall obtain the written consent of the child's parent(s) or legal guardian for major decisions affecting the child. If the parent(s) or legal guardian fail to give consent, and it is essential to the child's health or well-being, a court order shall be obtained which will provide the authority to secure whatever is needed for the child. Whenever there is a question as to what shall be regarded as a decision requiring parental or judicial consent, the agency shall consult the court.

d. Relationship to other agencies and institutions. The local social service agency shall establish formalized agreements with those agencies and institutions which, in conjunction with the local social service agency, are serving a particular child. The purpose of such agreements is to ensure optimum cooperative planning and provision of services.

(1) Schools.

(a) Prior to foster care placement, the local social service agency shall involve in the placement planning the child's present school and

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the one which he may attend in order to assure that the child's social, educational and extracurricular needs will be met. The agency shall initiate contact with the schools.

(b) If a child is to remain in the same school, the local social service agency shall notify the school at such time as the child is to be placed in foster care or when the child is to be moved to another facility.

(2) Other social service agencies.

(a) The local social service agency shall not place a child in another county without the approval of the other county local social service agency.

(b) When a local social service agency requests services of another agency in effecting a placement, or receives such a request for service from another agency, there shall be a written agreement defining the responsibilities for services to be delivered, methods for evaluation and procedures for handling foster care payments.

e. Group homes. The local social service agency shall provide for the utilization of group homes for children requiring such services.

(1) The choice of facility and length of stay shall be determined by the needs of the child for the specific services offered by the facility.

(2) The child's service plan shall state the rationale for placement of the child in a group facility.

(3) The local social service agency shall provide or arrange for services not available in the group facility.

f. Practice components of service. All local social service agencies, in delivering foster care services, shall:

(1) provide at least one pre-placement visit for the child to the foster or group home. This requirement is waived for newborn infants being placed from a hospital into a foster home.

(2) provide help to the child in his initial adjustment to the foster home through the placement worker's visit to the home within four days of the placement;

(3) plan with the parent(s) for a parent visit with the child within a week of the placement;

(4) provide casework to the child on a planned regular basis, at least twice a month for the first three months and as frequently as necessary thereafter.

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(5) provide or arrange for casework and other indicated services to the child's family on a planned regular basis, and at least twice a month, to help them:

(a) fulfill their roles and responsibilities as parents to the placed child;

(b) remedy the conditions which necessitated placement;

(c) prepare for the child's return home or, if this return home is not possible, involve them in making an alternative plan;

(d) develop and maintain a constructive relationship with their child through a carefully planned and executed program of communication and visitation;

(6) provide assistance to the foster parents or group home operators with their responsibilities of incorporating the child into their family or facility. The foster parents and group home operators shall be provided a telephone number and an additional back-up number to call during the hours the agency is closed.

(7) provide follow-up services to the family and child when the child returns home to assist with the adjustment and to prevent recurrence of the circumstances which led to placement;

(8) evaluate, in conjunction with the foster parents or group home operators, the placement experience when a child leaves the facility to ascertain the facility's potential for future placements.

Those requirements listed under C. 1. f. "Practice components of service" which may not be applicable for children under state guardianship as dependent/neglected or for placements of children in emergency facilities in crisis situations may be waived. The agency may also waive those requirements under C. 1. f. "Practice components of service" which may be contrary to the child's best interests but must document the rationale behind such waivers.

g. Provision for meeting health needs. The local social service agency shall meet the health and dental needs of every child by:

(1) assuring that each child has a health examination prior to placement or, in emergency situations, within two weeks thereafter;

(2) assuring that a child's ongoing health and dental needs are met;

(3) assuring that the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are offered and/or provided pursuant to 12 MCAR § 2.061 to all children eligible for the Medical Assistance Program;

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(4) providing the foster or group home with information about the child's immunizations and other pertinent health data with instructions for the record to be kept up-to-date;

(5) providing to the foster or group home a written authorization for obtaining routine health care for the child with clear instructions as to who is to provide the care and how the billing is to be handled.

h. Service plan and review. For those children who are placed in foster family homes, group homes or relatives' homes (unless placement with the relative is planned to be permanent) and for whom the local social service agency has placement and/or supervisory responsibility, the agency shall comply with the following requirements:

(1) Service plan.

(a) The agency shall develop, in conjunction with the child's parent(s), or other custodian, the child's legal guardian, and if possible, the child, a service plan which includes:

(i) the specific reasons for the placement of the child in a foster home, including a description of the problems or conditions in the home of the parent or parents which necessitated removal of the child from his home;

(ii) the specific actions to be taken by the parent or parents of the child to eliminate or correct the problems or conditions identified in clause (i), and the time period during which the actions are to be taken;

(iii) the financial responsibilities and obligations, if any, of the parents for the support of the child during the period the child is in the foster home;

(iv) the visitation rights and obligations of the parent or parents during the period the child is in the foster home;

(v) the social and other supportive services to be provided to the parent or parents of the child, the child, and the foster parents during the period the child is in the foster home;

(vi) the date on which the child is expected to be returned to the home of his parent or parents;

(vii) the nature of the effort to be made by the social service agency responsible for the placement to reunite the family.

(viii) the actions to be taken for meeting the special educational needs of the child including the responsibilities of the foster parents and the child's parents.

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(b) The agency shall advise the parents of their right to receive assistance from any person or social service agency and their right to legal counsel in the preparation of the service plan.

(c) In those situations where the child's condition or behavior may require change before placement can be terminated, the service plan shall include actions to be taken or progress to be made by the child while in placement.

(d) The visitation plan shall be detailed and shall include, but not be limited to, the date and conditions of the first visit, specific days of visits, specific hours for beginning and ending of visits and special conditions of visitation.

(e) The agency shall explain to the parents that if the parents are unable to correct the conditions necessary for their child's return home, they could lose their parental rights.

(f) If the agency cannot comply with any service plan requirement, the agency shall document the reason in the record.

(2) Six-month administrative review of service plan. The local social service agency shall provide an administrative, supervisory, or conference review at least every six months for each child in placement to determine the appropriateness and adequacy of the service plan. The review shall include persons other than or in addition to the service worker responsible for the case. The administrative review may be waived if the court has reviewed the service plan within that six-month period.

(3) Review of service plan with parents and child. Within 180 days of the child's initial placement, if the child is still in foster care, the local social service agency shall review the service plan, including in the review all persons involved in the plan's preparation. The review may be waived if the court has reviewed the plan within the 180 day period.

i. Child's or foster parents' absence from foster home. The local social service agency's permission must be obtained any time the foster family and/or child are to be away from the licensed foster care facility within the state for a period exceeding three nights or, if the child leaves the state, for any period of time. However, the agency may provide specifically defined blanket permission for departures from the state where a family regularly departs the state for an identified routine purpose.

j. Protecting the child's heritage. The local social service agency shall provide for the preservation of the child's religious, racial, cultural and ethnic heritage through:

(1) placement if possible and indicated in a foster home of similar background;

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(2) education of the foster parents as to the importance of the heritage to the child;

(3) education of the foster parents as to the customs and values of the particular group;

(4) assistance to the foster parents or group home operators, so that they will be better able to provide a home which is accepting and supportive of the child's cultural, religious, racial, or ethnic identity.

k. Financial arrangements and funding considerations.

(1) The local social service agency and the parent(s) shall evaluate the various resources available to meet the costs of care.

(2) Parent(s) shall pay for the cost of care in a manner consistent with their ability to do so and with any applicable state laws or rules.

(3) If the local social service agency establishes that the parent(s) are able to meet some or all of the costs of care, but are unwilling to do so, the following courses of action are indicated:

(a) For a child under legal custody, the local social service agency shall make a written report to the court for determination by the judge of the parents' responsibility to reimburse the agency.

(b) For a child placed by voluntary agreement, the local social service agency shall file a dependency or neglect petition with the court and ask the court to establish the parents' responsibility to reimburse the agency.

(4) The local social service agency shall make the payments directly to foster parents and other providers of care.

l. Rates paid to foster homes.

(1) Rates paid for children in foster care shall be uniform regardless of funding source, and maintenance rates paid for children in foster care shall be established pursuant to 12 MCAR § 2.044. This requirement is waived when the local social service agency is being reimbursed pursuant to 12 MCAR § 2.030, Cost of Care for Mentally Retarded or Epileptic, or Emotionally Handicapped Children.

(2) When foster care is provided for a child through contract with another public or private agency, maintenance payments to the cooperating agency's foster care facilities shall be determined according to 12 MCAR § 2.044. If the local social service agency is contracting for administrative or social service costs, payments to the cooperating agency shall be an amount which is additional to the maintenance rates established in 12 MCAR § 2.044.

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m. Foster care benefits up to age 21.

(1) Within the six months prior to a child's 18th birthday, the local social service agency shall advise the child, the child's parents or legal guardian, and the foster parents of the availability of benefits up to age 21 of the foster care program.

(2) Upon the request of a person between the ages of 18 and 21 who is not under state guardianship as dependent/neglected and who had been receiving foster care benefits immediately prior to his or her 18th birthday and who is in foster care at the time of the request, or upon the request at any time between the ages of 18 and 21 of a person who had been under state guardianship as dependent/neglected, the local social service agency shall develop, in conjunction with the foster child and other appropriate parties, a specific plan related to that person's vocational, educational, social or maturational needs and shall assure that any maintenance or counseling benefits are tied to that plan.

D. Foster home recruitment and development.

1. The local social service agency shall attempt to recruit and license a sufficient number and variety of foster homes in order to be able to meet the particular needs of each child needing placement.

2. The local social service agency shall provide for the development of foster parents by:

a. provision of training on an ongoing basis;

b. provision of opportunities to attend educational workshops and conferences;

c. provision of opportunities for recognition.

3. The local social service agency shall involve the foster parents on an advisory basis in the development of policies and procedures pertaining to foster care.

4. Before recommendation for relicensure, the local social service agency shall evaluate with the foster parents factors in the home pertinent to continued utilization of the home as a foster care resource. These factors shall include the services provided by both the foster family and the agency and an evaluation of the year's placement experiences. A copy of the evaluation shall be given to the foster family.

5. The local social service agency shall assess the foster care applicant's or foster care provider's capacity for accepting children of another race, religion, color or national origin. If the family's reason for refusing to accept such children is based upon racism or bigotry, that is, negative attitudes toward people of a particular race, religion, color or national origin, the agency

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shall, in the case of a new applicant, refuse to recommend the home for licensure. If the agency ascertains the existence of racism or bigotry in a licensed foster family home, the agency shall, at time of relicensure, establish a plan for phasing the home out of the foster care program and no additional children shall be placed in the home.

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§ 2.205 Home delivered and congregate meals.

A. Introduction.

1. This rule governs the provision of home delivered and congregate meals by local social service agencies.

2. Definitions.

a. Home delivered or congregate meals: The preparation and delivery of one or more nutritionally adequate hot meals daily to the homes of persons who are physically unable to leave their own homes and unable themselves to prepare nourishing meals; or the making available of such meals at a center used for serving congregate meals.

b. Local social service agency: Local agency under the authority of the county welfare board and human service board which is responsible for social services.

B. Provision of service.

1. A local social service agency that elects to provide home delivered or congregate meals:

a. Shall assure that such meals are made available to persons in accordance with the local social service agency's annual service plan.

b. Shall purchase such meals only from providers licensed by the State Health Department or from nutrition programs developed under Title VII of the Older Americans Act of 1965, as amended and administered by the Governor's Citizens Council on Aging.

(Cite 1 S.R. 497)
Effective Date: October 17, 1976.

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§ 2.206 Homemaking services.

A. Introduction.

1. This rule governs the administration, purchase and provision of homemaking services.

2. Definitions.

a. Local service agency: Local agency under the authority of the county welfare board or human service board which is responsible for social services.

b. Homemaking service: The provision and/or teaching of child care, personal care and home management to individuals and families.

B. Standards of services.

1. Each local social service agency shall make homemaking services available to eligible families and adults, consistent with state and local social service plan requirements.

2. The local social service agency shall assure that each individual and family receiving homemaking services is served by a qualified homemaker.

a. The local social service agency shall assure that the recruitment, selection, and duties of homemakers are consistent with Merit System Standards.

b. The local social service agency shall provide for training for homemakers and staff responsible for homemaking services.

(1) Each homemaker shall have a minimum of 24 hours of training (initial and ongoing) the first year of the homemaker's employment, and 24 hours training annually thereafter.

(2) Such training shall include courses in homemaker skills, child and personal care, human growth and development, the aging process, nutrition and home management; and training in working with mentally retarded, mentally ill, chemically dependent, physically handicapped and family malfunction.

c. The assignment of homemakers shall be made on the basis of the particular abilities and skills of the homemaker.

3. A homemaker is to be utilized only as indicated by the service plan developed by the client, social worker and homemaker. The service plan shall be managed by the social worker.

4. The role of the homemaker shall be either that of a surrogate care-

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taker or that of a demonstrator or teacher working with individuals and families to help them achieve self-support, self-care, home-based care or remedy of neglect, abuse or exploitation of family members. The tasks shall include assisting with or giving child care, personal care, home management, food planning and preparation, laundering and general household duties.

5. The local agency shall develop guidelines for the use of the homemaking service to assure quality of practice. These guidelines shall include the following:

a. Client-social worker discussion of the case which suggests the need for a homemaker.

b. Client participation in the decision to use homemaking services.

C. Contracting for services.

1. Purchase homemaking services shall meet or surpass the same standards as the local service agency should it provide services directly.

2. The local social service agency shall assure that it purchases that part of the homemaking services that the vendor is qualified to provide.

3. When the local social service agency purchases homemaking services, it has the responsibility to develop the service plan, provide ongoing, counseling help to the client, supervise the homemaker's activities provided in the service plan and periodically assess progress and continued need for service, unless the contractor is a recognized social service agency capable of performing these functions.

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12 MCAR § 2.207 Protective services to children—adopted.

A. Introduction.

1. This rule governs the administration and provision of protective services to children through local social services agencies.

2. The purpose of a child protective service system is to carry out community responsibility for safeguarding the rights and welfare of children whose parents/caretakers are unable or unwilling to do so, or whose parents/caretakers activity violate their children's rights or jeopardize their welfare.

B. Definitions.

1. Local social service agency. Local agency under the authority of the county welfare or human services board or county board of commissioners which is responsible for social services.

2. State agency. Minnesota Department of Public Welfare.

C. Administration and organization of protective service program.

1. Local social service agency responsibility in the delivery of child protective services.

a. Any child in Minnesota who is in need of protection is to receive such service in the county in which the child lives or is found, irrespective of family income and legal or poor relief settlement of the child or family.

b. The local social service agency must accept all complaints alleging that a child has been physically or sexually abused or neglected. Neglect includes conditions or actions which threaten either the child's physical health or the child's mental health. Upon receiving such complaints, the local social service agency shall immediately notify the local police or sheriff's department.

(1) All reports shall be assessed at the time they are received to determine the agency's initial response.

(a) For complaints alleging that a child is abandoned, life threatened, or likely to experience physical injury due to abuse an immediate on site contact with the family and/or child is required.

(b) When a child is not in need of immediate care but is allegedly physically or sexually abused, the local social service agency shall contact the family within 24 hours.

(c) When child is not in need of immediate care but is allegedly neglected, the local social service agency shall contact the family within 72 hours.

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See new: ARO2535F.

(d) Reports for which no response is required include those which do not fall within the parameters of child maltreatment (although a referral to a more appropriate agency may be made); those which do not contain enough information to be investigated; or those which concern a complaint that has recently been investigated and determined to be unsubstantiated.

(2) Where contacts with the family are required the child protection worker shall assess the validity of the complaint.

(3) If upon the initial assessment there appears to be substance to the complaint, the child protection worker shall attempt to determine the following:

(a) the risk posed if the child or children involved remain in the home environment;

(b) the current physical and/or emotional condition of the child or children involved, as well as an assessment of prior injuries;

(c) the name, address, age, sex and relationship of the alleged perpetrators to the involved child/children;

(d) family composition, including the name, age, and sex of the child or children involved.

(4) If the child protection worker determines that neither neglect nor abuse are present but that the family may be experiencing problems, the worker may:

(a) offer the family such services as may be appropriate;

(b) inform the family of the agency's availability and willingness to work with the family upon request.

(5) If the child protection worker determines that the child is in need of immediate care due to circumstances or surroundings that jeopardize the child's physical or mental health or welfare, the parents must be given the opportunity to voluntarily place the child or seek an alternative that, in the worker's judgment, assures the safety of the child.

(6) If when given the opportunity, the parents are unwilling or unable to cooperate, the child protection worker shall petition the court for immediate custody of the child or seek the assistance of a peace officer in taking the child into custody.

c. Where the need for protective intervention has been established, the local social service agency shall, whenever possible, provide services that preserve the child within the family unit while at the same time assuring the child a safe environment. Such services may include, but are not limited to:

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(1) family counseling,

(2) homemaking services,

(3) referral to parent support organizations to courses in parenting or child care such as may be available in the community.

d. If services necessary to provide the child a safe environment are rejected, the child protection worker shall petition the court for authorization to intervene.

e. When the need for removal of a child from its home is considered necessary but not emergent, the local social service agency shall request permission of the juvenile court for sufficient time to place the child in an orderly fashion.

(1) When a child is under legal custody and has been removed from its home, the local social service agency shall obtain the consent of the child's parents for major decisions affecting the child. If the parents fail to consent, and the decision is essential to the child's health and safety, a court order may be obtained.

(2) The local social service agency shall obtain the written consent of the child's parents, and a court order, if a child under legal custody is to be placed in a facility outside the state. If the parents refuse or fail to give consent, a court order is sufficient.

(3) The local social service agency shall provide the court written reports and recommendations at such times as the court may direct or prior to the expiration of any order giving it responsibility for a child. Such reports shall contain information sufficient to support the recommendation and to enable the court to make a decision in the child's best interest.

f. Local social service agency responsibility in accepting reports of acts of prostitution or involvement in the production of obscene material or performances by persons under 18 years of age.

(1) Upon receiving a report of juvenile prostitution or juveniles involved in the production of obscene material or performances, the local social service agency shall:

(a) assess the victim's circumstances to determine the need for protective services;

(b) provide counseling and assistance to the victim in order to encourage and support her/him in discontinuing in prostitution; or involvement in the production of obscene acts or material;

(c) offer the victim and the victim's family such services as may be needed to:

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(i) protect the victim,

(ii) preserve or reestablish family relationships.

(d) If such services are rejected, inform the victim and family of the agency's responsibility and authority to seek juvenile court intervention.

(2) If immediate custody is necessary to protect the victim or to restrain the victim from engaging in prostitution, or involvement in the production of obscene acts or material, the protective service worker shall request a juvenile court order granting the agency temporary legal custody.

g. When child maltreatment is reported in a state supervised or licensed facility, including a foster home, the local social service agency shall:

(1) immediately contact the facility to determine the validity of the report;

(2) where such reports are valid, the local social service agency shall:

(a) assess present risk to the child and assure steps are taken to protect the child;

(b) as soon as possible, inform the child's parents or guardians of the incident;

(c) when an incident involves a child placed out of his/her home county, inform the agency responsible for the child's placement;

(d) make an oral report to the state agency within 24 hours. Such reports shall include:

(i) the identity of facility in which the incident occurred, the name, age and sex of the victim and the name and status of the alleged perpetrator if known;

(ii) the nature and extent of the child's injuries, measures taken to assure necessary treatment and protection, and the name of the protective services worker responsible for investigating the incident.

h. Every incident of suspected physical or sexual abuse or neglect reported to the local social service agency shall be reported to the state agency on forms provided by the state agency.

(1) Such reports shall be sent to the state agency within 20 days of receipt of the report.

(2) Reports to the state agency are for statistical information

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only. The identity of the victim, the victim's family and suspected perpetrator should not be included on the copy of the report sent to the state agency.

i. The local social service agency shall assess and classify and record all reports as either substantiated, unsubstantiated, or unable to substantiate within 90 days of receiving the initial report. At the conclusion of the assessment the subjects of the report shall be notified in writing of the agency's determination of the classification of the report. The subjects of the report shall also be informed of their right to review the report subject to applicable Minnesota law.

(1) Records relating to substantiated reports.

(a) Records relating to reports made pursuant to Minn. Stat. § 626.556 which are supported by evidence and information obtained during the assessment, and are determined by the agency to be substantiated, shall be destroyed seven years following the date of the final entry in the case record.

(b) The name of the individual submitting a report which is determined to be substantiated shall be disclosed only upon court order, or with the knowledge and consent of the person making the report.

(2) Records relating to unsubstantiated or false reports made pursuant to Minn. Stat. § 626.556 shall be destroyed immediately, upon determination that they are unsubstantiated and the name of the individual submitting the report shall be disclosed upon request of the subject of the report.

(3) Records relating to reports which upon initial assessment cannot be substantiated to the satisfaction of the local social service agency may be kept for one year. Since there is substance to the reports, and they are, therefore, not unsubstantiated, the name of the individual making the report shall not be disclosed unless the report is later found to be unsubstantiated, or one year passes, or with the knowledge and consent of the person making the report.

2. Administrative requirements.

a. The local social service agency must provide for the availability of protective services 24 hours per day, seven days a week, for response to emergencies.

b. Every local social service agency shall designate a member of staff to be responsible for the protective services program.

c. Each agency shall designate a licensed facility which can be available seven days a week for the emergency care of abused or neglected children.

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(1) The local social service agency must designate a staff member to be responsible for placements in such facility under such conditions as it deems necessary.

(2) Emergency placements shall not exceed 30 days.

d. Every local social service agency shall coordinate its child protection activities with other agencies involved with the child's family and may:

(1) participate as a member of a team utilizing a multidisciplinary approach;

(2) not assign its primary statutory responsibility to another agency.

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§ 2.208 Family planning services.

A. Introduction.

1. This rule governs the provision of family planning services by the local social service agency.

2. The purpose of family planning services is to arrange for and provide social, educational, and medical services (including sterilization) and supplies to enable individuals to determine family size or prevent unplanned pregnancies.

3. Local social service agency: Local agency under the authority of the county welfare or human services board which is responsible for social services.

B. Administrative conditions.

1. The local social service agency's family planning service shall include:

a. Counseling service to help clients decide whether they wish to use a family planning method.

b. Facilitative service, such as transportation and child care, to enable clients to avail themselves of family planning services.

c. Information about where medical contraceptive service can be obtained, and assistance in obtaining the service.

2. The local social service agency shall establish public information programs to inform the community and potential clients about the availability of family planning services from the agency.

C. Individuals to be served.

1. Family planning services shall be offered to all recipients of Aid to Families with Dependent Children (~~A~~FDC) and shall be provided to all such recipients who request it.

2. Individuals may not be denied family planning services on the basis of age or marital status.

3. Family planning shall be voluntary on the part of the client and may not be a prerequisite or impediment to eligibility for receipt of any other service or aid.

4. At the request of any individuals served by Minnesota state institutions, local social service agencies and mental health centers, information

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shall be provided relating to mandatory procedures governing consents for nontherapeutic sterilizations.

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insert new: ARO 2185T
12 MCAR S 2.209

12 MCAR S 2.209 Day care for children.

A. Introduction.

1. This rule governs the administration and provision of day care services by local social service agencies for children and their families.

2. The authority for this rule and for the administration of day care services for children is found in: Minnesota Statutes, sections 256.01, 256.011, 256E.02, 256E.05, and 15.0412, subdivision 3; Public Law, sections 93-647 and 94-401; and 45 Code of Federal Regulations, sections 228.13 and 228.42.

3. Definitions.

a. Child -- A person 14 years of age or younger.

b. Child development training -- Training by an accredited institution or courses approved by the local social service agency designed to maintain or improve the quality of care for children.

c. Certification -- The action taken by the state or county agency to indicate that a day care service provider meets federal day care requirements.

d. Certified day care provider -- A direct day care service provider who has received certification by the state or county agency.

e. Commissioner -- The commissioner of public welfare.

f. Day care resource -- Any person or entity providing direct or indirect day care services.

g. Day care service -- The less than 24-hour-a-day service which provides care for children as a substitute for or supplement to parental care for a planned period of time.

h. Direct day care service provider -- A person or entity who provides care for one or more children for pay in a home or center as a substitute for the parent(s) of the children.

i. Indirect day care service provider -- A person or entity which provides support services to direct day care service providers, including training, planning and coordination, toy lending libraries, health services which are intended to improve the quality of care for children.

j. In-home day care -- Day care services in the child's own home.

k. Lead agency -- An agency designated by the commissioner as having primary responsibility for the local

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child care advisory committee.

l. Local child care advisory committee (CCAC) -- A citizens' group approved by the commissioner to advise the local social service agency on day care services.

m. Local social service agency -- County board of commissioners or other agency designated by the county board as responsible for social services.

n. State agency -- Minnesota State Department of Public Welfare.

B. Resource development.

1. Planning and coordinating day care resources and development -- To insure a system of planning and coordinating among multidisciplined persons and entities that affect day care services, including both direct and indirect day care service providers, the social service agency or combination of agencies shall establish and/or maintain a local child care advisory committee (CCAC).

a. The child care advisory committee.

(1) The local CCAC shall serve no less than one county but may, by agreement of the county boards of commissioners or human services boards, encompass two or more contiguous counties.

(2) Composition of a CCAC: The membership of the CCAC shall be no fewer than seven persons and shall be representative of the racial minorities, ethnic groups, socioeconomic groups and geographical area served. The membership shall be volunteer but may be compensated for participation in functions of official business if the social service agency(s) should wish to implement such a plan. Reimbursement for expenses and compensation shall be determined by the agency(s). The membership shall include:

(a) One-third (1/3) parents who use day care services;

(b) Providers of direct day care services. The providers who are recruited and selected shall reflect the varying kinds of day care resources in the area. Wherever feasible, it shall include at least one person from each kind of direct day care service provider in the county or geographic area.

(c) Indirect service providers, including local social service agencies and/or boards, health services, early childhood educators, public schools and community groups.

(3) Responsibilities of a CCAC: The local CCAC shall cooperate with the social service agency to achieve the

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following:

(a) Coordination among day care resources, public and private service agencies and persons;

(b) Public information and parent education regarding the developmental needs of children;

(i) The CCACs shall develop a public education and information program to communicate to the community the need for day care resources and services as identified in a needs study or assessment.

(ii) The CCACs shall advise the local social service agency regarding tools and stratagems to communicate to parents needing day care services the importance of quality care and child development experiences during the child's early years.

(c) Identification of local day care needs;

(d) Community interest in the development of needed day care resources and services;

(e) Coordination and planning for training of day care providers and parents;

(f) Funding plans for the development of day care resources, implementation of a sliding fee for day care services and the use of Title XX funds for providing direct services to eligible children; and

(g) Other day care activities as the CCAC and/or lead agency deems necessary and appropriate.

(4) Organizational structure: Each CCAC shall have an organizational plan (bylaws and charter) to govern the activities of the committee and to perpetuate its membership through a democratic process. Where no organizational plan currently exists or has not been approved by the commissioner, the CCAC shall prepare one for its operational use. The organizational plan of each CCAC shall be submitted to the commissioner for approval within one year after the CCAC is formed and functioning or within one year after the promulgation of this rule, whichever is later.

b. The lead agency.

(1) Lead agency designation: The commissioner shall biennually designate a local social service agency or other community agency to serve as the lead agency for the local CCAC.

(a) Single county -- If the CCAC area encompasses only one county, the lead agency is the social service agency unless the commissioner designates an alternate;

(b) Multi-county -- If the CCAC area encompasses

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more than one county, the commissioner shall designate one county or community agency to serve as the lead agency for that geographic area. The following procedures shall be followed in the determination of a lead agency:

(i) The commissioner shall issue an announcement to all local social service agencies in that CCAC area of intent to designate a lead agency for the local CCAC and solicit their recommendation for this designation.

(ii) The commissioner shall direct that any recommendations from the local social service agencies be made within 45 days after the issuance of the announcement.

(iii) After the 45-day recommendation period, the commissioner shall designate a lead agency and notify all of the agencies and the CCAC chairperson of that decision within 30 days following the recommendation or the end of the 45 days recommending period.

(2) Lead agencies responsibilities.

(a) Coordinate and supervise CCAC functioning: The lead agency shall work with the CCAC as a representative of all local social service agencies in the geographic area served by the CCAC.

(i) Planning the CCAC's activities: On an annual basis, the lead agency shall plan with the local social service agencies in the CCAC area to establish priorities for determining the CCAC calendar of advisory activities.

(ii) Communicate to CCAC and local social service agencies: The lead agency shall communicate with the CCAC regarding the local social service agencies plans and decisions for delivering day care services each planning year. The lead agency shall communicate the CCAC recommendations to each local social service agency being served.

(iii) Coordination of resources for the CCAC: The lead agency shall serve as the recipient of financial and service resources from all social service agencies for distribution to the CCAC to maintain its functioning.

(iv) Monitoring of the CCAC: The lead agency shall annually, or at shorter intervals if needed, monitor the activities of the local CCAC according to criteria established in the CCAC's charter and bylaws.

(b) Development of the CCAC: To develop or redevelop a local CCAC the commissioner shall inform the lead agency or other designate of the need to facilitate the establishment or reestablishment of a new CCAC.

(i) Notification -- Within 30 days after notification by the commissioner, the lead agency or designated

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agency shall notify, by written announcement, all licensed child care providers and, by public notice, all other interested persons in the geographic area of its intent to develop or redevelop the local CCAC.

(ii) Within 60 days of the commissioner's request, the lead agency shall convene a public meeting of the child care community (providers, support services and parent recipients of day care services) and temporarily preside at such meeting until the persons present elect their own leadership and establish a working agenda.

(iii) When a new or reestablished CCAC has been organized, the county board(s) (or human service board(s) where such boards have responsibility for social services) within the geographic service area shall review and recommend to the commissioner approval or disapproval of the CCAC applicant within 60 days of the applicant's request for approval. Reasons for approval or disapproval shall be stated in writing to the applicant and the commissioner.

(iv) When the applicant CCAC has the approval (disapproval) of the county board(s) or human service board(s), it shall apply to the commissioner for recognition as the CCAC for the geographic service area.

(v) The commissioner shall recognize or withhold recognition of the applicant within 45 days of the receipt of the application. If recognition is withheld, the commissioner shall inform the applicant and lead agency of the deficiencies and identify conditions to be met.

(c) Provide resources: The lead agency shall provide resources (money and services), consultation, technical assistance and other needed support as mutually agreed upon by the functioning CCAC and the lead agency on behalf of all local social service agencies being served.

2. Development of day care resources. The local social service agency shall recruit day care resources to meet the community's day care needs.

a. There shall be diversity in kinds of day care resources developed.

(1) There shall be diversity in direct day care service providers.

(a) There shall be diversity in the type of direct day care service resource (in-home, family day care, group family day care, center); ages of children served (infants, toddlers, preschool, school-age); number of children to be served; and program that meets individual children's needs (e.g., enrichment, children with special needs).

(b) There shall be diversity in location of

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direct day care service provider resources including all major geographic areas where the service is needed so that the services are accessible to all parents and children who need it.

(c) There shall be diversity in programs to include day care provider resources that meet developmental, ethnic, cultural, and bilingual language needs.

(2) There shall be diversity in indirect day care resources to support and improve the quality of day care services.

(a) There shall be resources that directly support the day care service delivery such as: toy lending libraries; health and social services, program facilitators, substitute providers and periodic training programs.

(b) There shall be ongoing support service resources that provide professional expertise and training to all direct and indirect service providers.

b. Planning and coordination: Each social service agency shall provide or purchase planning and coordination services to ensure a system of information and referral of direct day care service providers to parents, as well as other community services; consultation and technical assistance to providers seeking funding from existing resources; coordination between direct day care service providers, day care resources and community and governmental agencies, needs assessments, and planning for training activities.

c. Funds for development: Potential day care providers shall be informed about funds available to them for meeting startup costs or licensure requirements.

C. Day care regulations -- The local social service agency shall provide the following services to individuals and groups that plan to be licensed and/or certified as day care providers.

1. Licensing.

a. Group day care centers:

(1) The local social service agency shall refer any inquiry on establishing a new group day care center to the Licensing Division of Public Welfare for licensure as defined in 12 MCAR S 2.003.

(2) The local social service agency shall refer all operating unlicensed day care centers to the Licensing Division of Public Welfare.

b. Family day care homes: The local social service agency shall inform all inquirers regarding family day care licensure of the standards as defined in 12 MCAR S 2.002 and provide the necessary consultation and inspections pursuant to

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the requirements in the licensure standards. If the applicant meets the family day care licensing requirements, the local social service agency shall recommend the home to the state agency for state licensure.

2. Certification. All day care providers that care for children whose day care services are paid with federal funds must be certified as meeting federal requirements for receipt of such funds.

a. Group day care centers: The licensing division of the state agency is responsible for certification of group day care centers.

b. Family day care homes:

(1) The local social service agency is responsible for certification of family day care homes and group family day care homes that meet federal requirements.

(2) Relative and one-family exemptions from licensing do not apply when federal funds are used.

(3) Unless the local social service agency has determined that the home or provider do not have the capability of providing a healthy and safe environment for the children in care, the following providers need not meet licensing and certification requirements to receive payment from federal funds:

(a) Providers who provide child care three hours or less in a 24-hour period.

(b) Providers who give less than 30 days of care in any 365-day period.

(4) The local social service agency shall provide information regarding certification to each family day care or group family day care provider and provide consultation and services to those who wish to be certified to care for children placed by the social service agency. If they meet the federal requirements, the agency shall certify them and shall recertify them annually. If at any time after certification, the local social service agency determines that a family day care provider does not meet the requirements for certification, the local social service agency shall revoke the certification.

(5) Records shall be maintained by the county agency on forms developed by the state agency as documented evidence that the home meets certification requirements.

c. In-home day care providers:

(1) The local social service agency is responsible for certification of in-home day care providers and shall certify those providers who meet the provider's standards set out below. If, at any time, after certification, the local

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social service agency determines that the provider does not meet these standards, the local social service agency shall revoke certification.

(2) Unless the local social service agency has determined that the provider does not have the capability of providing a healthy and safe environment for the children in care, the following providers need not meet the certification requirements to receive payment from federal funds:

(a) Providers who provde day care three hours or less in a 24-hour period.

(b) Providers who give less than 30 days of care in any 365-day period.

(3) The following standards are established by the state agency as meeting the federal requirements for in-home day care providers:

(a) Provider's standards.

(i) The provider shall be at least 18 years of age. A waiver of this standard may be granted by the local social service agency to a younger person (other than a child) who possesses sufficient maturity to assure compliance with standards of care required by this rule and who has an adult on call for emergency assistance. In any event, there shall be no more than two preschool children placed in the care of a person under 18 years at any one time.

(ii) The provider shall have experience and demonstrated competence in caring for children.

(iii) The provider shall supply evidence to the local agency that he/she has had a negative intradermal tuberculin test or chest X-ray within the past year. If the test is negative, he/she need not have one thereafter. If the test is positive, the provider must have a chest X-ray each year for five years.

(iv) The provider shall supply a statement from his/her physician dated within six months prior to the application, and annually thereafter, that the applicant has received a physical examination and is receiving all necessary continuing medical treatment to assure that he/she remains physically capable of caring for young children.

(v) The in-home provider shall not have any of the following conditions unless the agency staff believes that the condition will not adversely affect the care of children.

(aa) Has committed an act of child battering, child abuse or molesting as defined by the Child Abuse Reporting Law;

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(bb) Uses alcohol or drugs, such that its effects are evident during the hours the children are in care, or has an uncontrolled addiction to drugs or alcohol, either currently or within the past 12 months;

(cc) Has had own child(ren) in foster care within the previous 12 months, unless the primary reason for such placement was a physical illness of the parent, the mental retardation of the child or a temporary foster placement of an infant being relinquished for adoption;

(dd) Has demonstrated behavior patterns which include acts of violence to persons of any age or negligence toward the applicant's own children.

(vi) The in-home provider shall provide nutritionally sound meals that follow the family's feeding plan, observing hours and kinds of food as planned by parent(s). When parents do not provide foods in the four basic food groups, the provider has the responsibility of alerting the parents to the nutritional requirements of young children.

(vii) The in-home day care provider shall plan and establish a learning environment appropriate for the family and age level of the child. Materials, activities, and space shall be used to provide the child with opportunities to develop to his fullest potential physically, emotionally, socially, intellectually and psychologically.

(b) Service standards.

(i) In-home day care providers shall care for no more than the following number of children (including their own children) at any one time:

(aa) Five children if all are of preschool age (0 - 5 years).

(bb) Six children if one or more of the children are of school age (6 - 14 years)

(ii) The in-home provider shall provide care for no more than 14 hours per day. A waiver of this standard shall be granted by the local agency for a family emergency or other similar circumstances until the parent or agency has had the opportunity to plan more comprehensive care by a homemaker for the child(ren). The waiver shall not exceed a period of ten days for any one situation or circumstances.

(4) Each certified in-home day care provider shall be recertified annually.

(5) Records shall be maintained by the local social service agency on forms developed by the state agency as documented evidence that the in-home providers meet certification requirements.

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d. Training - Each certified family day care or in-home day care provider shall participate in a minimum of four (4) hours of child development training within the first three months of service and 16 hours of child development training annually thereafter or qualify as exempt from training for three years on the basis of qualifying for a credential on Minnesota's competency-based assessment program for family day care providers.

e. Appeal of certification denial, nonrenewal or revocation: The local social service agency shall promptly notify by certified mail or personal service any applicant or day care provider whose certification is proposed to be denied, revoked, or not renewed by the local social service agency. This notification shall state the grounds for such action and shall inform the applicant or provider of his/her right to appeal the action. Any applicant or provider whose certification is proposed to be denied, revoked or not renewed may appeal to the commissioner by mailing written notice of appeal to the commissioner within 20 days after receipt of the proposal for denial, revocation, or nonrenewal. Upon receiving a timely written notice of appeal, the commissioner shall give the applicant or provider reasonable notice and opportunity for a prompt hearing in accordance with Minnesota Statutes, sections 15.0418 to 15.0422. If the commissioner finds that the health, safety, or rights of children in day care are in imminent danger, he shall immediately suspend the provider's certification, subject to subsequent notice and hearing as provided in this paragraph.

D. Service delivery. The local social service agency must meet the following standards in providing services to all social service clients where day care is a needed service:

1. The local social service agency shall maintain a staff to fulfill the responsibilities described in this rule.

2. The local social service agency shall make available supportive services for children in direct day care resources to assure quality of care for children in the facility or home.

3. The local social service agency shall maintain an accurate resource file on all day care/child development services and resources in the geographic area to be served.

4. The local social service agency shall make available services to assist parents in planning for the day care placement of their children to assure services that meet the children's individual needs.

a. The local social service agency shall inform the parent(s) about the eligibility requirements for financial assistance with the payment of day care services as described in the agency's social service.

b. The local social service agency shall plan with the

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parent(s) to develop the child's service plan as a basis for selecting a certified day care center or provider that has a program and environment that meets the child's individual developmental needs.

c. The following procedures shall be used to select the day care providers for children needing day care services.

(1) The local social service agency shall recommend at least two certified resources or providers that meet the child's programmatic needs and the parents' transportation needs.

(2) The parent(s) shall be given the opportunity for a preplacement visit with each day care provider recommended by the agency.

(3) The parent(s) shall be given an opportunity to recommend to the local social service agency which day care he/she wishes to use for the care of the child or may recommend an alternative that meets certification standards and more nearly fits the family and child's needs.

(4) The local social service agency shall make available day care services in the day care resource (center, family day care home or in-home provider) selected and agreed upon by the agency, the parent(s) and provider, based on the assessed needs of the child as documented in the service plan for the child.

d. The local social service agency placement worker shall visit the child(ren) at least once annually to assure that the child is making progress toward the goals in his/her service plan.

e. The local social service agency shall assume responsibility for health and dental assessments for each child placed in day care as part of a casework plan, determine parental or agency responsibility for payment of the service, and assist parents of these children in making arrangements for treatment as recommended by the person(s) making the assessment(s).

E. Training.

1. Provider training.

a. The local social service agency shall assume responsibility for the maintenance and/or improvement of the quality of day care services provided by all family day care and in-home day care providers.

b. The local social service agency shall make available a minimum of 24 hours of child development training annually. The training provided shall include courses such as: family life, human growth and development, child rearing, child nutrition, first aid and child care program skills.

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c. When the local social service agency has been trained, they shall make available a competency-based assessment for each family day care provider who makes application for an assessment. The department shall furnish the necessary materials and training for agency staff to initiate the program.

2. Social service agency staff training. The local social service agency shall make available child development training for staff responsible for day care services.

a. All day care licensing staff shall complete six hours of child development training each year.

b. All new day care licensing staff shall complete six hours of training in the licensing process within six months of their employment on this assignment. This training shall be in addition to the child development training as identified in a. above.

c. Placement workers who work with families in planning day care services shall be given the opportunity to participate in the child development training.

d. Each day care licensor who wishes to improve his/her skills in assessing the competency of a family day care provider shall be given the opportunity to participate in a competency-based training program.

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§ 2.210 Counseling services for families and individuals.

A. Introduction.

1. This rule governs the provision of counseling services for families and individuals by local social service agencies.

2. Definitions:

a. Local social service agency: Local agency under the authority of the county welfare board or human service board which is responsible for social services.

b. Counseling services for families and individuals: The utilization of a professional helping relationship to enable individuals and families to deal with and to resolve whatever intra or interpersonal relationship problems or stress is encountered by them.

B. Standards of service.

1. The local social service agency electing to offer counseling services for individuals and families shall indicate in its annual social service plan the components of the service the agency intends to provide.

2. The local social service agency, in the delivery of this service, may offer any one or combination of the following components:

a. Assistance to an individual in resolving problems in relationship with others or with problems in individual adjustment.

b. Assistance to families in resolving marriage problems.

c. Assistance to families in resolving family problems.

d. Assistance to unmarried parents in resolving problems related to an unwanted pregnancy or in planning for the care of the child.

e. Family life educational programs.

3. The local social service agency may offer, upon approval of the Department of Public Welfare, such other components in the delivery of counseling services for families and individuals as are consistent with state and federal laws.

4. The local social service agency upon referral from a family or domestic relations court shall:

a. Provide premarriage counseling to individuals and prepare an evaluation for the court.

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§ 2.211 Educational assistance.

A. Introduction.

1. This rule governs the provision of educational assistance by local social service agencies.

2. Definitions:

a. Local social service agency: Local agency under the authority of the county welfare board or human service board which is responsible for social services.

b. Educational assistance: Educational assistance are those services which are designed to arrange and provide education and training, not directly related to employment, most appropriate to the individual's abilities–including special educational assistance to the blind, deaf and other disability groups and individuals with school adjustment problems.

B. Standards of service.

1. The local social service agency electing to offer educational assistance shall indicate in its annual social service plan the components of the service the agency intends to provide.

2. The local social service agency, in the delivery of this service, may offer any one or combination of the following components:

a. Social service in a school setting.

b. Counseling to parents and children to facilitate school adjustment.

c. Assisting mentally ill/behaviorly disabled persons to obtain educational training opportunities.

d. Assisting physically handicapped to obtain appropriate educational and training opportunities.

3. The local social service agency may offer, upon approval of the Department of Public Welfare, such other components in the delivery of educational assistance services as are consistent with state and federal laws.

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§ 2.212 Housing services.

A. Introduction.

1. This rule governs the provision of housing services by local social service agencies.

2. Definitions:

a. Local social service agency: Local agency under the authority of the county welfare board or human service board which is responsible for social services.

b. Housing service: Housing services are those services which are designed to help individuals obtain, maintain and improve housing and/or to modify existing housing.

B. Standards of service.

1. The local social service agency electing to offer housing services shall indicate in its annual social service plan the components of the service the agency intends to provide.

2. In the delivery of this service, the local social service agency may offer any one or combination of the following components:

a. Assisting individuals in finding rental or purchased housing.

b. Information on how to obtain technical assistance to make housing improvements.

c. Education concerning home purchase, rental, repairs, remodeling.

d. Assistance in resolving tenant-landlord conflict.

e. Assistance in maintaining or enforcing, or improving housing codes.

f. Finding emergency shelter in crisis situations.

3. The local social service agency may offer, upon approval of the Department of Public Welfare, such other components in the delivery of housing services as are consistent with state and federal laws.

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§ 2.213 Information and referral services.

A. Introduction.

1. This rule governs the provision of information and referral services by local social service agencies.

2. The purpose of this service is to provide accurate and up-to-date information about social and human services to individuals seeking such information, and to facilitate access to these services by individuals through a referral procedure.

3. Definitions:

a. Information and referral: The provision of information to individuals seeking knowledge of social and human services, and the assistance to individuals in making contact with a resource that can respond to their need or problem.

b. Local social service agency: Local agency under the authority of the county welfare board or human service board which is responsible for social services.

c. Resource file: Compilation of information that identifies the opportunities, resources and services in a community, a region, or a state and the agencies and organizations through which they are available to a total consumer population.

d. Information giving: Provision of information about services and programs that may include a brief assessment of the need or problem and some effort to obtain sufficient background material about the inquirer to determine his/her potential eligibility for a specific service or agency.

e. Referral: The identification for a client of an agency or organization able and willing to provide the service needed and aiding the person in making contact with that agency or organization through such procedures as a written summary of the problem or request, telephone or personal contact on behalf of the client.

f. Follow up: Process of making contact with either the inquirer or the agency to which (s)he was referred to determine what was the outcome of the referral.

g. Escort: Provision of a person to assist inquirer in gaining access to the service.

h. Outreach: Activity in which an active effort is made to reach out to individuals to help them make use of existing services and agencies.

i. Intake: Process providing help to clients in clarifying need, con-

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sidering alternative services appropriate to need, defining goals client desires to achieve, and arrive at an understanding in regard to utilization of services or assistance.

B. Local social service agency standards of service.

1. Information and referral may be provided as a separate and discrete service and/or as a function of the intake service of the agency.

2. The local social service agency planning to offer information and referral services shall indicate in its annual plan whether information and referral is provided as a separate and discrete service or as a function of the intake service of the agency.

3. When information and referral is offered as a separate and discrete service, in addition to the standards set forth in Sections B4 through B8 the agency shall:

a. Maintain a separate telephone listing for information and referral services.

b. Make efforts to publicize through media and other forms of public information such services as a separate agency function.

c. Have staff with identifiable tasks relating to information and referral.

4. Information and referral service shall include the maintenance of a comprehensive resource file. The resource file shall be updated and revised at least semi-annually.

5. Information and referral service shall include the offering of the following services:

a. Information giving.

b. Referral.

c. Follow-up on at least a sample of referrals.

6. Information and referral service may include provision of the following supplementary services:

a. Escort to referral agency.

b. Outreach services.

7. The information and referral service shall include the development and maintenance of a system for recording data that shall:

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a. Record the nature of calls received and of the agencies and organizations to which they are directed or referred.

b. Indicate what follow up activities were undertaken.

c. Maintain records of services which were needed but were not available.

8. The information and referral service shall include the maintenance of records and reports in such a manner that the identity of persons using the service are not revealed or accessible to anyone other than the staff members undertaking to assist them.

9. The agency may elect to offer data gathered in the delivery of information and referral services to appropriate community and state planning agencies.

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§ 2.214 Legal services.

A. Introduction.

1. This rule governs the provision of legal service by local social service agencies.

2. Definitions:

a. Local social service agency: Local agency under the authority of the county welfare board or human service board which is responsible for social services.

b. Legal services: Legal services are those services which are designed to arrange and provide for assistance in resolving civil legal matters and the protection of legal rights.

B. Standards of service.

1. The local social service agency electing to offer legal services shall indicate in its annual social service plan the components of the service the agency intends to offer.

2. The local social service agency, in the delivery of this service, may make available legal counsel for the following kinds of legal problems:

a. Divorce proceedings.

b. Custody hearings.

c. Tenant-landlord disputes.

d. Property purchase - sale.

e. Contract problems.

f. Appeals on behalf of clients challenging the actions or policies of federal, state or local public welfare agencies.

g. Consumer problems.

h. Actions on behalf of clients challenging the laws, rules, regulations or policies of federal, state or local public welfare agencies.

3. The local social service agency may offer, upon approval of the Department of Public Welfare, such other components in the delivery of legal services as are consistent with state and federal laws.

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insert new: ARO2485T 12MCAR § 2.215

§ 2.215 Money management services.

A. Introduction.

1. This rule governs the provision of money management services by local social service agencies.

2. The purpose of this service is to assist eligible individuals in the management of their income so that they are able to obtain a stable level of economic functioning within the limits of their present financial resources.

3. Definitions:

a. Local social service agency: Local agency under the authority of the county welfare board or human service board which is responsible for social services.

b. Money management services: Money management services are those services that arrange and provide assistance in developing effective personal budgets and managing indebtedness.

c. Consumer education: Consumer education is the offering of, on an individual or group basis, education in management of a household budget, food purchasing and preparation, credit buying and other consumer related concerns.

d. Financial counseling: Financial counseling is a process whereby the client is assisted in developing a workable budget and is helped to change poor money management habits.

e. Debt adjustment: Debt adjustment is a service whereby the agency, with permission of the client, receives a portion or entire amount of his/her income and pays creditors an agreed upon pro-rated amount each month from the income received.

f. Protective payment: Protective payment is a procedure whereby a money payment is not given directly to the client, but rather, to an individual designated by the agency to assume responsibility for the client's expenditures.

g. Vendor payment: Vendor payment is a procedure limited to public assistance recipients whereby a designated portion of the AFDC payment is made directly by the agency to a provider of goods or services.

B. Standards of service.

1. The local social service agency electing to offer money management services shall indicate in its annual social service plan the component of the service the agency intends to provide.

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2. In the delivery of this service, the local social service agency shall offer to potential clients any one or combination of the following components:

a. Consumer education.

b. Financial counseling.

c. Debt adjustment service.

3. The local social service agency may offer, upon approval of the Department of Public Welfare, such other components in the delivery of money management services as are consistent with state and federal laws.

C. Money management service in the use of protective and vendor payments.

1. Upon referral from the Income Maintenance Division of the local welfare agency, the local social service agency shall determine the need for a protective or vendor payment arrangement for public welfare clients.

2. The local social service agency shall:

a. Make an assessment of the problem;

b. Offer money management services to resolve the problem;

c. Determine if protective or vendor payments are needed.

3. Every effort shall be made to resolve money management problems through provision of services that leave the client with the greatest degree of control of his/her affairs consistent with the well-being of the individual and his family.

4. When it is established that money management services are not adequate to resolve the problem, the local social service agency shall recommend to the referring party the establishment of protective or vendor payments.

5. In making the recommendation the local social service agency shall:

a. Document that the client's present management of funds is threatening to his/her well-being or the well-being of his/her children.

b. Recommend the payment method (protective or vendor) most appropriate to the client's need.

c. Recommend the choice of a protective payee. The client is to be involved in the selection process.

(1) Excluded payees are county welfare directors, welfare board

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members, landlords, grocers, and vendors of goods and services who deal directly with clients.

(2) A local social service agency staff member may be the protective payee for clients if no other suitable payee can be found.

d. Define the respective responsibilities of the protective payee, agency and client in writing with copies given to payee, the client and the agency.

6. The local social service agency shall continue to offer money management services to assist the client to resume total responsibility for managing his/her grant.

7. The local social service agency shall review the need for protective/vendor payments quarterly and inform the referring party whether there is a need to continue protective or vendor payments.

8. Protective and vendor payments in AFDC cases shall not continue for more than two years, and are subject to a fair hearing appeal by the recipient.

9. In AFDC cases, the local social service agency shall recommend appointment of a guardian or other legal representative if money management problems are not resolved after two years of protective/vendor payments.

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§ 2.216 Residential treatment service.

A. Introduction.

1. This rule governs the provision of residential treatment service by local social service agencies to individuals placed in residential facilities.

2. Definitions.

a. Residential treatment service: The arrangement for and provision of a therapeutic or developmental experience within a controlled 24-hour-a-day residential facility.

b. Residential facility: Any facility, public or private, which provides 24-hour-a-day substitute care, food, lodging, training, education, supervision, habilitation, rehabilitation and treatment which cannot be furnished in a person's own home. Residential facilities include, but are not limited to, state institutions, residential treatment centers, residential training centers, maternity shelters, group homes, residential programs such as halfway houses and primary treatment centers, or schools for handicapped children. Residential facilities, for purposes of this rule, do not include foster family homes.

c. Local social service agency: Local agency under the authority of the county welfare board or human service board which is responsible for social services.

d. State agency: Minnesota Department of Public Welfare.

B. Standards of service.

1. The local social service agency shall utilize only those residential facilities which meet all licensing or certification standards established by the state. If out-of-state facilities are utilized, the facility shall meet standards comparable to those established by Minnesota state agencies.

2. The local social service agency shall base its selection of a residential facility on the facility's capacity to meet the client's individual needs. When there is more than one approved vendor who could meet the client's needs, the local agency shall help the client to participate in the selection of the most appropriate facility.

3. The local social service agency shall give the residential facility that information which the facility determines that it needs to provide appropriate care and treatment, provided that the information is accompanied by a signed release-of-information form from the client.

4. The local social service agency shall collaborate with the facility in the development, ongoing evaluation and implementation of the client social service plan and, to the extent possible, shall utilize the assistance of the fa-

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cility in developing post-discharge plans for the local agency's continuing services to the total family.

5. The local social service agency shall establish a written agreement with the residential facility which shall include, but not be limited to, the following:

a. Goals of the placement.

b. Specific responsibilities of the placing agency and the facility in the delivery of services to the client and/or the client's family.

c. Requirements for progress reports.

d. Expectations of what services will be delivered, and by whom, when the client is discharged.

6. The local social service agency shall help the client:

a. Determine if he needs a residential facility.

b. Participate in the selection of a suitable residential facility.

c. Determine what assistance he may want from the agency.

d. With his adjustment to the facility and to bring any concerns about conditions in the facility to the attention of the operator.

e. Plan for disposition of belongings, if appropriate, or plan for the retention of his room, apartment, or house for that period of time that he receives services in a residential facility.

7. The local social service agency shall assure that provision is made to help the client, to the extent possible, to:

a. Maintain family and community ties.

b. Make use of community resources, if appropriate, including social, health, and recreational opportunities.

c. Obtain regular health and dental evaluation, if needed, carry out any prescribed program of health care, and arrange for needed funding for such care.

d. Secure and utilize supportive services, such as transportation.

e. Move to an independent living arrangement or another facility, when such a move is to occur.

f. Achieve the objectives of the post-discharge plan.

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§ 2.217 Social and recreational services.

A. Introduction.

1. This rule governs the provision of social and recreational services by local social service agencies.

2. Definitions:

a. Local social service agency: Local agency under the authority of the county welfare board or human service board which is responsible for social services.

b. Social and recreational services: Social and recreational services are those services which are designed to arrange and provide opportunities for personal growth and development and which enable individuals to participate in activities that maintain physical and mental vitality.

B. Standards of service.

1. The local social service agency electing to offer social and recreational services shall indicate in its annual social service plan the components of the service the agency intends to provide.

2. The local social service agency, in the delivery of this service, may offer any one or combination of the following components:

a. Activities that individuals participate in growth experiences such as camping, hobbies, recreational social programs in the community.

b. Programs that provide youth an opportunity for relationships with an adult.

c. Activities that involve senior citizens in special social recreational programs for the aged.

3. The local social service agency may offer, upon approval of the Department of Public Welfare, such other components in the delivery of social and recreational services as are consistent with state and federal laws.

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§ 2.218 Transportation services.

A. Introduction.

1. This rule governs the provision of transportation services by local social service agencies.

2. Definitions:

a. Local social service agency: Local agency under the authority of the county welfare board or human service board which is responsible for social services.

b. Transportation services: Transportation services are those services which are designed to arrange and provide travel and escort to and from community resources and facilities.

B. Standards of service.

1. The local social service agency electing to offer transportation services shall indicate in its annual social service plan the components of the service the agency intends to provide.

2. The local social service agency, in the delivery of this service, may offer any one or combination of the following components:

a. Arranging for volunteer drivers to transport individuals to and from community resources and facilities.

b. Reimbursement for transportation cost incurred in going to and from community resources and facilities.

c. Escorting individuals to and from community resources and facilities in agency owned or leased vehicle.

3. The local social service agency may offer, upon approval of the Department of Public Welfare, such other components in the delivery of transportation services as are consistent with state and federal laws.

4. The local social service agency shall use for transportation services only drivers or carriers that have a valid drivers license and adequate insurance coverage including auto insurance required by the state.

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12 MCAR S 2.221 Protective services by local social services agencies to vulnerable adults.

A. Applicability. 12 MCAR S 2.221 governs the investigation and reporting of maltreatment of vulnerable adults and some aspects of the emergency and continuing protective social services required to be furnished by local social services agencies under Minnesota Statutes, section 626.557.

B. Definitions. As used in 12 MCAR S 2.221, the following terms have the meanings given them.

1. Abuse. "Abuse" means:

a. Any act which constitutes a violation of Minnesota Statutes, section 609.322 related to prostitution;

b. Any act which constitutes a violation of Minnesota Statutes, sections 609.342 to 609.345 related to criminal sexual conduct; or

c. The intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress.

2. Caretaker. "Caretaker" means an individual or facility which has responsibility for the care of a vulnerable adult as a result of family relationship, or which has assumed responsibility for all or a portion of the care of the vulnerable adult voluntarily, by contract, or by agreement. A person who has assumed only financial responsibility for an adult is not a caretaker.

3. County of financial responsibility. "County of financial responsibility" means the county designated as the county of financial responsibility pursuant to Minnesota Statutes, section 256E.08, subdivision 7.

4. Facility. "Facility" means a hospital or other entity required to be licensed pursuant to Minnesota Statutes, sections 144.50 to 144.58; a nursing home required to be licensed pursuant to Minnesota Statutes, section 144A.02; an agency, day care facility, or residential facility required to be licensed pursuant to Minnesota Statutes, sections 245.781 to 245.812; a mental health program receiving funds pursuant to Minnesota Statutes, section 245.61; and any entity required to be certified for participation in Titles XVIII or XIX of the Social Security Act, 42 United States Code, section 1395 et seq.

5. False. "False" means disproved to the satisfaction of the investigating agency.

6. Host county. "Host county" means the county in which a facility is located.

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7. Impairment of mental or physical function or emotional status. "Impairment of mental or physical function or emotional status" means a condition which includes being substantially unable to carry out one or more of the essential major activities of daily living, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning or working; being unable to protect oneself from hazardous or abusive situations without assistance; a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality or ability to cope with the ordinary demands of life; substantial difficulty in engaging in the rational decision-making process and inability to weigh the possible benefits and risks of seeking assistance; a condition in which an individual is so fearful, so ashamed, so confused, or so anxious about the consequences of reporting that that individual would be unable or unlikely to make a responsible decision regarding whether or not to report abuse or neglect.

8. Licensing agency. "Licensing agency" means:

a. The commissioner of health, for a facility which is required to be licensed or certified by the Department of Health;

b. The Commissioner of Public Welfare for facilities required by Minnesota Statutes, sections 245.781 to 245.812 to be licensed;

c. Any licensing board which regulates persons pursuant to Minnesota Statutes, section 214.01; and

d. The Minnesota Department of Health if the human services occupation of the alleged perpetrator is credentialed pursuant to Minnesota Statutes, section 214.13 or 149.02.

9. Local social services agency. "Local social services agency" means the local agency under the authority of the human services board or board of county commissioners which is responsible for social services.

10. Neglect. "Neglect" means failure by a caretaker to supply or to ensure the supply of necessary food, clothing, shelter, health care, or supervision for a vulnerable adult.

11. Report. "Report" means any verbal or written report of abuse or neglect of a vulnerable adult received by the local social services agency, police department, county sheriff, or licensing agency.

12. State agency. "State agency" means the Minnesota Department of Public Welfare.

13. Substantiated. "Substantiated" means proved to the satisfaction of the investigating agency.

14. Vulnerable adult. "Vulnerable adult" means any

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person 18 years of age or older:

a. Who is a resident or patient of a facility;

b. Who receives services at or from a facility required to be licensed pursuant to Minnesota Statutes, sections 245.781 to 245.812; or

c. Who, regardless of residence, is unable or unlikely to report abuse or neglect without assistance because of impairment of mental or physical function or emotional status.

15. Inconclusive. "Inconclusive" means a report which cannot be substantiated or disproved to the satisfaction of the investigating agency.

C. Complaint investigation by local social services agencies.

1. Duty to accept and investigate complaints. The local social services agency shall accept and investigate all complaints alleging that a vulnerable adult has been abused or neglected in that agency's county. The local social services agency shall notify each relevant licensing agency and the local police departments or county sheriffs and shall cooperate in coordinating its investigation with the investigations of the licensing agencies, police departments, and sheriffs. The local social services agency shall immediately send a report of its findings to all other agencies notified concerning the complaint in question.

2. Time limits to initiate investigations. The local social services agency shall begin to investigate all complaints within the following time limits.

a. The local social services agency shall conduct an immediate on-site investigation for complaints alleging or from which it can be inferred that a vulnerable adult is in need of immediate care or protection because the adult is life threatened or likely to experience physical injury due to abuse or abandonment.

b. The local social services agency shall begin its investigation within 24 hours for complaints alleging, or when there is substantial evidence, that a vulnerable adult is not in need of immediate care or protection but is allegedly abused.

c. The local social services agency shall begin its investigation within 72 hours for complaints alleging, or when there is substantial evidence, that a vulnerable adult is not in need of immediate care or protection but is allegedly neglected.

3. Investigations related to a facility. When an investigation involves an alleged incident or situation related to a facility, the local social services agency shall make an on-site visit to the facility to assess the validity of the complaint. This investigation shall include the following

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activities when necessary to make an accurate assessment, but activities specified in a., c., and e. need not occur on the site of the facility:

a. Discussion with the reporter;

b. Discussion with the facility administrator or responsible designee;

c. Discussion with the physician or other professionals, or any corroborating contacts as necessary;

d. Contact with the alleged victim;

e. Discussion with the alleged perpetrator;

f. Examination of the physical conditions or the psychological climate of the facility; and

g. Inspection of the alleged victim's record.

The local social services agency shall also determine whether the reported abuse or neglect places other vulnerable adults in jeopardy of being abused or neglected.

The local social services agency shall immediately send a report of its findings to all other agencies notified concerning the complaint in question.

4. Investigations not related to a facility. When an investigation involves an alleged incident or situation which is not related to a facility, the local social services agency shall assess the validity of the complaint. This investigation shall include the following activities where necessary to make an accurate assessment:

a. Discussion with the alleged victim;

b. Discussion with the reporter or any corroborating contacts, as necessary;

c. Discussion with the alleged perpetrator;

d. Discussion with the physician or other professionals; and

e. Examination of the physical conditions or the psychological climate of the residence.

The local social services agency shall also determine whether the reported abuse or neglect places other vulnerable adults in jeopardy of being abused or neglected.

5. Investigations by agencies which are not in the county of financial responsibility. When a complaint involves a vulnerable adult who is receiving services from a facility

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located in a county other than the adult's county of financial responsibility, the local social services agency of the host county shall:

a. Investigate the complaint in accordance with C.3. and determine whether the complaint is substantiated, inconclusive or false;

b. Notify each relevant licensing agency, the police or sheriff, and the county of financial responsibility;

c. Consult with the county of financial responsibility, unless the host county must take immediate emergency measures and representatives of the county of financial responsibility are not available;

d. Take whatever measures are necessary to correct the situation or to remove the adult from the facility and notify the county of financial responsibility of the actions taken to correct the situation or of the removal of the adult from the facility; and

e. Complete and transmit all required written forms and findings to appropriate agencies.

The local social services agency of the county of financial responsibility shall then resume responsibility for ensuring ongoing planning and services for the vulnerable adult.

6. Use of outside experts. When it is investigating alleged abuse or neglect of a vulnerable adult, the local social services agency shall consult persons with appropriate expertise if the local agency believes that it lacks the expertise necessary for making judgments pertaining to the allegations. This consultation may include matters of physical health, mental health, specialized treatment such as behavior modification, geriatrics, or other matters.

7. Investigations after initial complaint assessment. If upon the initial assessment required by 1.-6. there appears to be substance to a complaint, the local social services agency shall attempt to determine the following:

a. The risk posed if the vulnerable adult remains in the present circumstances;

b. The current physical and emotional condition of the vulnerable adult, including the history or pattern of abuse or neglect or related prior injuries;

c. The name, address, age, sex, and relationship of the alleged perpetrator to the vulnerable adult; and

d. In a complaint of neglect, the relationship of the caretaker to the vulnerable adult, including the agreed-upon roles and responsibilities of the caretaker and the vulnerable

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adult.

8. Protective services. The local social services agency shall offer emergency and continuing protective social services for purposes of preventing further abuse or neglect and for safeguarding and enhancing the welfare of the abused or neglected vulnerable adult.

D. Classification of complaints. Within 90 days of receiving the initial complaint, the local social services agency shall assess, make a finding, and classify all complaints as either substantiated, false, or inconclusive. At the conclusion of the assessment, the alleged victim of maltreatment and the alleged perpetrator shall be notified in writing as to whether the complaint was substantiated, false, or inconclusive.

E. Actions on behalf of a vulnerable adult who refuses services. If a vulnerable adult who is the victim of abuse or neglect by a caretaker refuses an offer of services from a local social services agency and in the judgment of that agency the vulnerable adult's safety or welfare is in jeopardy, the agency shall seek the authority to intervene on behalf of that adult. If the agency believes it to be in the adult's best interest, it shall seek or help the family or victim seek any of the following:

1. A restraining order or a court order for removal of the perpetrator from the residence of the vulnerable adult pursuant to Minnesota Statutes, section 518B.01.

2. Guardianship or conservatorship pursuant to Minnesota Statutes, sections 525.539 to 525.6198, or guardianship or conservatorship pursuant to Minnesota Statutes, chapter 252A.

3. A hold order or commitment pursuant to the Minnesota Hospitalization and Commitment Act, Minnesota Statutes, chapter 253A.

4. A referral to the prosecuting attorney for possible criminal prosecution of the perpetrator under Minnesota Statutes, chapter 609.

F. Reports to the state agency.

1. Initial report. Every incident of abuse or neglect reported to the local social services agency shall be reported to the social services division of the state agency on forms provided by the state agency. The local agency shall send the completed report form to the state agency within 20 days of receiving the complaint, whether or not the classification of the report has been determined according to D.

2. Subsequent report. When the classification of the report has been determined or if the classification has changed subsequent to the time of the initial report to the state agency, the local agency shall advise the state agency in

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writing of the correct information. The local agency shall do this within 90 days of when the local agency received the complaint.

3. Data privacy. Reports to the social services division of the state agency are for statistical purposes only. The identity of the vulnerable adult and of the perpetrator shall not be included on the copy of the report sent to the state agency.

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2.490

12 MCAR S 2.490 Definitions.

A. The following definitions apply to 12 MCAR SS 2.490-2.841 unless the context clearly requires another meaning.

1. Allocation. "Allocation" means the assignment of a position to an appropriate class on the basis of the kind, difficulty, and responsibility of the work performed in the position.

2. Appointing authority. "Appointing authority" means the county board, county welfare board, human service board or officer authorized by statute or lawfully delegated authority to make appointments to positions under the Merit System.

3. Board. "Board" means the county board, county welfare board, or human service board.

4. Change in allocation. "Change in allocation" means the reclassification of a position resulting from significant sudden changes imposed by the appointing authority affecting the duties and responsibilities of a position.

5. Class. "Class" means one or more positions sufficiently similar in the duties performed; degree of supervision exercised or required minimum requirements of training, experience, or skill; and such other characteristics that the same title, the same tests of fitness, and the same schedule of compensation may be applied with equity to all of the positions.

6. Commissioner. "Commissioner" or "Commissioner of Public Welfare" means the administrative head of the Department of Public Welfare.

7. Council. "Council" means the merit system council.

8. County agency. "County agency" means the organization created by the county board, county welfare board or the human service board to carry out the functions and policies of the board with regard to community social service or income maintenance programs funded in whole or in part by federal grants-in-aid requiring a merit system of personnel administration.

9. County register. "County register" means the sub-register established for a county from a statewide competitive or promotional register containing the names of persons who have legal residence in the county or, in the event of a promotional examination, who are employed by the county agency.

10. County welfare board. "County welfare board" means the county welfare board, county board or human service board.

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11. Day. "Day" means a calendar day except when otherwise specified in the specific rule.

12. Demotion. "Demotion" means a change by an employee from a position in one class to a position in another class with less responsible duties and a lower salary range.

13. Disabled veteran. "Disabled veteran" means a veteran who is rated or certified as disabled, in accordance with the provisions of Minnesota Statutes, section 43A.11.

14. Dismissal. "Dismissal" means the termination of employment for cause.

15. Eligible. "Eligible" means any person whose name is on a register.

16. Emergency employee. "Emergency employee" means an employee who was appointed to perform certain duties when an emergency situation exists.

17. Employee. "Employee" means any person in the employ of a county board, county welfare board, or human services board, exclusive of its members, who occupies a position covered by 12 MCAR SS 2.490-2.841 and who is paid a salary or wage.

18. Exclusive representative. "Exclusive representative" has the meaning given in Minnesota Statutes, section 179.63, subdivision 6.

19. Facsimile. "Facsimile" means a replica. A facsimile of 12 MCAR S 2.841 is a chart showing each of the salary rates adopted by an agency divided into monthly and hourly rates and either daily rates and bi-weekly rates or four-week rates if paid on this basis or the daily rate based on the number of working days in the month--20, 21, 22, or 23 days if paid on a monthly basis.

20. General adjustment. "General adjustment" means the merit system recommended salary adjustment based on a salary survey or a review of consumer price index changes.

21. Intermittent employee. "Intermittent employee" means an employee who works whenever needed or on a schedule that cannot be predicted in advance.

22. Layoff. "Layoff" means the termination of employment because of abolishment of a position, lack of funds, shortage of work, or other reason beyond the control of the employee.

23. Layoff list. "Layoff list" means a list of permanent or probationary employees who have been laid off by reason of abolishment of their positions, lack of funds, shortage of work, or other reason beyond the control of the employee.

24. Merit increase. "Merit increase" means an increase

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given to an employee based on meritorious job performance.

25. Military leave. "Military leave" means a leave of absence granted by state law to employees entering active duty in the armed forces of the State of Minnesota or of the United States of America.

26. Minimum qualifications. "Minimum qualifications" means the requirements of training and experience necessary to qualify for a given class.

27. Original appointment. "Original appointment" means the date of initial entry to probationary status normally through appointment from an open-competitive list.

28. Overtime. "Overtime" means hours worked in excess of a normal work shift or beyond a normal work week.

29. Permanent employee. "Permanent employee" means an employee who has successfully completed a probationary period or who has attained permanent status upon the installation of the Merit System.

30. Position. "Position" means a group of current duties and responsibilities assigned or delegated by competent authority requiring the full-time or part-time employment of one person.

31. Probationary employee. "Probationary employee" means an employee who is serving a probationary period in a class to which the employee has been appointed from an eligible list.

32. Probationary period. "Probationary period" means the six-month working trial period during which a new employee is required to demonstrate fitness for the position to which the employee is appointed by actual performance of the duties of the position.

33. Promotion. "Promotion" means a change of an employee from a position in one class to a position in another class with more responsible duties and a higher salary range.

34. Provisional employee. "Provisional employee" means an employee who meets the minimum qualifications for the position but who has been appointed to a position without having been appointed from an eligible register.

35. Reallocation. "Reallocation" means the reclassification of a position resulting from significant changes in the duties and responsibilities of the position that occur gradually over a period of time.

36. Reclassification. "Reclassification" means a reallocation or change in allocation of a position to a higher, lower, or equivalent class.

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37. Reemployment list. "Reemployment list" means a list of former permanent or probationary employees who have been laid off and the names of former permanent or probationary employees who have voluntarily separated from Merit System employment in good standing and whose applications for reemployment in the Merit System are submitted within one year of separation.

38. Register. "Register" means an officially established list of eligibles for a particular class.

39. Resignation. "Resignation" means the termination of employment made at the request of the employee.

40. Salary adjustment. "Salary adjustment" means an increase given to employees due to cost-of-living factors, going rates for similar jobs, or labor market conditions.

41. Salary increase. "Salary increase" means an increase granted to an employee on the basis of working out of class or due to unusual employment conditions and not based on job performance, cost-of-living factors, going rates for similar jobs or labor market conditions.

42. State agency. "State agency" means the State Department of Public Welfare.

43. Supervisor. "Supervisor" means the merit system supervisor.

44. Suspension. "Suspension" means an enforced leave of absence with or without pay, for disciplinary purposes or pending investigation of charges made against an employee.

45. Temporary employee. "Temporary employee" means an employee who has been appointed to a position from an eligible register but the appointment has a definite ending date.

46. Transfer. "Transfer" means the movement of an employee from one position to another in the same class or in another class having the same salary range and usually involving the performance of similar duties and requiring essentially the same qualifications of training and experience.

47. Veteran. "Veteran" means every person defined as a veteran by Minnesota Statutes, section 197.447.

48. Veterans preference. "Veterans preference" means preference granted to veterans by Minnesota Statutes, section 43A.11.

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006377

12 MCAR S 2.491 Statement of policy and means of effecting policy.

A. Objectives. It is the aim of the Department of Public Welfare of the state of Minnesota, through the establishment of the county welfare merit system, to provide appointing authorities with an effective system of personnel administration based on merit principles. Specific objectives are:

1. Economy and effective service in the Minnesota welfare and human services program;

2. The proper classification of positions so that positions essentially alike in duties and responsibilities are treated alike and positions not so alike are treated with due consideration to the nature and extent of the differences between them;

3. Fair and equal opportunity for all qualified persons to compete for positions and promotions under the jurisdiction of the merit system solely on the basis of merit and fitness as ascertained through practical examinations;

4. Equitable pay scales for the various classes established on the basis of equal pay for equal work; and

5. An attractive career service in public welfare and human services employment within the state of Minnesota.

B. Adoption and amendment of the rules.

1. Statutory authority. In order to accomplish the objectives stated in A., 12 MCAR SS 2.490-2.841 have been promulgated by the commissioner of public welfare in accordance with Minnesota Statutes, sections 256.01, subdivision 4, 256.012, and 393.07, subdivision 5, and in compliance with Minnesota Statutes, chapter 15.

2. Procedures. The commissioner of public welfare, with the advice and recommendations of the council, may amend 12 MCAR SS 2.490-2.841 after compliance with the provisions of Minnesota Statutes, chapter 15.

C. Editing the rules.

1. Prior to issuing or reissuing sections of the merit system rules, the supervisor shall edit the rules and make the following, and only the following, changes:

a. To correct spelling or typographical errors.

b. To correct grammatical construction, but such changes shall not alter the interpretation, intent, or purpose of the rule.

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c. To correct exact quotations of statutes that are clearly identified by enclosure in quotation marks and by citation of statutory reference, when enactment of statutory amendments makes such action necessary to make the quotations true and accurate.

d. To renumber rules or rule references as necessary because of adoption of new rules or abolition of existing rules by the commissioner after proper notice and hearing.

2. Such changes shall not be deemed to be amendments to the rules, and each shall be reported to the commissioner before release of the material. Any changes not approved by the commissioner shall be excluded from the material to be released.

D. Positions covered by these rules.

1. These rules shall apply to all positions and employees in these positions engaged in the administration of community social service or income maintenance programs funded in whole or in part by federal grants-in-aid requiring a merit system of personnel management under the jurisdiction of appointing authorities except duly appointed or elected members of these boards, all employees of institutions, sanatoria and hospitals under the jurisdiction of such boards, and the director of community social services. These rules shall be applicable to such positions until such time as the counties adopt and maintain rules and regulations affecting classification and compensation, examination, and certification of eligibles and other personnel standards acceptable to the commissioner.

E. Violations.

1. By employees. Violations of any of the provisions of 12 MCAR SS 2.490-2.841 by an employee in the service shall be considered sufficient cause for the dismissal of that employee.

2. By an appointing authority. Violations of 12 MCAR SS 2.490-2.841 by an appointing authority shall be brought to the attention of the appointing authority by the supervisor. The notice shall include remedial measures necessary to correct past violations and to ensure future compliance. If the appointing authority refuses to take corrective action, the supervisor shall inform the commissioner who shall deny or suspend payment of all or part of state and federal administrative reimbursement funds, suspend services from the merit system, or require that other corrective action be taken.

3. Appeals. An appointing authority may appeal any denial or suspension of administrative reimbursement to the merit system council which shall, after a review of the record available to the commissioner, make its recommendation to the commissioner. The commissioner's decision shall be final.

F. Political activity.

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1. No employee shall use his or her official authority or influence for the purpose of interfering with or affecting the result of an election or nomination for office.

2. No employee shall directly coerce, attempt to coerce, command, or advise a merit system employee to pay, lend, or contribute anything of value to a party, committee, organization, agency, or person for political purposes.

3. No employee shall be a candidate in a partisan election for any public office or for any political party office which is obtained through a partisan election.

4. An employee continues to be covered by the Federal Hatch Act restrictions including all restrictions listed in 1.-5. while on annual leave, sick leave, leave without pay or administrative leave. Any employee shall resign from the service upon filing as a candidate for public office, except as provided in 5.

5. Any employee may be a candidate in nonpartisan elections. These are elections in which none of the candidates is to be nominated or elected as representing a political party whose candidates for presidential election received votes in the last presidential election.

6. All prohibitions of political activity provided in the Federal Hatch Act apply to employees under the merit system.

G. Prohibition against discrimination.

1. In general. No person shall be discriminated for or against in recruitment, examination, appointment, tenure, compensation, classification, or promotion or in conditions, facilities, or privileges of employment because of race, color, creed, religion, national origin, physical disability when such disability does not interfere with the completion of assigned duties, age, marital status, status with regard to public assistance, or sex. Any person aggrieved by a violation of these prohibitions may file a complaint under the provisions of Minnesota Statutes, chapter 363.

2. Political opinions. No person shall be discriminated for or against as provided in 1. because of his political opinions or affiliations within the limitations imposed by F. nor shall discrimination occur because of any other non-merit factor. Any person aggrieved by a violation of a prohibited discrimination that does not come within the jurisdiction of Minnesota Statutes, chapter 363 may file a complaint with the merit system supervisor, setting forth the basis for his belief that an act or threat or promise of an act of discrimination occurred and identifying by name and position the person alleged to have committed the act or threat or promise of an act of discrimination.

3. Investigations. The supervisor or a designated

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representative shall conduct an investigation of the alleged discrimination and shall report the complaint and the findings of the investigation to the merit system council at its next meeting. The complainant shall have the right to present the complaint personally to the council. The council shall order any further investigation or hearing as may be warranted prior to making its decision. If the council finds that discrimination has occurred, it shall take whatever action it deems warranted and within its authority to remedy the effect of any act or threat or promise of an act of discrimination and to prevent discrimination.

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12 MCAR S 2.492 Organization.

A. Duties and powers of the commissioner. The Commissioner of Public Welfare shall have authority to require methods of administration which are necessary for compliance with requirements of the Federal Social Security Act, as amended, and for the proper and efficient operation of all welfare programs. The adoption of methods relating to the establishment and maintenance of personnel standards on a merit basis for all employees in positions covered by 12 MCAR SS 2.490-2.841 and the examination thereof, and the administration thereof, shall be directed and controlled exclusively by the Commissioner of Public Welfare pursuant to Minnesota Statutes, sections 256.012 and 393.07. Nevertheless, the Commissioner of Public Welfare shall exercise no authority in the selection, tenure of office, and compensation of a specific individual employed in accordance with these methods.

B. Organization of the merit system council.

1. The merit system council members shall be appointed by the governor from a panel of names submitted by the Commissioner of Public Welfare. The council shall be composed of three members who shall be public-spirited persons of recognized standing and of known interest in the improvement of public administration and in the impartial selection of efficient government personnel. No member shall have held political office or have been an officer in a political organization during the year preceding appointment, or during the term of the appointment. No member of the council shall have been an employee of the state agency or an employee or member of an appointing authority within one year prior to appointment.

2. Members of the council shall serve for a term of three years or until successors have been appointed. A member appointed to fill a vacancy occurring prior to the expiration of a term shall be appointed for the remainder of such term.

3. The council shall elect a chairman from its membership. Such term shall be for a two-year period. The election of a chairman shall be considered every other year at the first meeting of the new year.

4. The supervisor shall serve as secretary of the council. The supervisor shall keep a calendar of all business to be transacted at each meeting, issue notices of regular and special meetings, present to the council all matters that require consideration by the council, keep records and files of the council and minutes, and handle other matters as the council may direct or circumstances indicate as necessary and proper in order to facilitate and give effect to the actions of the council within the scope of its powers and duties.

C. Meetings of the council.

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1. Meetings of the council shall be held as often as necessary and practicable, upon the call of the chairman, or of the commissioner. The commissioner shall have the right to be represented at all meetings of the council, but such representation shall be without voting power. The council shall adopt procedures for the conduct of its activities.

2. Two members shall constitute a quorum for the transaction of business at any meeting, and the concurrence of two members shall be necessary to make any action effective.

D. Duties of the merit system council. It shall be the duty of the council within the scope of 12 MCAR SS 2.490-2.841:

1. To establish general policies for the administration of merit examinations and the hearing of personnel appeals as provided in 12 MCAR S 2.5081;

2. To hear such appeals or to appoint an appeal board of three members or to appoint a referee to hear such appeals on its behalf;

3. To consult with the Commissioner of Public Welfare about the appointment of a full-time merit system supervisor;

4. To consult with the supervisor in formulating procedures for the purpose of ensuring conformity with the rules and the policies of the council.

5. To review the classification and compensation plans and to make recommendations to the commissioner about their adoption and subsequent revision;

6. To make recommendations to the commissioner about internal personnel policies to ensure conformity with the rules;

7. To promote public understanding of the purposes, policies, and practices of the merit system; and

8. To review and make recommendations to the commissioner about any amendments to the rules of the merit system.

E. Compensation of council members. Each member of the council shall be paid $50 per regular meeting, but no member shall be paid more than $600 in any one calendar year for regular meetings. Each member of the council shall be paid $50 per day when serving on an appeal or hearing board. In addition, members whose residence is in excess of 50 miles from the place of meeting shall be compensated for travel expenses and, in an instance in which the meeting is scheduled for more than one day or when the hour of the beginning of the meeting, or the close of the meeting, does not allow coming from or returning to the place of residence within a reasonable time, for lodging and meals.

F. Appointment of the merit system supervisor. The

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commissioner, after consultation with the council, shall appoint a merit system supervisor in accordance with Minnesota Statutes, chapter 43A, and the rules of the Minnesota Department of Employee Relations. The supervisor shall be a person who has had training and experience in a field related to merit system administration and who has known symphathies with the merit principle in government service and shall possess such other qualifications as are requisite for the performance of the duties defined in G. Within three years prior to appointment, the supervisor shall not have held, nor during the term of office shall the supervisor hold, political office or office in any political organization.

G. Duties of the supervisor. In conformance with 12 MCAR SS 2.490-2.841, it shall be the duty of the supervisor to:

1. Develop and put into continuous effect policies and procedures for the administration of the Merit System program as they relate to the preparation, administration, and scoring of examinations; the preparation, custody, and maintenance of registers of eligibles; the determination of availability to eligibles for appointment; the certification for appointment; and the determination of the adequacy of existing registers.

2. Develop the classification and compensation plans and consult with the council on the adoption and revision of such plans as they relate to the Merit System program of recruitment and examination.

3. Promote public understanding of purposes, policies, and practices of the merit system program.

4. Appoint staff members, including technicians, clerks, stenographers, and other permanent or temporary employees who are necessary to carry out the provisions of 12 MCAR SS 2.490-2.841. Employees shall be chosen in accordance with the provisions of the Minnesota Department of Employee Relations rules.

5. Review, develop and propose amendments to existing merit system rules for consideration and recommendation by the merit system council and in accordance with the provisions of Minnesota Statutes, chapter 15.

6. Perform other duties which are prescribed by 12 MCAR SS 2.490-2.841.

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2.493

12 MCAR S 2.493 Classification plan.

A. Preparation and adoption.

1. Commissioner's duty. The Commissioner of Public Welfare shall formally adopt and make effective a comprehensive classification plan for all positions covered by 12 MCAR SS 2.490-2.841 which shall be published as part of the Public Welfare Merit System Manual. The plan shall be based on investigation and analysis of the duties and responsibilities of each position, and each position shall be allocated to its proper class in the classification plan. The plan shall be developed after consultation with supervisory officials, classification specialists, and persons technically familiar with the character of the work. When complete, the classification plan shall include for each class of positions an appropriate class title, a description of the duties and responsibilities, and the minimum requirements of training, experience, and other qualifications.

2. Review by council. The proposed classification plan, and any changes therein, shall be submitted to the Merit System council for review and recommendations. After that review and recommendation and upon formal adoption by the Commissioner of Public Welfare, the classification plan shall be the official plan for all positions. Class titles established by the adoption of the classification plan shall be used in all personnel and financial records of the Department of Public Welfare and appointing authorities, as well as in all examination procedures.

B. Allocation of positions. Every position under the jurisdiction of an appointing authority shall be allocated by the supervisor to one of the appropriate classes established by the classification plan. No person shall be appointed or promoted to any position until it has been properly classified as herein provided. As additional classes are established or existing classes are abolished or changed, the necessary allocations or reallocations shall be made by the supervisor to new or existing classes as necessary.

C. Revision of plan. Existing classes may be abolished or changed, or new classes added, in the same manner as the classification plan is originally adopted.

D. Incumbents of reclassified positions.

1. Appointment authorized. When a position is reclassified and it is determined to be a reallocation resulting from a significant change in the duties and responsibilities of the position occurring gradually over a period of time, the supervisor shall authorize an appointing authority to promote the incumbent of the reallocated position. An employee promoted in accordance with this provision shall serve a probationary period in the higher class.

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2. Eligibility. When a position is reclassified resulting from a change in allocation the incumbent shall not be eligible to continue in the position except as provided in 3. or unless he is eligible for original appointment, promotion, transfer, or demotion to the new class of positions. If he is ineligible to continue in such a position, he may be transferred, promoted, or demoted by appropriate action of the appointing authority in accordance with the applicable provisions of 12 MCAR SS 2.490-2.841. If ineligibility of a permanent or probationary incumbent of such a reclassified position arises from the existence of an eligible register established from an examination that the incumbent did not take, he may be permitted to take the same or equivalent examination from which the existing register was established, providing that his name is not on the existing register, he did not take and fail the examination from which the existing register was established, and he was eligible to take the examination at the time it was given. The names of successful candidates examined under this rule shall be placed on the existing register in accordance with the score attained. In any case in which the incumbent is ineligible to continue in the position and he is not transferred, promoted, or demoted, the provisions of these rules about layoff shall apply. Any transfer, promotion, demotion or layoff in accordance with those provisions must occur within 60 days of the notification of reclassification of the position.

3. Change in agency size. If a position is reclassified as a direct result of the change in size of the employing agency without change in duties and functions, an incumbent with permanent or probationary status in the lower class shall be permitted to take a non-competitive qualifying examination without regard to the qualifications for the class. An incumbent whose name is on a competitive promotional register for the higher class may be certified to the position regardless of the relative ranks of other candidates on the eligible register.

4. Equivalent duties. The Commissioner of Public Welfare may authorize the reclassification of a position from one classification to a higher designated classification when the duties to be performed in the higher class are not significantly different from those performed in the lower class and where both classifications are in the same occupational grouping. Incumbents of positions so reclassified must meet the specified minimum qualifications for the higher designated class and promotions shall be made following a non-competitive promotional examination which shall include an evaluation by the appointing authority of the incumbents' ability to perform in the higher class.

5. Incumbent appointed after exam. If the incumbent examined in accordance with 4. successfully completes the examination process, the supervisor may certify only the name of the eligible incumbent to the appointing authority.

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6. Probation prohibited. Notwithstanding the provisions of 12 MCAR S 2.500 B.1.a., an employee appointed under 5. shall not be required to serve a new probationary period in the higher classification.

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12 MCAR S 2.494 Compensation plan.

A. Preparation and adoption.

1. Preparation of plan. In accordance with Minnesota Statutes, chapter 15, the commissioner shall formally adopt and make effective a comprehensive compensation plan, 12 MCAR S 2.840, for all classes of positions which shall apply to all agencies covered by the merit system except as otherwise negotiated for employees in a bargaining unit in agencies where there is an exclusive representative or in those instances where the requirements of F.2.c. have been satisfied. The plan shall include salary schedules for the various classes, with the salary of each class consistent with the functions outlined in the class specifications. Minimum, intervening, and maximum rates of pay for each class shall be established to provide for salary advancement without change in duty, in recognition of meritorious service. The advice and suggestions of appointing authorities, prevailing salary rates for similar and competing types of employment in business and government, and other relevant factors shall be taken into consideration in developing the salary schedules.

2. Review by council. The proposed compensation plan, and any amendments to it, shall be submitted to the merit system council for review and recommendation. Upon review and recommendation by the council and after compliance with the provisions of Minnesota Statutes, chapter 15, the commissioner shall formally adopt the compensation plan which shall be the official salary schedule of the Minnesota merit system, effective the date specified.

3. Salary plans. The comprehensive compensation plan adopted by the commissioner shall provide for separate alphabetically designated salary plans for different occupational groupings of classes reflecting progressively higher salary ranges except for those classes where a single range of rates is found to be appropriate. Plans shall be established as provided in 12 MCAR S 2.840 as follows:

a. Professional - A, B and C;

b. Support personnel - A, B and C;

c. Clerical - A, B and C;

d. Maintenance and trades - A and B.

B. Selection of salary ranges by appointing authority.

1. Adoption of official plan. Appointing authorities shall choose, by resolution, a salary plan for each occupational grouping of classes from among the plans listed in A.3. except when salaries are negotiated with an exclusive representative or the provisions of 5. are applicable. The plans adopted shall

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become the official plans for the appointing authority until amended.

2. Selection of rates. Within the minimum and maximum salaries for classes in the adopted plans, appointing authorities shall designate, by resolution, the minimum, intervening and maximum salary rates to be paid for each class of positions used by the appointing authority. The supervisor shall be promptly notified of the rates selected by each appointing authority.

3. Plan amendments. The appointing authority may amend, by resolution, its official plan for one or more occupational groupings of classes. The supervisor shall be promptly notified of the official action taken by the appointing authority to amend its plan.

4. Incumbents. Salary rates for incumbents of positions shall be established in accordance with the provisions of F.2. and 3. on the basis of the plan adopted by the appointing authority as provided in A.3.

5. Nonrepresented employees. In agencies with an exclusive representative, the appointing authority may pay confidential, supervisory and other personnel not covered by an exclusive representative who are in the same class as employees who have an exclusive representative, the same rate of pay and salary ranges as negotiated for the class under D.1. In no case would this rule allow the appointing authority to reduce the rate of pay of confidential, supervisory or other excluded employees.

C. Adjustment of the official salary schedule of the Minnesota merit system.

1. Consumer price index. The compensation plan provided in 12 MCAR S 2.840 shall be adjusted for changes in the level of salary rates in business and government for similar and competing types of employment and for changes in the Twin City Consumer Price Index.

2. Biennial review of labor market. In every odd-numbered year the supervisor shall conduct a review of the changes in the level of salary rates in the labor market since the time of the most recent adjustment of the compensation plan. This review shall utilize the data and findings of other labor market surveys and shall, to the extent possible, be based upon similar surveys and data used in previous reviews. The supervisor shall complete this study and report the findings to the Commissioner of Public Welfare on or before July 31 of each odd-numbered year.

3. Plan amendments. From the results of this study, the supervisor shall propose amendments to the compensation plan in accordance with the provisions of Minnesota Statutes, chapter 15, and as outlined in 12 MCAR S 2.494 A. An amended

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compensation plan shall not be effective until the next succeeding January 1, or for those agencies on a bi-weekly or four-week payroll period on the beginning date of the first payroll period following the next succeeding January 1.

4. Biennial review of consumer price index. In every even-numbered year, the supervisor shall conduct a review of the changes in the consumers price index for urban wage earners and clerical workers for Minneapolis-St. Paul, as published by the Bureau of Labor Statistics, new series index (1967=100). The supervisor shall recommend that all rates of pay in the professional, support, clerical and maintenance and trades salary schedules be adjusted by an amount equal to 80 percent of the increase between the consumer price index for June of the current year and the consumer price index for June of the preceding year. This amount shall be rounded to the nearest tenth of a percent and may not exceed 9 percent. The new recommended monthly salary rates shall be rounded to the nearest whole dollar. The same percentage increase recommended by the supervisor for all rates of pay shall be recommended as a general salary adjustment for all incumbents of positions in the professional, support, clerical and maintenance and trades salary schedules. An amended compensation plan resulting from these recommendations shall not be effective until the next succeeding January 1, or for those agencies on a bi-weekly or four-week payroll period on the beginning date of the first payroll period following the next succeeding January 1.

5. Plan adjustments. The appointing authority may implement an adjusted compensation plan by adjusting the salaries of the employees to the same numerically designated salary rate on the adjusted plan that such employees were paid under the former plan.

D. Negotiation of a salary schedule.

1. Role of exclusive representative. In those agencies where employees have elected an exclusive representative the appointing authority and the exclusive representative may negotiate their own salary schedules for employees in the bargaining unit by class, with the salary for each class consistent with the functions outlined in the class specifications. Minimum, intervening, and maximum rates of pay for each shall be established to provide for steps in salary advancement without change of duty, in recognition of meritorious service. When a new classification not previously used in the agency is established in the middle of the contract period and such class falls within the bargaining unit and no provision exists in the contract for establishing such salaries, the appointing authority and the exclusive representative shall negotiate a salary schedule for the new classification within 60 days of the date of establishment of the classification.

2. Filing. A complete copy of the negotiated salary schedule must be filed with the supervisor within ten days after the signing of the contract or agreement. If the contract or

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agreement calls for succeeding increases in the salary schedule which change the original minimum and maximum salaries or intervening steps a new adjusted salary schedule must be filed with the supervisor within ten days after the effective date of any such succeeding adjustment.

E. Administration of the plan. In those agencies without an exclusive representative or where the collective bargaining agreement is silent regarding initial salaries, the entrance salary for any new employee shall normally be at the minimum rate of pay for the class to which the appointment is made. Requests to appoint above the minimum rate of pay may be made based on the exceptional qualifications of the candidate or the unavailability of candidates at the minimum rate, giving consideration to the salaries of current employees in the same classification. All candidates with similar exceptional qualifications must be offered the same rate of pay which shall be one of the established steps in the agency's adopted salary range for the class to which the appointment is made. Requests, including the reasons, must be submitted in writing by the appointing authority to the supervisor for prior approval.

F. Salary adjustments and increases.

1. Availability of funds. Before salary increases and adjustments are made in accordance with 12 MCAR S 2.494, or in accordance with a negotiated collective bargaining agreement, the appointing authority shall have in its records and carry in its minutes a definite statement that funds for this purpose are available.

2. Plan requirements. In agencies where there is no exclusive representative or collective bargaining agreement, negotiated adjustments in the rates of pay of incumbents of positions, in order to conform to a newly adopted or currently effective compensation plan, shall be in accordance with the following provisions.

a. If the rate of pay of an employee is below the minimum of the range prescribed for the employee's classification on the Merit System Compensation plan adopted by the appointing authority, the rate shall be adjusted to that minimum.

b. If the rate of pay of an employee is at or above the new minimum salary adopted for their class, the employee may receive the general merit system adopted adjustment, and if the employee's class was adjusted to a greater extent than the general adopted adjustment, the employee may receive the additional adjustment as provided in C.4. as long as the additional adjustment does not place the employee's salary over the new maximum adopted salary for the class.

c. In those situations where the appointing authority has determined that the general merit system adopted adjustment is inappropriate for its employees, it may grant a different

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adjustment; however, the authority must file with the supervisor the new salary steps by class and a salary conversion table as provided for in 12 MCAR S 2.841. These adjustments shall at least place employees at the minimum salary and not over the maximum salary for their class on the salary plan adopted by the agency.

d. Employees at the maximum salary for their class may be granted salary adjustments over the maximum salary prescribed for their class, only if such a Merit System adjustment is adopted and only in the amount adopted for incumbents of that class.

e. If the rate of pay of an employee is higher than the maximum of the range prescribed for the employee's class of positions, the rate may remain the same as long as the employee retains the same classification.

f. If the rate of pay of an employee falls between the minimum and maximum of the salary range prescribed for the employee's class but does not correspond to any intervening steps in the range, due to the adoption of Merit System general adjustment, such rate may remain the same. In the case of subsequent merit increases, the employee shall be placed back on a step in the adopted salary range for his or her class.

g. Employees at the maximum salary rate for their class may be granted merit system adopted salary adjustments only in the amount adopted for incumbents of that class. If an appointing authority wishes to grant a larger general adjustment to its employees than that adopted by the Merit System and such an adjustment would place an employee's rate of pay above the maximum salary rate for their class, the appointing authority, by prior resolution, may grant to that employee the annual equivalent of the difference between the merit system adopted adjustment for incumbents and the agency adopted adjustment in the form of a single lump sum salary payment on the effective date of the general adjustment. The employee's base salary rate shall remain at the maximum salary rate for his or her class.

h. An appointing authority may propose a salary increase within the salary range to an employee upon detailed written statements to the supervisor specifying the unusual employment conditions that make the action necessary and the interests of the agency that will be served by the action. The supervisor shall review each proposal, giving due consideration to the salary rates paid other employees in the same class in the agency and shall deny any request which does not assure equitable compensation for comparable work. Salary increases proposed in accordance with this section are not based on employee performance or a general merit system adopted salary adjustment. The granting of such an increase shall not affect the employees' eligibility for subsequent merit increases or salary adjustments in accordance with merit system rules. If the unusual employment conditions giving rise to such an increase are of a temporary nature, the employee's salary shall

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be decreased to its previous level upon conclusion of those conditions. This decrease is not subject to H. or 12 MCAR S 2.5081 D.

3. Recommended adjustment. The merit system general adjustment recommended for incumbents is eight percent for employees on the professional, support, clerical, and maintenance and trades salary schedules.

4. Salary differentials. Intra-agency salary differentials between employees in the same class of positions, between employees in different classes of positions in the same occupational field, and between occupational fields in the same agency are recognized as important factors in the maintenance of satisfactory morale. If the general adjustments result in the reduction of the differential between employees in the same class of positions or between employees in different classes of positions in the same occupational field, adjustments may be made that will, insofar as practicable, maintain such differentials within the limits of the new plan. In maintaining such differentials, the appointing authority shall take into consideration the length of service and quality of performance of the employees affected.

5. Collective bargaining agreements. In agencies where there is an exclusive representative and a negotiated salary schedule for employees in the bargaining unit, adjustments in the rates of pay of employees shall follow the wording of the contract or agreement.

G. Merit increases.

1. Increases by steps. Merit increases from the minimum on the official merit system compensation plan or on any negotiated salary schedules or on any salary schedules filed with the supervisor pursuant to F.2.c. shall be by successive intervening steps of pay for the class, with due consideration for length of service and quality of performance.

2. Eligible employees. In those agencies that have adopted a merit increase policy, an employee may be considered for a merit increase upon the satisfactory completion of the probationary period.

3. Annual review for merit increases. In those agencies that have adopted a merit increase policy, a merit increase for each employee not at the maximum salary for his or her classification shall be considered at least once each 12 month period unless otherwise negotiated through a contract or agreement by the appointing authority and the exclusive representative. In the event an increase is not granted, the reasons for the denial of the increase shall be reported, in writing, to the employee and to the merit system supervisor.

4. Restriction on frequency of increases. In those agencies that have adopted a merit increase policy and, except

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as otherwise negotiated by the appointing authority and the exclusive representative, a merit increase shall not be granted until the employee has served at least six months at the rate of pay from which an increase is proposed, except that in cases of exceptionally meritorious service, a merit increase of more than one salary step in the range or at less than a six month interval may be permitted. In each case, however, the facts upon which the merit increase is based shall be recorded in the official minutes kept by the appointing authority and reported to the merit system supervisor.

5. Increases based on additional education. In those agencies that have adopted a merit increase policy, an extraordinary merit increase within the agency's salary range may be granted upon satisfactory completion of 15 additional credits in a field or fields pertinent to the employee's class. In each case the employee's transcript of coursework must accompany the proposed merit increase.

6. Lump sum payments. In those agencies that have adopted a merit increase policy, the appointing authority may grant an employee who meets all other agency eligibility requirements for a merit increase but whose salary is at or above the maximum rate of pay in the adopted salary range for their classification the annual equivalent of a one step merit increase in the form of a single lump sum payment in recognition of meritorious job performance. For this provision to be effective, appointing authorities, prior to the beginning of the year in which such merit increases, if granted, are effective must establish, by resolution, as its official policy that these payments will be granted for meritorious job performance. The base salary of an employee receiving a lump sum merit increase shall remain at the rate attained immediately prior to the increase.

H. Salary decreases.

1. In general. Except as otherwise negotiated by an agency and the exclusive representative, a salary decrease within the range prescribed for the class may be made only for just cause. A permanent employee shall be notified of the intent to effect a reduction in pay and the reasons for the action at least ten calendar days prior to the date on which the reduction becomes effective. A copy of the notice shall be sent to the supervisor. A permanent employee whose salary is reduced may request a hearing as provided in 12 MCAR S 2.5081 D.

2. Exemption. Collective bargaining agreement provisions whereby a salary adjustment or salary increase is negotiated for a set period of time do not fall within the provisions of 1.

I. Work out of class. If an employee is expressly assigned in writing to perform all the duties of a position allocated to a higher classification that is temporarily unoccupied for reasons other than vacation or sick leave and that work exceeds 15 consecutive work days in duration, the employee so assigned

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shall be paid for all hours of the assignment at least at the minimum rate of pay of the salary range for the higher class or may be granted a one step salary increase within the assigned employee's salary range. If the assignment is to a position in a classification at an equal or lower level, the employee shall be paid for all hours of the assignment at the employee's current rate of pay. A work out of class assignment may be proposed only if the duration of the vacancy is anticipated to be less than six months. Approval of such assignments by the supervisor is required and must be received by the supervisor within five calendar days of the assignment. Upon completion of the work out of class assignment, the employee's salary shall be reduced to its previous level. This decrease is not subject to H. or 12 MCAR S 2.5081 D.

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12 MCAR § 2.495 Recruitment.

A. Physical examinations.

1. Applicants may be required to pass a satisfactory physical examination before appointment.

B. Applications.

1. All applications shall be made on forms prescribed by the Supervisor and must be filed on or before the closing date specified in the announcement, or postmarked before midnight of that date. On such applications the Supervisor shall require all pertinent information pertaining to education, experience, age, and any other information that the Supervisor may deem necessary. All applications shall be signed and the truth of all statements contained therein certified by such signature.

2. In those classes of positions in which there is difficulty in obtaining qualified eligibles, the Supervisor may establish a program that will be both positive and continuous. Under such a plan, applications may be accepted at any time and examinations held whenever applicants have filed in sufficient numbers to insure adequate competition.

C. Disqualification of applicants.

1. The Supervisor may refuse to examine an applicant, or after examination he may disqualify such applicant or remove his name from a register, or he may refuse to certify any eligible person on a register if the applicant:

a. Is found to lack any of the preliminary requirements established for the examination for the class of positions.

b. Is physically, mentally, or emotionally so disabled as to be rendered unfit for the proper performance of the duties of the class.

c. Is addicted to habit-forming drugs or is a habitual user of intoxicating liquors to excess.

d. Has been guilty of any crime involving moral turpitude or of infamous or notoriously disgraceful conduct.

e. Has been dismissed from the public service or any other position for delinquency or misconduct.

f. Has made false statement of any material fact in his application.

g. Has used or attempted to use a political pressure of bribery to obtain an advantage in the examination or appointment.

h. Has directly or indirectly obtained information about the examinations to which as an applicant he was not entitled.

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i. Has failed to submit his application correctly or within the prescribed time limits.

j. Has taken part in the compilation, administration, or correction of the examination.

k. Has otherwise violated provisions of these rules.

l. Is not available in an area under the jurisdiction of the Merit System.

2. A disqualified applicant shall be promptly notified of such action, and an applicant who is not admitted to an examination because of failure to meet the preliminary requirements shall be notified by letter of his last-known address sufficiently in advance of the examination to allow for an appeal from rejection as provided in 12 MCAR § 2.508 A.

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12 MCAR S 2.496 Examinations.

A. Character of examinations.

1. In general. Examinations for entrance into the Public Welfare and Public Safety Merit Systems shall be conducted on a competitive basis. Examinations shall be practical in nature, shall be constructed to reveal the capacity of the applicant for the particular position for which he is competing, as well as his general background and related knowledge, and shall be rated objectively.

The supervisor shall determine the content of all examination processes which shall include: performance tests, written examinations, ratings of experience and training, promotional ratings, or oral examinations.

2. Weight assigned to parts. The supervisor shall assign definite weights to each part of the examination prior to its public announcement.

3. Positions for disadvantaged groups. Recruitment and selection for those positions identified in the minimum qualifications of the class specification as directed toward clients and other disadvantaged groups will be limited to persons of low income or low educational achievement, including the physically and mentally disabled. It will be the specific responsibility of the individual appointing authorities to effectively make known opportunities for these jobs to such persons. Persons who do not meet these limitations will be disqualified from competition for these positions and notified of the reasons therefor. Examinations for these positions will include at least one of the following: performance test, oral examination, written test, or oral directions test combining aspects of performance and minimum literacy. The supervisor shall assign a definite weight to each part of the examination prior to its public announcement. Eligible lists will be established on an area or county basis only. Certification of eligibles on an area basis smaller than the county unit may be approved by the supervisor. Because these positions cover a broad range of duties requiring many different abilities, knowledges, and basic skills, notwithstanding other provisions of 12 MCAR SS 2.490-2.841, the supervisor also may approve selective certification of eligibles who possess a particular ability, knowledge, or skill.

B. Notice of examination. The supervisor shall announce all examinations for original entrance into the Public Welfare and Public Safety Merit Systems at least two weeks in advance of the closing date for receipt of applications, and shall make every reasonable effort to attract qualified persons to compete in these examinations. Notice of examinations shall be posted in important centers throughout the state, and copies shall be distributed among appointing authorities throughout the state, newspapers, public officials, educational institutions,

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professional and vocational societies, and such other organizations and individuals as the supervisor may deem expedient. Public announcement of examinations shall specify the title and salary ranges of the class of positions, the duties to be performed, the minimum qualifications required, the final date on which applications will be received, and all other conditions of competition, including the relative weights assigned to the various parts of the examination.

C. Conduct of examinations.

1. Place; monitors. Written tests shall be conducted simultaneously in as many places as are necessary for the convenience of the applicants and as are practicable for proper administration. The supervisor may designate such monitors as may be necessary to conduct examinations under instructions prescribed by him and may also arrange for the use of public buildings in which to conduct the examinations. The supervisor shall provide for the compensation of monitors in accordance with the approved budget for the purpose.

2. Refusal to score. The supervisor shall refuse to score the examination of an applicant who copies another applicant's examination paper, or falsifies an identity to gain admittance to the examination, or who otherwise meets the criteria for disqualification as provided for in 12 MCAR S 2.495 C.1.

D. Rating examinations.

1. Determination of score. The supervisor shall determine a final score for each applicant's examination, computed in accordance with the weights for the several parts established by the supervisor as set forth in the announcement. Failure in any part of an examination shall disqualify the applicant in the entire examination. All applicants for the same position shall be accorded uniform and equal treatment in all phases of the examination procedure.

2. Determination of passing point. The supervisor shall utilize appropriate scientific techniques and procedures in rating the results of examinations and in determining the final scores of the applicants. The supervisor shall establish reasonable passing points for all examinations, giving due regard to the number of vacancies that may reasonably be expected to occur during the life of the register.

E. Rating training and experience. When training and experience form a part of the total examination, the supervisor shall determine a procedure for the evaluation of the training and experience qualifications of the various applicants. The formula used in appraisal shall give due regard to recency and quality, as well as quantity, of experience and to the pertinency of the training. This procedure shall allow for the substitution of training for experience, and experience for training, within the limits stated in the class specifications.

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F. Oral examination. When an oral examination forms a part of a total examination for a class of positions, the supervisor shall select one or more oral examination boards as needed. An oral examination board shall consist of two or more members who shall be known to be interested in the improvement of public administration and in the selection of efficient government personnel and at least one of whom shall be technically familiar with the character of work in the position for which the applicant will be examined. Any person holding political office or any officer or committee member of any political organization, or any person actively engaged in the work of any political organization, shall not serve as a member of a board. If practicable, all applicants qualifying for the oral examination for the class of positions shall be rated by the same oral examination board. A member of an oral examination board shall disclose each instance in which he knows the applicant personally and, in those instances, the supervisor shall determine whether the oral examination board member shall rate that applicant. prior to its public announcement. Eligible lists will be established on

G. Notice of examination results.

1. Each applicant passing all parts of the examination shall be notified by mail by the Supervisor of his final rating as soon as the rating of the examination has been completed and the register established. An eligible, upon request and presentation of proper identification, shall be entitled to information about his relative position on a register. An applicant who fails any part of the examination or the total examination shall be promptly notified of his failure.

H. Examination records. The supervisor shall be responsible for the maintenance of all examination records. Applications and other necessary examination records shall be kept during the life of the register. Examination records of appointees shall be kept permanently, but examination records of applicants not appointed may be destroyed 30 days after the register expires.

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12 MCAR § 2.497 Registers.

A. Establishment of registers.

1. After each examination the Supervisor shall prepare and maintain registers of persons who attain passing scores in the examination. The names of eligible persons shall be placed on registers in the order of their final rating, beginning with the highest, except as modified by veteran's preference. If two or more persons have final ratings that are identical, their names shall be arranged on the register in the order in which their applications for examination were accepted. Remaining tie scores shall be broken by arranging names in alphabetical order.

2. Eligible registers resulting from examinations shall be of three kinds: open-competitive registers, from which original appointment shall be made; promotional registers, from which promotions shall be made; and trainee registers, from which trainee appointments shall be made. Other registers or lists of persons eligible for appointment may be established in accordance with other provisions of these rules.

3. Promotional registers shall consist of the names of permanent and probationary employees who attain passing scored in the examination for promotion to a class of positions.

4. Trainee registers shall consist of the names of persons who qualify in an examination for a trainee classification or those persons who qualify for appointment to a regular class of positions and who also apply for placement on a trainee sub-register of the established register for the regular class of positions.

5. Registers shall normally be established on a state-wide basis. Nevertheless, the Supervisor, with the approval of the Commissioner of Public Welfare, may offer examinations on a county or area basis or may establish a county area sub-register of a state-wide register. Eligibility for placement on a county or area sub-register shall be determined by legal residence in the county or area or, in the case of a promotional register, by employment with the county welfare department.

6. Layoff lists shall be established by county and shall include the names of permanent and probationary employees who have been laid off from employment because of lack of funds or lack of work in accordance with the provisions of these rules. Names shall be placed on this list in reverse order of layoff.

7. The Supervisor may establish a reemployment list of the names of former permanent and probationary employees who are eligible under the rules for reinstatement to a class of positions and who apply for placement on this list. Names shall be placed on this list in the manner determined by the Supervisor. All persons on such list are equally eligible for appointment, and no rank or position shall be assigned.

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B. Change of address.

1. Each applicant or eligible shall file with the Supervisor notice of any change of address.

C. Duration of registers.

1. The life of each register shall normally be one year from the date of its establishment, but this period may be reduced or extended by the Supervisor with the approval of the Council. In no case, however, shall a register be in existence for a period of more than three years. A register may be deemed by the Supervisor to be exhausted if fewer than three available eligibles remain on it. Upon exhaustion of a register, or if the Supervisor, with the approval of the Council, reduces the life of a register, he shall notify each eligible remaining on such register to this effect by mail to his last-known address.

D. Removal of names from registers.

1. The Supervisor may remove the name of an eligible from a register for any of the following causes:

a. Appointment through certification from such register to fill a probationary appointment.

b. Appointment through certification from a register for another class whose minimum salary is either equal to or higher than the minimum salary for this class of positions; but, at the request of the appointee in such a case, his name may be continued on, or restored to, any or all registers other than the one from which the appointment was made, for the remainder of the life of such register.

c. Filing of a statement by the eligible that he is not willing to accept appointment. Such statement of unwillingness may be restricted to a limited period of time or to geographic locations or positions involving other conditions of employment, as specified. The name of the eligible shall then be treated as not available and shall be passed over in certification to fill any vacancy under the conditions specified as though such name did not appear on the register. Any eligible may file a new statement at any time notifying for future consideration any prior statement about the time, place, or other conditions under which appointment will be accepted.

d. Declination of appointment under such conditions as the eligible previously has indicated he would accept.

e. Failure to respond within five days to any inquiry of the Supervisor, the Personnel Officer, or any appointing authority relative to availability for appointment.

f. Consideration of a probationary appointment from a promotional

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register by three different appointing authorities, or three times by one appointing authority, and not appointed.

g. Consideration of a probationary appointment from an open-competitive register to a class of positions within the preceding two years by three different appointing authorities, or three times by one appointing authority, and not appointed.

h. Any cause specified in 12 MCAR § 2.495 C.

2. The Supervisor, upon noting any declination or failure of any eligible to respond, may send a notice to the eligible of the removal of his name from the register. Such notice may include any inquiry about the reasons for such declination or failure to respond and a question as to whether the eligible is willing to accept the next appointment offered under such conditions as he may specify. Upon the furnishing of reasons satisfactory to the Supervisor for the declination or failure to respond, and a statement of willingness to accept appointment, the name of the eligible may be restored to the register for certification for appointment under the conditions specified. It shall be considered impossible to locate an eligible when any communication mailed to him at the last-known address of record supplied by him is not replied to within five days or is returned unclaimed, or if a telegram is not replied to within three days. It shall be known to the Supervisor that an eligible is not willing to accept a position when a declination of appointment or statement of unwillingness to accept appointment is on file with the Supervisor.

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2.498

12 MCAR S 2.498 Certification of eligibles.

A. Vacancies. Vacancies in the classified service shall be filled by reemployment, original appointment, promotion, transfer, demotion, or reinstatement.

B. Requisition for certification. If a vacancy in any position under an appointing authority is to be filled other than by reinstatement, non-competitive examination, transfer, or demotion, and a new employee is needed, a requisition shall be submitted by the appointing authority to the supervisor. This requisition shall state the number of positions to be filled in each class, together with the class title and other appropriate information. In addition, desirable special qualifications for the particular position under consideration may be indicated. In requesting the certification of individuals with special qualifications, the appointing authority shall state in the request the reasons for the special qualifications requested. Eligibles shall be certified in strict order of standing on the register, except in a case in which the supervisor has determined that there is reason for a certification of an eligible with special qualifications. Requests for certification of individuals with special qualifications approved by the supervisor shall be reported to the council at its next scheduled meeting.

C. Certification methods.

1. Entrance register. Upon receiving a requisition, the supervisor shall certify the names of available eligibles. If one position is involved, the supervisor shall certify the seven highest available names together with any additional names of persons having an examination rating within three points of the person on the certification with the highest examination rating, and any additional names of persons having the same examination score as that of the seventh person certified, from the open-competitive entrance register established for the class of positions. Names of available eligibles from the appropriate reemployment register, if one exists, shall also be certified as additional names.

2. Promotional register. The supervisor may also certify the three highest available names together with any additional names of persons having an examination rating within three points of the person on the certification with the highest examination rating, and any additional names of persons having the same examination scores as that of the third name certified, from the appropriate promotional register if such register exists and is requested. Names of available eligibles from the appropriate reemployment register, if one exists, shall also be certified as additional names.

3. Certification for more than one vacancy. If more than one vacancy exists, the supervisor shall certify at least as many names from the register as there are vacancies to be

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filled, together with any additional names of persons having an examination rating within three points of the person on the certification with the highest examination rating, and any additional names of persons having the same examination score as that of the last person certified on a competitive certification or as that of the last person certified on a promotional certification. Supplementary certifications will be issued only in instances in which it is found that there are fewer than seven available candidates on the competitive certification or three available candidates on the promotional certification.

4. Selection for appointment. The appointing authority may select for appointment anyone among the certified candidates who is eligible for appointment.

5. When the number of names available for filling any vacancy by original appointment, promotion, or reinstatement is fewer than seven on a competitive certification or three on a promotional certification, and there are fewer than three different names on all registers combined, the appointing authority may decline certification for that vacancy and may request certification from a register, or registers, that the supervisor deems appropriate.

6. If there is no register that the supervisor deems appropriate, then the vacancy may be filled provisionally as provided for in 12 MCAR S 2.499 B.

D. County-option certification.

1. The appointing authority may request from the supervisor names of eligibles from either the state-wide original entrance register or from a sub-register for the county, a restricted area, or a district of the state, as set forth in 12 MCAR S 2.497 A.5. The supervisor, upon receipt of such requisition, shall refer names of eligibles from the register as requested.

2. If an appointing authority requests a certification of eligibles from a sub-register established for a specific locality but there are insufficient eligibles thereon, certification shall be made on a state-wide basis.

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12 MCAR § 2.499 Appointments.

A. Appointment from registers.

1. The employment of any person from a certification from an open-competitive register shall be deemed to be an original appointment. In selecting persons from among those certified by the Supervisor for original appointment, the appointing authority shall be permitted to examine their application and reports of investigation and to interview them. Final selection and the action taken on each candidate shall be reported to the Supervisor in the manner prescribed by him.

2. Promotional appointments shall be made in the same manner as original appointments as specified in 12 MCAR § 2.499 A. 1., above, except that the person appointed is selected from a certification from a promotional register.

3. Trainee appointments shall be made in the same manner as original appointments as specified in 12 MCAR § 2.499 A. 1., above, except that the person appointed is selected from a certification from a trainee register. A trainee appointment shall be to a specific trainee classification as provided in the classification plan and shall be for the period of training, which shall not exceed one year in duration. Trainees so appointed shall be advanced to the classification for which they are in training upon the satisfactory completion of the training program and shall then serve a probationary period in the regular classification. A trainee appointment may be terminated at any time by the appointing authority.

B. Provisional appointment.

1. Whenever in the option of the appointing authority there are urgent reasons for filling a vacancy and the Supervisor is unable to certify eligibles from a register established as a result of an examination for the position, and no appropriate promotional register or other appropriate register exists, the appointing authority may submit to the Supervisor the names of persons to fill the position pending examination and establishment of a register. If such person's qualifications are certified by the Supervisor as meeting the minimum qualifications for training and experience for the position, such persons may be provisionally appointed to fill the existing vacancy until an appropriate register is established and appointment made therefrom. No provisional appointment shall be made until the position has been allocated to a proper class and minimum qualifications established therefor in accordance with these rules nor without prior approval of the Merit System Supervisor.

2. In the absence of a promotional register, a provisional promotional appointment of a permanent or probationary employee meeting the minimum qualifications may be made pending the establishment of a promotional register or the administration of a non-competitive promotional examination.

3. No provisional appointment shall be continued for more than 30

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days after an appropriate register has been established for the class of positions and in no event for more than six months after the date of appointment. Successive provisional appointments of the same person shall not be permitted, and a position shall not be filled by repeated provisional appointments. Provisional appointments may be extended at the end of six months period with the approval of the Merit System Supervisor, and successive provisional appointments of the same individual to different positions and successive provisional appointments to the same position may be made in exceptional circumstances, subject to the following conditions:

a. That an examination has been publicly announced and the Supervisor has found that a sufficient number of applicants are not available to assure adequate competition.

b. That continuous receipt of applications had been provided in accordance with 12 MCAR § 2.495 B. 2. and the examination is to be held whenever the Supervisor finds that enough applicants have filed to ensure adequate competition.

4. All appointments made subsequent to the adoption of this rule but prior to the establishment of a register from which eligibles can be certified shall be considered as provisional appointments.

C. Emergency appointment.

1. Whenever an emergency exists that requires the immediate services of one or more persons and it is not possible to obtain such persons from appropriate registers, the appointing authority may appoint a person or persons without consideration of other provisions of these rules governing appointment, except as provided in 12 MCAR § 2.518. Such appointments normally shall be limited to no more than 45 working days during any calendar year for the same person; however, such appointment of the same person can be extended to 70 working days with prior approval by the Supervisor.

D. Limited-term appointment.

1. If an employee is needed for a limited period of not more than six months, a certification may be made by the Supervisor of the names of those eligibles, in the order of their place on an appropriate register, who have indicated willingness to accept temporary employment. Certification shall be made in the manner set forth in 12 MCAR § 2.498. The duration of the limited-term appointment shall be for the period of need only, and in no case shall such appointment continue for more than six months in any twelve-month period. The addeptance or refusal of a limited-term appointment shall not affect an eligible's standing on a register or his eligibility for appointment to a permanent position, and the period of the limited-term appointment shall not constitute a part of a probationary period. Successive limited-term appointments to the same position shall not be made, nor shall an employee receive continued limited-term appointments.

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E. Employee's appointment prior to adoption of these rules.

1. An employee on the staff of a county welfare board prior to the adoption of these rules by the board, with more than six months of continuous service, and who is certified by the appointing authority as having given satisfactory service since that time may be admitted to the examination for the position held by him on the date of adoption of these rules without consideration of minimum qualifications of training and experience. Upon certification by the Supervisor that he has attained a passing grade in the first examination held in accordance with 12 MCAR § 2.496, he may be appointed as a permanent employee by the appointing authority without being required to serve a probationary period.

2. Such employee, certified as having given satisfactory service, who has been transferred or promoted to a position in another class within six months prior to the adoption of these rules and before the first examination for the position currently held, shall be admitted to the examination on the basis of the minimum qualifications of training and experience for the new class that were in effect at the time of his transfer or promotion. Such an employee may, on certification by the Supervisor that he has attained a passing grade in the examination for that position previously held by him, be retained in that position as a permanent employee, provided that there is a vacancy in the class.

3. The services of an employee whom the Supervisor does not certify as having attained a passing grade in the examination for either of the positions referred to above shall be terminated within 90 days after the establishment of a register for such position or positions in accordance with these rules.

4. Such employee, certified as having given satisfactory service, who has been hired within six months before the adoption of these rules but prior to the first examination on the basis of the minimum qualifications of training and experience for the class that were in effect at the time of his hire. Such an employee may, on certification by the Supervisor that he has attained a passing grade in the examination for that position, be retained as a probationary employee by the appointing authority. An employee hired as described above who fails in the examination for the position held by him shall be terminated within 90 days after the establishment of a register for such position in accordance with these rules.

5. A new employee appointed after the adoption of these rules by a county welfare board but prior to the holding of the first examination under these rules shall be considered as having a provisional appointment and shall be required to compete in the examination without preference. Such new employee shall be admitted to the examination for the position on the basis of the minimum qualifications in effect at the time of his appointment.

F. Veteran's preference.

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1. Preference in the establishment of eligible registers shall be given to veterans in accordance with the provisions of Section 43.30, Minnesota Statutes.

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12 MCAR S 2.500 Probationary period.

A. Purpose.

1. The probationary period is an essential part of the examination process and shall be used to closely observe the employee's work, to obtain the most effective adjustment of a new employee to the obligations of the position, and to remove any employee whose performance does not meet the required standard of work.

B. When required.

1. A person employed by an appointing authority in any of the following ways shall serve a probationary period:

a. Appointment from an eligible register other than the layoff list, and except appointment under 12 MCAR S 2.493 D.;

b. Reinstatement of a former probationary employee or of a former permanent employee in an agency other than the last employing agency;

c. Transfer of an employee between counties except when specifically waived, in writing to the merit system supervisor, by the new employing county prior to the date on which the transfer of a permanent employee becomes effective; or

d. Transfer or reinstatement to a position on the basis of eligibility from a comparable position in a similar merit system jurisdiction.

2. An appointing authority may effect a probationary period in an employment action in which such period is not required as specified above by writing this condition of appointment on the appointment report submitted to the merit system. In no case, however, may a probationary period be required of a permanent employee who is appointed from the layoff list.

C. Duration of probationary period. The probationary period shall consist of the equivalent of the first six full months of compensated service following the date of the appointment action requiring a probationary period, except as provided in D. Unpaid leave of ten or fewer workdays during the probationary period does not affect the duration of the probationary period.

D. Extension of probationary period.

1. In rare or unusual circumstances or conditions that prevent the making of a full and fair determination as a basis for granting permanent status or separating the employee from the service, an extension of the probationary period for up to three months may be granted. Initiation of a request to the merit system supervisor for extension must occur on or before

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the beginning of the sixth month of the probationary period and shall specify the reasons why the extension is necessary. A current evaluation of the employee's performance shall accompany the request. A copy of the request for extension and the evaluation shall be provided to the probationary employee by the appointing authority.

2. The supervisor's decision on the request shall be given to the agency and the employee at least ten days in advance of the end of the initial probation period.

3. Each formal request for extension of the probationary period and the decision on the request shall be reported to the merit system council at its next meeting.

E. Promotion during probation.

1. An employee serving a probationary period may be promoted to a position in a higher class. An employee who is promoted begins a probationary period in the higher classification as of the date of that appointment.

2. A probationary employee who is promoted to a position in a higher class in the same occupational field shall complete his probationary period in the lower class by service in the higher position.

F. Transfer during probation. A probationary employee may be transferred from a position under one appointing authority to a position in the same class under another appointing authority if the employee was not appointed from a certification from a county register.

G. Demotion during probation. A probationary employee who is demoted to a class of positions in the same occupational field shall have included as a part of the probationary period in the lower class his period of service in the higher class unless the appointing authority writes on the report of the demotion to the merit system that a new probationary period is required in the lower class.

H. Removal during probation.

1. A probationary employee may be dismissed by an appointing authority without the right to an appeal or hearing except as may otherwise be provided by law. The employee shall be given written notification, including the reasons for his dismissal, at least five days in advance of the date on which the dismissal becomes effective and a copy of the notification shall be submitted to the supervisor. ~~request. A copy of the request for extension and the evaluation shall be~~

2. A probationary employee who has permanent status in another class in the same agency and who is not granted permanent status in the new classification shall be restored to a position in the class from which he was promoted as his

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seniority permits or in a comparable class as these rules permit, unless the failure to grant permanent status was due to the mis-conduct of the employee.

3. When there is no position to which the employee can be restored, because of abolishment of jobs or lack of seniority, the provisions of 12 MCAR S 2.503 D. apply.

I. Completion of probationary period.

1. The appointing authority shall submit written notice of the satisfactory completion of the probationary period to the employee and to the merit system at least ten days in advance of the expiration of the probationary period. A rating or appraisal of the employee's performance shall accompany the notice. The employee shall then be granted permanent status in the position the day following the last day of the probationary period.

2. If an appointing authority fails to implement the purpose and intent of the probationary period by appropriate action as provided in 12 MCAR S 2.500, a probationary employee who is not certified permanent in accordance with 1. and is not removed or demoted but is continued in employment beyond the full six-months period shall obtain permanent status in the position by the default of the agency. The payment of salary beyond the six-months probationary period shall be deemed to be evidence of the determination by the appointing authority that permanent status shall be granted to the employee. The supervisor shall enter such status on the record of the employee and shall notify the appointing authority and the employee of the change in status.

3. Each instance in which permanent status is granted to an employee in accordance with the provisions of 2. shall be reported to the merit system council. The council may recommend and the commissioner may take appropriate action to insure that the purpose and intent of the probationary period shall be given effect in the agency in all future appointments.

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12 MCAR § 2.501 Promotions.

A. Methods of making promotions.

1. As far as is practicable and feasible, a vacancy shall be filled by promotion of a qualified probationary or permanent employee based upon the performance of his duties, as evidenced by recorded service ratings, with due consideration for length of service and for his capacity for the new position. The appointing authority, in making a promotion, may consult with the Supervisor about the promotional status of an employee. A candidate for promotion must be certified by the Supervisor to possess the qualifications for the position as set forth in the specifications for the class of positions for which he is a candidate, and he shall be required by the Supervisor to qualify for the new position by promotional competitive or noncompetitive examination administered by the Supervisor.

B. Promotion by competitive examination.

1. An employee, to be eligible to compete for promotion, must have permanent or probationary status and must meet the minimum qualifications for training and experience for the class of positions.

2. At the discretion of the Merit System Supervisor and the appointing authority involved, a promotional competitive examination may be limited to the employees of one county welfare board or may be open to the employees of all county welfare boards. If it is determined by the Commissioner of the Department of Public Welfare for the state-wide service to fill vacancies in a particular class of positions by promotional competitive examination, such examination shall be given under the direction of the Supervisor. A promotional competitive examination may consist of any combination of the following: written tests, ratings of training and experience, evaluation of recorded service ratings, promotional ratings, seniority, performance tests, and oral examinations. The combination in each case and procedure for the determination of the passing grade shall be announced by the Supervisor in advance of the examination and shall take into consideration approved practices.

3. All employees who receive a passing grade shall be placed on a promotional register for the class of positions in order of their final ratings, except as modified by 12 MCAR § 2.499 F.

4. If a promotional register and an original entrance register exist, the same number of names shall be certified from each register in accordance with 12 MCAR § 2.498. The appointing authority may make its selection from the names submitted from either register, giving such preference to present employees as the good of the service will permit.

C. Promotion by noncompetitive examination.

1. If it is determined by the appointing authority and the Merit System

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Supervisor to fill a vacancy on a county welfare staff by a noncompetitive promotional examination, the permanent or probationary employee proposed for promotion shall be examined by the Supervisor; and if found to qualify for the new position, his name shall be certified as eligible for probationary appointment. When more than three permanent or probationary employees of a county welfare board meet the minimum qualifications for a class of positions, a noncompetitive promotional examination shall not be given to fill a vacancy in this class.

2. A noncompetitive promotional examination may consist of any combination of the following: written tests, ratings of training and experience, evaluation of recorded service ratings, promotional ratings, seniority, performance tests, and oral examinations. The combination in each case and procedure for the establishment of the passing grade shall be determined by the Supervisor and shall take into consideration approved practices.

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12 MCAR § 2.502 Transfers and demotions.

A. Transfers.

1. A transfer of an employee from a position in one organizational subdivision of a county welfare staff to a position of the same class in another organizational subdivision of the county welfare staff may be made at any time by the appointing authority concerned.

2. Transfer of a permanent employee from a position on one county welfare staff to a position of the same class on another county welfare staff may be made with the approval of the appointing authorities concerned and the Supervisor, subject to the provisions of 12 MCAR § 2.500 A. and B. All such transfers must be reported to the Supervisor.

3. A permanent employee may be transferred from a position in one class to a position in another class, the transfer being either within one county welfare staff or between county welfare staffs, providing that the Supervisor certifies that the examination upon which appointment of the employee was based was of a character and standard to test the fitness of such employee for the position to which it is proposed to make such transfer and requires substantially similar qualifications.

B. Demotions.

1. An appointing authority may demote an employee for inefficient performance of his duties, for disciplinary reasons, or for other just causes.

2. A permanent employee shall be furnished with a statement in writing, setting forth the reasons for the demotion, before the action is taken. He shall be permitted five days time to reply thereto, in writing, or upon request, to appear personally and reply to the appointing authority. A copy of the statement and the employee's reply, if any, shall be filed with the Supervisor prior to the effective date of the demotion. The permanent employee, upon written request, may demand a hearing before the Council in accordance with the provisions of 12 MCAR § 2.508 E. 2.

3. At any time during the probationary period that an appointing authority determines that the employee's performance does not meet work standards, he may demote the employee, except that no employee serving a probationary period following his transfer or promotion shall be demoted except for just cause or with his consent during the first 30 calendar days of the probationary period.

4. Seniority of an employee in the class to which he is demoted shall be limited to service in the agency and shall consist of the combined total of his prior seniority in the class to which demotion occurs, in all higher classes, and in all other classes that the Supervisor determines to be sufficiently similar to the class to which demotion occurs.

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5. Any permanent or probationary employee about to be laid off shall be demoted to displace any employee with less seniority in the next lower class in which he previously served unless he elects to be laid off. In either event the name of such employee shall be placed on an appropriate layoff list and upon his written application may be placed on an appropriate reemployment list.

6. An appointing authority, with the consent of the affected employee, in lieu of layoff, may demote a permanent or probationary employee not covered by the preceding provision. Such action shall not entitle the employee to a hearing, in the demotion, but his name shall be placed on the layoff list and upon request may be placed on the reemployment list for the class from which he was demoted. No employees so demoted shall displace a permanent or probationary employee except in order of seniority.

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12 MCAR S 2.503 Separation, tenure and reinstatement.

A. Resignations.

1. An employee who resigns shall present the reasons therefor in writing to the appointing authority. A copy of the resignation shall be forwarded to and recorded by the supervisor.

2. Any absence of an employee from duty that is not authorized by specific grant of leave of absence under the provisions of these rules shall be deemed an absence without leave. Any such absence shall be without pay and may be made grounds for disciplinary action. In the absence of such disciplinary action, any employee who absents himself for three days without leave may be deemed to have resigned, but such absence may be covered by a subsequent grant of leave if the conditions warrant.

B. Dismissals.

1. Employees who do not have permanent status may be dismissed at any time at the discretion of the appointing authority except those serving the first 30 calendar days of a probationary period following a transfer. Employees serving the first 30 calendar days of a probationary period following a transfer can only be dismissed for just cause.

2. No employee who has permanent status shall be dismissed from a position except for just cause. Before the action is taken, a permanent employee shall be furnished with a statement, in writing, setting forth reasons for the dismissal. The employee shall be permitted five days time to reply thereto, in writing, or, upon request, to appear personally and reply to the appointing authority. A copy of the statement and the employee's reply, if any, shall be filed with the supervisor prior to the effective date of the dismissal. Any such employee who is dismissed may demand a hearing before the merit system council in the manner prescribed by 12 MCAR S 2.5081 D.

3. Any employee who willfully practices, or attempts to practice, any deception or fraud in his application, in his certificate, in his examination, or in obtaining his eligibility or appointment, shall upon discovery and proof thereof, be removed and discharged. Charges alleging such deception or fraud may be initiated by the appointing authority or by the supervisor, in conformity with the provisions of this section relating to notice of discharge and hearing before the merit system council.

C. Suspension. After written notice, the appointing authority may suspend any employee without pay for just cause for a period not to exceed 30 calendar days in any one calendar year. Suspensions of five or fewer consecutive working days or ten or fewer working days in a calendar year are not appealable to the council under 12 MCAR S 2.5081 D.

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D. Layoff.

1. An appointing authority may lay off an employee in the classified service by reason of abolishment of the position, lack of funds, shortage of work or other reason outside the control of the employee. No permanent employee, however, shall be laid off while any emergency, provisional, limited-term or probationary employee is continued in a position of the same class in the agency. Layoff shall be made in inverse order of seniority by employment conditions in the class of work in the agency. Seniority for purposes of layoff shall be the length of service in the class from which layoff occurs in the agency.

2. If two or more persons in the class in which layoff occurs have equal seniority, the order of layoff shall be in inverse order of the date of acquisition of permanent status in the class. If a tie still remains, the order of layoff shall be determined by the average of the last two service ratings, if available, or the last service rating if only one is available and the employee with the lowest such average or rating shall be laid off first. If no service ratings are available, the order of layoff shall be determined by the appointing authority in such a way as to retain in the agency the employee(s) considered most valuable.

3. Any permanent or probationary employee about to be laid off shall be demoted to replace the employee with the least seniority in the next lower class in which that employee previously served, unless the employee elects to be laid off.

4. The appointing authority shall notify in writing the employee and the supervisor at least ten working days before the effective date of the layoff and shall state the reason for the layoff. If the appointing authority fails to certify before the effective date thereof that the layoff was for reasons not reflecting discredit on the employee, it shall be deemed a dismissal and shall be subject to the rules regarding dismissal.

5. The names of permanent or probationary employees laid off or demoted in lieu of layoff shall be placed in order of seniority on the layoff list for the class and the agency from which the layoff took place. The affected employees shall have their names placed also on the reemployment list for the class from which the layoff took place and any other class in which they have permanent or probationary status prior to layoff.

6. Names of laid off employees will remain on the layoff list for a minimum of one year and eligibility shall be extended to a period of time equal to the employee's previous service in the merit system not to exceed five years.

7. Whenever an appointing authority submits a requisition to fill a vacancy for a new position in the agency and a layoff list exists for that agency for the class in which the position to be filled is classified, the one name highest on the layoff list shall be certified to the agency for appointment.

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8. The provisions of this rule shall apply to all layoffs, except where otherwise provided in written contract between an agency and an exclusive bargaining representative.

E. Tenure of office.

1. The tenure of office of every permanent employee shall be during good behavior and the satisfactory performance of his duties as recorded by his service ratings. This provision, however, shall not be interpreted to prevent the separation of an employee for cause or the separation of an employee because of lack of funds or curtailment of work or by retirement of the employee, when made in accordance with these rules.

F. Reinstatement of former permanent employee. Upon written request of an appointing authority to and with the approval of the supervisor, an employee who has successfully passed a merit examination and has acquired permanent status in a class under 12 MCAR SS 2.490-2.841 may be reinstated to a position in the same class at any time within two years after the date of his resignation in good standing. Under the same conditions, a reinstatement may be made within a period of time, not to exceed five years, equivalent to the continuous period of the employee's service since January 1, 1940, in a county welfare agency. Reinstatement shall be without benefit of previously acquired seniority. Upon approval of the supervisor, reinstatement may be made directly by an appointing authority, provided that there is a vacancy.

G. Reinstatement of former probationary employee. Upon written request of an appointing authority and with the approval of the supervisor, a probationary employee who has resigned in good standing may be reinstated as a probationary employee to a position in the same class at any time within a year after the date of resignation.

H. Retirement.

1. Any employee in the merit system who attains the age of 70 may be retired at the option of the appointing authority. For the purpose of these rules, the age of the employee shall be the age attained on his last birthday and shall be subject to verification.

I. Reemployment of former permanent or probationary employees.

1. Former permanent or probationary merit system employees who voluntarily separate in good standing with a satisfactory or better separation rating may, upon request, have their names placed on a reemployment list for their last class of employment and for any other classes in which they possessed permanent status prior to separation. Requests must include which classes, locations and employment conditions the former employee is willing to consider and must be submitted to the merit system within one year of separation. A person may remain

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on the reemployment list(s) for up to three years and must return to the merit system within four years of separation. Former employees reemployed under the provisions of this rule must serve a new probationary period upon appointment.

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12 MCAR S 2.504 Leaves of absence.

A. In general.

1. Leave policies stated in B. are minimum standards and shall apply to all employees except when otherwise negotiated by the appointing authority with an exclusive representative. At the discretion of the appointing authority, these negotiated benefits may be applied to all employees of the agency.

2. Beyond the minimum standards listed in B. the appointing authority may adopt an optional leave of absence policy to the extent allowed in C.

3. Agencies without an exclusive representative that adopt an optional leave policy beyond the minimum standards listed in B. shall file a copy with the supervisor.

B. Minimum policy.

1. Jury or witness duty.

a. After notice to the appointing authority, any employee under the merit system shall be granted leave with pay for service upon a jury or appearance before a court, legislative committee, or other judicial or quasi-judicial body as a witness in an action involving the Federal Government, state of Minnesota, or a political subdivision thereof, in response to a subpoena or other direction by proper authority.

b. At the option of the appointing authority the employee may be required to turn over to the agency any per diem payment received as a result of serving on a jury or as a witness as described in a. Moneys received as expenses shall be kept by the employee.

c. Any absence, whether voluntary or in response to a legal order to appear and testify in private litigation, not as an employee of the county agency but as an individual, shall be taken as annual leave, as leave of absence without pay, or as a deduction from authorized accumulated overtime.

2. Leaves of absence without pay. Any person holding a permanent or probationary position in the classified service of the Minnesota merit system shall be granted a leave of absence without pay on the grounds of sickness or disability and may be granted a leave of absence without pay for other good or sufficient reasons, provided that no such leave shall exceed one year. Disabilities caused or contributed to by pregnancy, miscarriage, abortion, childbirth, and recovery therefrom are, for all job-related purposes, temporary disabilities and the women so affected shall be treated the same as other persons who are not so affected, but who are similar in their ability or inability to work. The appointing authority shall establish the proof required of the existence of sickness or disability and

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the continuance thereof during that one-year period. The appointing authority may require that the employee produce medical certification from a registered practicing physician that the employee is fit for work before returning the employee to the job. Any employee who is granted a leave of absence without pay shall be accorded thereby an unqualified right to be reinstated to the same position if the leave is for 60 calendar days or less. An employee who is granted a leave of absence without pay shall be accorded thereby an unqualified right to be reinstated to a position in the same class at the expiration of leave, except that when all the positions in the class previously held by that employee have been abolished, the name of the employee shall be restored to the appropriate reemployment register provided for in 12 MCAR S 2.503 D.5. If all the positions in the class are filled, the least senior employee in the class shall vacate his or her position subject to any eligibility for layoff, transfer, or demotion that he or she may have acquired under these rules. An employee on leave of absence, with the approval of the appointing authority and the supervisor, may be reinstated to his or her class before the expiration of the leave in the same manner. Upon certification by a registered practicing physician, the employee who is physically or mentally capable of returning to work must comply within ten working days or face termination. If such an employee within the specified days cannot return to work, he or she must notify the appointing authority and request an approval for a leave of absence.

3. Vacation leave.

a. Upon the completion of six full months of satisfactory service in the merit system, vacation leave shall accrue to a permanent, probationary, or trainee employee for time served at the rate of one working day for each full month of service. No vacation leave shall be accrued or granted during the first six months of service in the merit system, but upon the satisfactory completion of such period, vacation leave shall accrue to a permanent, probationary, or trainee employee for the time served. Limited term and provisional employees with less than six full months of service and emergency employees shall not accrue vacation leave. Provisional employees with more than six months of service shall accrue vacation leave. Unused vacation leave shall accumulate to a total of at least 24 working days. The county agency shall determine the time at which vacation leave may be taken. Vacation leave may not be used prior to completion of the period in which it is accrued. Part time employees shall accrue vacation leave on a pro-rated basis based on hours worked in accordance with a schedule prepared by the appointing authority.

b. Vacation leave shall not accrue to an employee while in a non-pay status, except to employees on military leave.

c. A permanent employee who is transferred or promoted from one county agency to another shall be paid by the former agency for the number of working days of accrued but unused

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vacation leave unless the new agency, upon the request of the employee, agrees to accept all or a portion of the employee's accrued but unused vacation leave.

d. Any permanent, probationary, provisional, or trainee employee with six full months of satisfactory service in the merit system who is separated by layoff, resignation, death, or otherwise, shall be paid for the number of working days of unused vacation leave accrued to his credit.

4. Sick leave.

a. Every permanent, probationary, provisional, limited-term and trainee employee shall accrue sick leave at the rate of one working day for each completed month of service, and such accrued sick leave may be used under the conditions hereinafter prescribed:

Absence necessitated by an employee's inability to perform the duties of his or her position by reason of illness or injury, by necessity for medical or dental care, by reason of prenatal and postnatal care, by exposure to contagious disease under circumstances in which the health of the employees with whom associated or members of the public necessarily dealt with would be endangered by attendance on duty, or by illness in the employee's immediate family, for such period as shall be necessary. The term "immediate family" shall be limited to the employee's spouse, minor children, or parent living in the household of the employee when the parent has no other person to provide the necessary nursing care. Within the discretion of the appointing authority, use of sick leave also may be authorized in cases of death of the spouse, children, and wards of the employee and the brothers, sisters, parents, or grandparents of either the employee or the employee's spouse.

b. Unused sick leave shall accumulate to a total of at least 100 working days.

c. Sick leave with pay shall not accrue to emergency, hourly, or per diem employees.

d. Sick leave shall not accumulate to an employee while in a non-pay status, except employees on military leave.

e. Sick leave during vacation leave: When sickness occurs within a period of vacation leave, the period of illness may, on presentation of a report from a registered practicing physician, be charged as sick leave and the charge against vacation leave reduced accordingly.

f. The appointing authority may require the employee to produce medical certification from a registered practicing physician attesting to the need for sick leave or attesting that the employee is fit to return to work.

g. A former merit system employee who is reinstated or

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reemployed in accordance with merit system rules, except as a provisional or emergency appointee, may have previously accumulated and unused balance of sick leave revived and placed to the employee's credit upon approval of the new appointing authority.

h. A permanent or probationary employee who is transferred or promoted from one appointing authority to another may be granted credit in the new agency for all previously accrued but unused sick leave.

i. Sick leave may not be used prior to completion of the period in which it is accrued. Part-time employees shall accrue sick leave on a pro-rated basis based on hours worked in accordance with a schedule prepared by the appointing authority.

5. Military leave. Employees who are in service in the armed forces of the state or the United States shall be entitled to leave of absence as provided for by Minnesota Statutes, section 192.261.

6. Record of leaves. Each appointing authority shall maintain a record of leaves with pay granted to employees.

7. Holidays.

a. Full time permanent, probationary, provisional, limited-term, and trainee employees whose normally scheduled work day falls on a holiday listed below shall receive time off with pay. Compensatory time off shall be allowed for work done on these days except when payment is received. Emergency employees are not eligible for holiday pay. The following days are holidays:

New Year's Day--January 1

Lincoln's and Washington's Birthday--the third Monday in February

Memorial Day--the last Monday in May

Independence Day--July 4

Labor Day--the first Monday in September

Veteran's Day--November 11

Thanksgiving Day--the fourth Thursday in November

Christmas Day--December 25

Appointing authorities may designate one or both of the following as holidays:

Christopher Columbus Day--the second Monday in October

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Friday after Thanksgiving

b. When New Year's Day, Independence Day, Veteran's Day, or Christmas Day falls on Sunday, the following Monday shall be a holiday. When New Year's Day, Independence Day, Veteran's Day, or Christmas Day falls on Saturday the preceding Friday shall be a holiday.

c. Holidays which occur within the employee's vacation or sick leave period shall not be charged to the employee's vacation or sick leave time.

d. Employees must be on the payroll on the work day immediately preceding and the work day immediately following a holiday to be eligible for such holiday. For the purpose of determining eligibility for holiday pay, "on the payroll" means those who are in pay status.

e. Employees who work less than full-time or intermittent employees shall be compensated for holidays on a pro-rated basis in accordance with a schedule prepared by the appointing authority and approved by the supervisor.

C. Optional policy.

1. Beyond the minimum standards listed above, the appointing authority may adopt an optional leave of absence policy. The adoption of such a policy shall only be to increase the availability and use of leave of absences to employees.

2. Funeral leave.

a. Funeral leave, exclusive of sick leave or vacation leave, may be granted. Each appointing authority shall prepare written regulations governing such leave.

b. Funeral leave may be authorized in cases of death of the spouse, children, and wards and the brothers, sisters, parents, or grandparents of either the employee or his/her spouse.

3. Additional holidays may be designated, with or without pay, to conform with the county-wide policy.

4. Educational leave.

a. Educational leave, with or without pay, may be granted for a period not to exceed two years to any permanent or probationary employee. Such leave shall be for work-related programs which are in the best interest of the agency and consistent with the agency's training and staff development plan approved by the Department of Public Welfare Staff Development Director. Such leave shall otherwise be subject to A.3. The appointing authority may allow the employee to continue to accrue eligibility for merit increases, as in 12 MCAR S 2.494 G., and the merit increase may be granted at the same time the

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increase would have been granted, but for the leave of absence. Educational leave with pay shall be approved by the supervisor prior to authorization.

b. In an instance in which an appointing authority grants an educational leave of absence to the agency director in order that the director can pursue a course of academic study and when it does not appear feasible to fill the vacant position through a contract with a neighboring county or by employing a new director on a temporary basis during the period of leave, the appointing authority may elect to name one of its professional staff members as acting director for the period of leave, not to exceed two years. The professional staff member shall remain in his/her present class and serve as director only in an acting capacity; however if the appointing authority so elects, it can increase the salary of the person so named up to, but not to exceed, the maximum salary of his/her present class.

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12 MCAR § 2.505 Service ratings.

A. Establishment of service-rating system.

1. The Supervisor, in consultation with appointing authorities, shall establish and make effective a system of service ratings designed to give a fair evaluation of the quality of work performed by employees in the Merit System program. In so far as practicable, the system of service ratings in the county welfare boards shall be uniform. Such ratings shall be prepared and recorded for all permanent employees at regular intervals at least annually.

B. Use of service ratings.

1. Service ratings shall be considered in determining salary advancements and in making promotions, demotions, and dismissals, and in determining the order of separations due to reduction of force.

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12 MCAR § 2.506 Employee training.

A. 1. The Supervisor shall cooperate with appointing authorities, employees, and others in fostering and aiding in programs of pre-service training for the county welfare service and in-service training of employees, to the end that the quality of personnel services rendered to the counties may be raised and that employees may be aided to equip themselves for advancement in the service.

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12 MCAR § 2.507 Other employment.

A. 1. No employee shall hold other public office, except as provided in 12 MCAR § 2.491 F. 5., or have conflicting employment while in the employ of the appointing authority. Determination of conflicting employment shall be made by the appointing authority subject to the approval of the Commissioner of Public Welfare.

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MN SCAN new: aR026357

12 MCAR § 2.509 Inter-agency operations.

A. Payroll review.

1. The Commissioner of Public Welfare shall adopt a plan providing for the review by the Supervisor of the payrolls or certified listings of employees and current salaries. Such plans shall provide for a periodic review of the payrolls or certified listings of employees and current salaries for conformity with the provisions of these rules.

B. Records and reports.

1. The Supervisor shall establish and maintain service records for each employee, showing name and classification, organizational unit, salary, changes in status, service ratings, and such other personnel information as may be considered pertinent. Every recommendation for a temporary or permanent change in the status of an employee shall be submitted by the appointing authority to the Supervisor on forms prescribed by him.

C. Cooperation with merit system agencies.

1. The Supervisor, with the approval of the Commissioner of Public Welfare, may cooperate with other state, federal, or local merit system agencies operating in conformity with the standards comparable to those contained in these rules. With the approval of the Commissioner of Public Welfare, the Supervisor may announce and administer joint examinations in conformity with the standards of these rules, and the registers so established shall be given recognition under these rules. With the approval of the Commissioner of Public Welfare, the Supervisor may add to the end of the established eligible registers the names of persons who are on comparable registers of jurisdictions operating under standards similar to those set forth in these rules. With the same approval and under the same conditions, the Supervisor may recognize an appropriate register in another jurisdiction for the purpose of certification or approve the transfer or reinstatement of eligible employees from such recognized agencies to comparable positions in the Merit System. All persons appointed under this rule shall be required to serve a six-months probationary period.

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12 MCAR § 2.510 Miscellaneous.

A. Amendments.

1. If and when it appears desirable in the interest of good administration, the Commissioner of Public Welfare, with the advice and recommendations of the Council, may make additions to or amend the rules.

B. Effective date.

1. These rules shall supersede and replace previous rules adopted on August 1, 1941, with amendments. These rules shall become effective on the formal adoption by the Commissioner of the Department of Public Welfare, providing that those employees now in the county welfare service who have acquired status under previous rules shall be accorded like status under these rules and providing that existing eligible registers are recognized and retained in accordance with the provisions of these rules.

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2.517

12 MCAR S 2.517 Salary computation provisions for full and part-time employment, vacation and sick leave pay upon termination, partial pay periods, overtime pay and part payment from another source.

A. Pay periods. The length of pay periods is at the discretion of the appointing authority but it may be negotiated when there is an exclusive representative.

B. Full-time and part-time employment.

1. All rates prescribed in 12 MCAR SS 2.840 and 2.841 shall be standard rates for full-time employees except as otherwise negotiated for employees in a bargaining unit in agencies where there is an exclusive representative or under the provisions of 12 MCAR S 2.494 F.2.c. If employment in a position is on a part-time or intermittent basis, only the proportional part of the rate for the time actually employed shall be paid. Such time may be paid on an hourly, working day or proportion of a month basis. The agencies using 12 MCAR S 2.840 shall use the table prepared in accordance with 12 MCAR S 2.841 in computing such payment.

2. Those agencies with an exclusive representative who negotiate different salary schedules from those shown in 12 MCAR S 2.840 under the provisions of 1. or those agencies operating under the provisions of 12 MCAR S 2.494 F.2.c. shall file within ten days after the signing of the contract such schedules with the supervisor. Attached thereto, shall be a table similar in format, computation, and information to the table provided for in 12 MCAR S 2.841. The table shall show monthly rates with appropriate conversion to hourly rates and to daily rates based on the number of working days and paid holidays in the month, and payment by payroll period for full-time work if such payment is made on other than a monthly basis.

C. Payment for less than a full payroll period. The amount of salary paid for a period less than a full payroll period to an employee shall be determined on the basis of the number of hours or days the employee worked in the payroll period. Agencies shall use the table provided for in 12 MCAR S 2.841 in computing this salary. Those agencies with an exclusive representative who have negotiated different salary schedules and those agencies operating under the provisions of 12 MCAR S 2.494 F.2.c. shall use their table prepared in accordance with 12 MCAR S 2.841 in computing this salary.

D. Part payment from another source. When part of the compensation of a county welfare or human service employee regularly is paid from another source, such as federal, state, city or county governmental departments, or from a different fund or account outside the control of the appointing authority, the total salary from all governmental sources combined shall not exceed the amount payable at the maximum rate for the class of position involved on the compensation plan adopted by the

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agency.

E. Compensation for vacation or sick leave or both upon separation.

1. An employee, who has permanent status in the county agency in some class, who is separated from the agency shall be paid for accumulated, unused vacation leave in accordance with 12 MCAR S 2.504 B.3.d. on the basis of the appropriate daily or hourly rate as shown on the table prepared in accordance with 12 MCAR S 2.841. This is illustrated by the following examples:

An employee who earns $844 a month and is paid $388 on a bi-weekly payroll ($38.80 daily rate) works 8 days in the payroll period and terminates her employment. She has 11 days of vacation accumulated. Daily rate of $38.80 X 19 days (8 regular working days plus 11 days of vacation) = $737.20.

An employee who earns $844 a month and is paid on a monthly basis works 8 days in the month which has 22 working days in it and terminates her employment. She has 11 days of vacation accumulated. Daily rates of $38.36 (for 22 day month) X 19 days (8 regular working days plus 11 days of vacation) = $727.70.

2. The amount of vacation pay due shall be added to the salary earned by the employee for time worked in the last pay period of his/her employment and made in the form of a single lump sum payment.

3. Compensation for sick leave payment, in cases where such payment is made on termination, shall be in the same manner as for vacation leave under 12 MCAR S 2.517 E.2.

F. Overtime compensation.

1. Except for the provisions of the Minnesota Fair Labor Standards Act, no additional compensation shall be paid for overtime, whether in the discharge of duties of the position or for the duties of another position, except in: (1) an emergency in which the appointing authority orders such overtime; or (2) when such overtime is otherwise approved in advance by the appointing authority or its designee; or (3) as may be otherwise negotiated. Rates of pay for this overtime work shall be decided by the appointing authority and it shall be discretionary with the appointing authority, whether the employee shall have compensatory time off or overtime pay, except as provided in the Minnesota Fair Labor Standards Act and/or as modified through contractual agreement in those agencies where employees have an exclusive representative. When payment is made for overtime, the rate and the number of hours worked shall be shown in the "remarks" column on the payroll report.

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2.518

12 MCAR S 2.518 Appointment, promotions, demotions, transfers, and reinstatements.

A. Appointment.

1. The entrance salary for the original appointment, provisional appointment, or emergency appointment of a new employee shall be at the minimum salary for the class of positions to which he is appointed, except when appointments are permitted above the minimum in accordance with 12 MCAR S 2.494 E.

2. An employee who is provisionally employed at a rate of pay higher than the minimum of the range prescribed for the class shall not be reduced in pay at the time of appointment from a register to the class.

B. Promotions.

1. An employee who is promoted shall have his or her salary raised to the minimum rate of pay for the new class. If his or her salary before promotion falls within the range of the new class but not on any step within that range, the salary shall be adjusted to the next higher step.

2. An employee granted a salary increase after having been promoted may be permitted to retain that increase when returned to a lower class, if the salary paid does not exceed the maximum salary for the lower class.

C. Demotions. An employee who is demoted except in accordance with 12 MCAR S 2.493 D. and whose salary is above the maximum rate for the lower class shall be reduced in salary to at least the maximum rate for the new class. If the former salary is within the salary range for the lower class, the same salary may be continued. An employee whose position is reclassified downward in accordance with 12 MCAR S 2.493 D. and remains in the same position may retain his or her former salary if it is above the maximum salary rate for the lower class but shall be ineligible to receive any further increases except those subsequently provided in the new classification.

D. Transfers. An employee who is transferred may be paid the same salary that he received prior to transfer. If an employee's salary prior to transfer falls within the salary range of the class to which the employee is transferring but not on a salary step in that range, the employee's salary may be increased to the next higher step in the range but it shall not be lowered.

E. Reinstatements. A former employee who is reinstated or reemployed may be paid the same salary rate that he last received in the same class of position if it coincides with a step on the current salary range for the class, or if it does not coincide, at the next higher step.

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12 MCAR § 2.519 County regulations.

A. 1. Any variation from the compensation plan adopted by the county welfare board shall be in accordance with the provisions of the Merit System Rules (see 12 MCAR § 2.494 B.).

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SUB-CHAPTER D - COMPENSATION PLAN

12 MCAR § 2.840 Compensation plan; Public Welfare - 1982

A. Professional

1. Plan A. The following salary steps in monthly salary amounts shall be applicable to the specified classes of positions. The salary steps shall not include any amounts paid by any county welfare board under Minnesota Statutes, section 471.61.

	1	2	3	4	5	6	7	8	9	10
Adm. Asst. I	1583	1656	1734	1814	1894	1982	2068	2163	2264	2366
Adm. Asst. II	1734	1814	1894	1982	2068	2163	2264	2366	2475	2584
Adm. Asst. III	2026	2117	2213	2316	2421	2532	2645	2770	2897	
Adm. Services Director	2117	2213	2316	2421	2532	2645	2770	2897	3028	
Adult Day Care Center Supvr.	1299	1358	1420	1485	1549	1620	1696	1777	1854	1939
Asst. Human Services Director	2117	2213	2316	2421	2532	2645	2770	2897	3028	
Asst. Welfare Director	2645	2770	2897	3028	3161	3299	3443	3600	3763	
Assoc. M.-&-P. Analyst	1241	1299	1358	1420						
Auditor	1549	1620	1696	1777	1854	1939	2026	2117	2213	2316
Center Coordinator	1420	1485	1549	1620	1696	1777	1854	1939	2026	2117
Chemical Dependency Coord.	1420	1485	1549	1620	1696	1777	1854	1939	2026	2117
Collection Services Supvr. II	1516	1583	1656	1734	1814	1894	1982	2068	2163	2264
Community-Health Serv. Supvr.	1583	1656	1734	1814	1894	1982	2068	2163	2264	2366
Community-Rela. Spec.	1620	1696	1777	1854	1939	2026	2117	2213	2316	

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Computer Programmer	1241	1299	1358	1420	1485	1549	1620			
Day Care Center Supvr.	1583	1656	1734	1814	1894	1982	2068	2163	2264	
Dev. Achievement Center Dir.	1299	1358	1420	1485	1549	1620	1696	1777	1854	1939
Dev. Achievement Center Teacher	1187	1241	1299	1358	1420	1485	1549	1620	1696	1777
Dev. Disabilities Coord.	1299	1358	1420	1485	1549	1620	1696	1777	1854	1939
Dietitian	1241	1299	1358	1420	1485	1549	1620	1696	1777	
Dir. Of Business Mgmt. I	1894	1982	2068	2163	2264	2366	2475	2584		
Dir. Of Business Mgmt. II	2316	2421	2532	2645	2770	2897	3028	3161	3299	
Dir. of Financial Asst.	2117	2213	2316	2421	2532	2645	2770	2897	3028	
Dir. of Planning	2117	2213	2316	2421	2532	2645	2770	2897	3028	
Dir. of Pub. Hlth. Nurs. I	1549	1620	1696	1777	1854	1939	2026	2117	2213	
Dir. of Soc. Services	2117	2213	2316	2421	2532	2645	2770	2897	3028	
Dir. of Support Services	2117	2213	2316	2421	2532	2645	2770	2897	3028	
Education Supervisor	1485	1549	1620	1696	1777	1854	1939	2026	2117	
Emp. Guid. Couns. I	1187	1241	1299	1358	1420	1485	1549	1620	1696	
Emp. Guid. Couns. II	1241	1299	1358	1420	1485	1549	1620	1696	1777	
Emp. Guid. Couns. III	1299	1358	1420	1485	1549	1620	1696	1777	1854	
Family Serv Coord. II	1358	1420	1485	1549	1620	1696	1777	1854		

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Finan. Asst. Supvr. III	1583	1656	1734	1814	1894	1982	2068	2163	2264	2366
Finan. Asst. Supvr. IV	1734	1814	1894	1982	2068	2163	2264	2366	2475	2584
Fiscal Supervisor III	1485	1549	1620	1696	1777	1854	1939	2026	2117	
Fiscal Supervisor IV	1696	1777	1854	1939	2026	2117	2213	2316	2421	2532
Home Care Coordinator	1358	1420	1485	1549	1620	1696	1777	1854		
Homemaker Supervisor	1485	1549	1620	1696	1777	1854	1939	2026	2117	
Human Services Dir. I	1894	1982	2068	2163	2264	2366	2475	2584	2708	2831
Human Services Dir. II	2213	2316	2421	2532	2645	2770	2897	3028	3161	
Human Services Dir. III	2421	2532	2645	2770	2897	3028	3161	3299	3443	
Human Services Supvr. I	1583	1656	1734	1814	1894	1982	2068	2163	2264	2366
Marriage Counselor	1549	1620	1696	1777	1854	1939	2026	2117	2213	
Med.-Care Advisor	1299	1358	1420	1485	1549	1620	1696	1777	1854	
Med.-Serv. Adm.	2117	2213	2316	2421	2532	2645	2770	2897		
Mental Health Worker	1420	1485	1549	1620	1696	1777	1854	1939	2026	2117
Meth.-&-Proc. Analyst	1452	1516	1583	1656	1734	1814	1894	1982	2068	
Meth.-&Proc. Supvr.	1696	1777	1854	1939	2026	2117	2213	2316	2421	
Nursing Care Advisor	1299	1358	1420	1485	1549	1620	1696	1777	1854	
Nutrition Proj. Asst. Dir.	1187	1241	1299	1358	1420	1485	1549	1620	1696	1777
Nutrition Proj. Dir.	1583	1656	1734	1814	1894	1982	2068	2163	2264	2366

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Occupa. Supvr. Inst. I	1136	1187	1241	1299	1358	1420	1485	1549	1620	1696
Occupa. Supvr. Inst. II	1299	1358	1420	1485	1549	1620	1696	1777	1854	1939
Office Manager	1187	1241	1299	1358	1420	1485	1549	1620	1696	
Personnel Officer	1187	1241	1299	1358	1420	1485	1549	1620	1696	1777
Personnel Director	1656	1734	1814	1894	1982	2068	2163	2264	2366	2475
Physical Therapist	1212	1269	1327	1387	1452	1516	1583	1656		
Planner (Human Services)	1485	1549	1620	1696	1777	1854	1939	2026	2117	
Policy/Program Analyst	1656	1734	1814	1894	1982	2068	2163	2264	2366	2475
Programmer Analyst	1485	1549	1620	1696	1777	1854	1939	2026		
Psychologist I	1420	1485	1549	1620	1696	1777	1854	1939	2026	
Psychologist II	1696	1777	1854	1939	2026	2117	2213	2316	2421	
Psychologist III	1982	2068	2163	2264	2366	2475	2584	2708		
Psychologist IV	2163	2264	2366	2475	2584	2708	2831	2961		
Pub. Health Educator I	1241	1299	1358	1420	1485	1549	1620	1696		
Pub. Health Educator II	1549	1620	1696	1777	1854	1939	2026	2117		
Public Health Nurse	1299	1358	1420	1485	1549	1620	1696			
Pub. Hlth. Nurse (TeamLeader)	1358	1420	1485	1549	1620	1696	1777			
Registered Nurse (A.A. Deg., 3 yr. Dip., or B.S. Deg.)	1241	1299	1358	1420	1485	1549				

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Sanitarian I	1241	1299	1358	1420	1485					
Sanitarian II	1358	1420	1485	1549	1620	1696	1777	1854		
Sr. Pub. Health Nurse	1420	1485	1549	1620	1696	1777	1854			
Social Worker I	1187	1241	1299	1358	1420	1485	1549	1620	1696	1777
Social Worker II	1299	1358	1420	1485	1549	1620	1696	1777	1854	1939
Social Worker III	1420	1485	1549	1620	1696	1777	1854	1939	2026	2117
Social Worker Trainee	1084									
Soc. Serv. Supvr. I	1583	1656	1734	1814	1894	1982	2068	2163	2264	2366
Soc. Serv. Supvr. II	1734	1814	1894	1982	2068	2163	2264	2366	2475	2584
Soc. Welf. Supvr. III	2026	2117	2213	2316	2421	2532	2645	2770	2897	
Soc. Welf. Supvr. Trainee	1516	1583	1656	1734	1814	1894				
Staff Trng. Supvr. I	1620	1696	1777	1854	1939	2026	2117	2213	2316	
Staff Trng. Supvr. II	1777	1854	1939	2026	2117	2213	2316	2421	2532	
Student Soc. Worker (Intern)	Rate proposed by appointing authority.									
Student Soc. Worker (SWEP)	Rate proposed by appointing authority.									
Systems Prog.-Analyst	1696	1777	1854	1939	2026	2117	2213	2316		
Trainee	Rate proposed by appointing authority and approved by the merit system supervisor and the Commissioner of Public Welfare.									
Vol.-Serv. Coord. I	1187	1241	1299	1358	1420	1485	1549	1620	1696	1777
Vol.-Serv. Coord. II	1485	1549	1620	1696	1777	1854	1939	2026	2117	

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Welfare Director I	1814	1894	1982	2068	2163	2264	2366	2475	2584	2708
Welfare Director II	1982	2068	2163	2264	2366	2475	2584	2708	2831	2961
Welfare Director III	2213	2316	2421	2532	2645	2770	2897	3028	3161	
Welfare Director IV	2421	2532	2645	2770	2897	3028	3161	3299	3443	
Welfare Director V	3299	3443	3600	3763	3932	4108	4302	4486	4795	
Work-Exp. & Trng. Spec.	1485	1549	1620	1696	1777	1854	1939	2026	2117	

2. Plan B. The following salary steps in monthly salary amounts shall be applicable to the specified classes of positions. The salary steps shall not include any amounts paid by any county welfare board under Minnesota Statutes, section 471.61.

	1	2	3	4	5	6	7	8	9	10
Adm. Asst. I	1656	1734	1814	1894	1982	2068	2163	2264	2366	2475
Adm. Asst. II	1814	1894	1982	2068	2163	2264	2366	2475	2584	2708
Adm. Asst. III	2117	2213	2316	2421	2532	2645	2770	2897	3028	
Adm. Services Director	2213	2316	2421	2532	2645	2770	2897	3028	3161	
Adult Day Care Center Supvr.	1358	1420	1485	1549	1620	1696	1777	1854	1939	2026
Asst. Human Services Director	2117	2213	2316	2421	2532	2645	2770	2897	3028	
Asst. Welfare Director	2645	2770	2897	3028	3161	3299	3443	3600	3763	
Assoc. M.-&-P. Analyst	1299	1358	1420	1485						
Auditor	1620	1696	1777	1854	1939	2026	2117	2213	2316	2421
Center Coordinator	1485	1549	1620	1696	1777	1854	1939	2026	2117	2213
Chemical Dependency Coord.	1485	1549	1620	1696	1777	1854	1939	2026	2117	2213

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Collections Services Supvr. II	1583	1656	1734	1814	1894	1982	2068	2163	2264	2366
Community-Health Serv. Supvr.	1656	1734	1814	1894	1982	2068	2163	2264	2366	2475
Community Rela. Spec.	1696	1777	1854	1939	2026	2117	2213	2316	2421	
Computer Programmer	1299	1358	1420	1485	1549	1620	1696			
Day Care Center Supvr.	1656	1734	1814	1894	1982	2068	2163	2264	2366	
Dev. Achievement Center Dir.	1358	1420	1485	1549	1620	1696	1777	1854	1939	2026
Dev. Achievement Center Teacher	1241	1299	1358	1420	1485	1549	1620	1696	1777	1854
Dev. Disabilities Coord.	1358	1420	1485	1549	1620	1696	1777	1854	1939	2026
Dietitian	1299	1358	1420	1485	1549	1620	1696	1777	1854	
Dir. of Business Mgmt. I	1894	1982	2068	2163	2264	2366	2475	2584		
Dir. of Business Mgmt. II	2316	2421	2532	2645	2770	2897	3028	3161	3299	
Dir. of Financial Asst.	2213	2316	2421	2532	2645	2770	2897	3028	3161	
Dir. of Planning	2213	2316	2421	2532	2645	2770	2897	3028	3161	
Dir. of Pub. Hlth. Nurs. I	1620	1696	1777	1854	1939	2026	2117	2213	2316	
Dir. of Soc. Services	2213	2316	2421	2532	2645	2770	2897	3028	3161	
Dir. of Support Services	2213	2316	2421	2532	2645	2770	2897	3028	3161	
Education Supervisor	1549	1620	1696	1777	1854	1939	2026	2117	2213	
Emp. Guid.	1241	1299	1358	1420	1485	1549	1620	1696	1777	

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Couns. I										
Emp. Guid. Couns. II	1299	1358	1420	1485	1549	1620	1696	1777	1854	
Emp. Guid. Couns. III	1358	1420	1485	1549	1620	1696	1777	1854	1939	
Family Service Coord. II	1420	1485	1549	1620	1696	1777	1854	1939		
Finan. Asst. Supvr. III	1656	1734	1814	1894	1982	2068	2163	2264	2366	2475
Finan. Asst. Supvr. IV	1814	1894	1982	2068	2163	2264	2366	2475	2584	2708
Fiscal Supervisor III	1485	1549	1620	1696	1777	1854	1939	2026	2117	
Fiscal Supervisor IV	1696	1777	1854	1939	2026	2117	2213	2316	2421	2532
Home Care Coordinator	1420	1485	1549	1620	1696	1777	1854	1939		
Homemaker Supervisor	1549	1620	1696	1777	1854	1939	2026	2117	2213	
Human Services Dir. I	1894	1982	2068	2163	2264	2366	2475	2584	2708	2831
Human Services Dir. II	2213	2316	2421	2532	2645	2770	2897	3028	3161	
Human Services Dir. III	2421	2532	2645	2770	2897	3028	3161	3299	3443	
Human Services Supvr. I	1656	1734	1814	1894	1982	2068	2163	2264	2366	2475
Marriage Counselor	1620	1696	1777	1854	1939	2026	2117	2213	2316	
Med.-Care Advisor	1358	1420	1485	1549	1620	1696	1777	1854	1939	
Med.-Serv. Adm.	2213	2316	2421	2532	2645	2770	2897	3028		
Mental Health Worker	1485	1549	1620	1696	1777	1854	1939	2026	2117	2213
Meth.-&-Proc. Analyst	1516	1583	1656	1734	1814	1894	1982	2068	2163	
Meth.-&-Proc.	1777	1854	1939	2026	2117	2213	2316	2421	2532	

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Supvr.										
Nursing Care Advisor	1358	1420	1485	1549	1620	1696	1777	1854	1939	
Nutrition Proj. Asst. Dir.	1241	1299	1358	1420	1485	1549	1620	1696	1777	1854
Nutrition Proj. Dir.	1656	1734	1814	1894	1982	2068	2163	2264	2366	2475
Occupa. Supvr. Inst. I	1187	1241	1299	1358	1420	1485	1549	1620	1696	1777
Occupa. Supvr. Inst. II	1358	1420	1485	1549	1620	1696	1777	1854	1939	2026
Office Manager	1241	1299	1358	1420	1485	1549	1620	1696	1777	
Personnel Officer	1241	1299	1358	1420	1485	1549	1620	1696	1777	1854
Personnel Director	1734	1814	1894	1982	2068	2163	2264	2366	2475	2584
Physical Therapist	1269	1327	1387	1452	1516	1583	1656	1734		
Planner (Human Services)	1549	1620	1696	1777	1854	1939	2026	2117	2213	
Policy/Program Analyst	1734	1814	1894	1982	2068	2163	2264	2366	2475	2584
Programmer Analyst	1549	1620	1696	1777	1854	1939	2026	2117		
Psychologist I	1485	1549	1620	1696	1777	1854	1939	2026	2117	
Psychologist II	1777	1854	1939	2026	2117	2213	2316	2421	2532	
Psychologist III	2068	2163	2264	2366	2475	2584	2708	2831		
Psychologist IV	2264	2366	2475	2584	2708	2831	2961	3091		
Pub. Health Educator I	1299	1358	1420	1485	1549	1620	1696	1777		
Pub. Health Educator II	1620	1696	1777	1854	1939	2026	2117	2213		
Public Health	1358	1420	1485	1549	1620	1696	1777			

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Nurse										
Pub. Hlth. Nurse (Team Leader)	1420	1485	1549	1620	1696	1777	1854			
Registered Nurse (A.A. Deg., 3 yr. Dip., or B.S. Deg.)	1299	1358	1420	1485	1549	1620				
Sanitarian I	1299	1358	1420	1485	1549					
Sanitarian II	1420	1485	1549	1620	1696	1777	1854	1939		
Sr. Pub. Health Nurse	1485	1549	1620	1696	1777	1854	1939			
Social Worker I	1241	1299	1358	1420	1485	1549	1620	1696	1777	1854
Social Worker II	1358	1420	1485	1549	1620	1696	1777	1854	1939	2026
Social Worker III	1485	1549	1620	1696	1777	1854	1939	2026	2117	2213
Social Worker Trainee	1084									
Soc. Serv. Supvr. I	1656	1734	1814	1894	1982	2068	2163	2264	2366	2475
Soc. Serv. Supvr. II	1814	1894	1982	2068	2163	2264	2366	2475	2584	2708
Soc. Welf. Supvr. III	2117	2213	2316	2421	2532	2645	2770	2897	3028	
Soc. Welf. Supvr. Trainee	1583	1656	1734	1814	1894	1982				
Staff Trng. Supvr. I	1696	1777	1854	1939	2026	2117	2213	2316	2421	
Staff Trng. Supvr. II	1854	1939	2026	2117	2213	2316	2421	2532	2645	
Student Soc. Worker (Intern)	Rate proposed by appointing authority.									
Student Soc. Worker (SWEP)	Rate proposed by appointing authority.									
Systems Prog.-	1777	1854	1939	2026	2117	2213	2316	2421		

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Analyst Trainee	Rate proposed by appointing authority and approved by the merit system supervisor and the Commissioner of Public Welfare.									
Vol.-Serv. Coord. I	1241	1299	1358	1420	1485	1549	1620	1696	1777	1854
Vol.-Serv. Coord. II	1549	1620	1696	1777	1854	1939	2026	2117	2213	
Welfare Director I	1814	1894	1982	2068	2163	2264	2366	2475	2584	2708
Welfare Director II	1982	2068	2163	2264	2366	2475	2584	2708	2831	2961
Welfare Director III	2213	2316	2421	2532	2645	2770	2897	3028	3161	
Welfare Director IV	2421	2532	2645	2770	2897	3028	3161	3299	3443	
Welfare Director V	3299	3443	3600	3763	3932	4108	4302	4486	4795	
Work-Exp. & Trng. Spec.	1549	1620	1696	1777	1854	1939	2026	2117	2213	

3. Plan C. The following salary steps in monthly salary amounts shall be applicable to the specified classes of positions. The salary steps shall not include any amounts paid by any county welfare board under Minnesota Statutes, section 471.61.

	1	2	3	4	5	6	7	8	9	10
Adm. Asst. I	1734	1814	1894	1982	2068	2163	2264	2366	2475	2584
Adm. Asst. II	1894	1982	2068	2163	2264	2366	2475	2584	2708	2831
Adm. Asst. III	2213	2316	2421	2532	2645	2770	2897	3028	3161	
Adm. Services Director	2316	2421	2532	2645	2770	2897	3028	3161	3299	
Adult Day Care Center Supvr.	1420	1485	1549	1620	1696	1777	1854	1939	2026	2117
Asst. Human Services Director	2117	2213	2316	2421	2532	2645	2770	2897	3028	
Asst. Welfare	2645	2770	2897	3028	3161	3299	3443	3600	3763	

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Director										
Assoc. M.-&-P. Analyst	1358	1420	1485	1549						
Auditor	1696	1777	1854	1939	2026	2117	2213	2316	2421	2532
Center Coordinator	1549	1620	1696	1777	1854	1939	2026	2117	2213	2316
Chemical Dependency Coord.	1549	1620	1696	1777	1854	1939	2026	2117	2213	2316
Collections Services Supvr. II	1656	1734	1814	1894	1982	2068	2163	2264	2366	2475
Community-Health Serv. Supvr.	1734	1814	1894	1982	2068	2163	2264	2366	2475	2584
Community-Rela. Spec.	1777	1854	1939	2026	2117	2213	2316	2421	2532	
Computer Programmer	1358	1420	1485	1549	1620	1696	1777			
Day Care Center Supvr.	1734	1814	1894	1982	2068	2163	2264	2366	2475	
Dev. Achievement Center Dir.	1420	1485	1549	1620	1696	1777	1854	1939	2026	2117
Dev. Achievement Center Teacher	1299	1358	1420	1485	1549	1620	1696	1777	1854	1939
Dev. Disabilities Coord.	1420	1485	1549	1620	1696	1777	1854	1939	2026	2117
Dietitian	1358	1420	1485	1549	1620	1696	1777	1854	1939	
Dir. of Business Mgmt. I	1894	1982	2068	2163	2264	2366	2475	2584		
Dir. of Business Mgmt. II	2316	2421	2532	2645	2770	2897	3028	3161	3299	
Dir. of Financial Asst.	2316	2421	2532	2645	2770	2897	3028	3161	3299	
Dir. of Planning	2316	2421	2532	2645	2770	2897	3028	3161	3299	

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Dir. of Pub. Hlth. Nurs. I	1696	1777	1854	1939	2026	2117	2213	2316	2421	
Dir. of Soc. Serv.	2316	2421	2532	2645	2770	2897	3028	3161	3299	
Dir. of Support Services	2316	2421	2532	2645	2770	2897	3028	3161	3299	
Education Supervisor	1620	1696	1777	1854	1939	2026	2117	2213	2316	
Emp. Guid. Couns. I	1299	1358	1420	1485	1549	1620	1696	1777	1854	
Emp. Guid. Couns. II	1358	1420	1485	1549	1620	1696	1777	1854	1939	
Emp. Guid. Couns. III	1420	1485	1549	1620	1696	1777	1854	1939	2026	
Family Serv. Coord. II	1485	1549	1620	1696	1777	1854	1939	2026		
Finan. Asst. Supvr. III	1734	1814	1894	1982	2068	2163	2264	2366	2475	2584
Finan. Asst. Supvr. IV.	1894	1982	2068	2163	2264	2366	2475	2584	2708	2831
Fiscal Supervisor III	1485	1549	1620	1696	1777	1854	1939	2026	2117	
Fiscal Supervisor IV	1696	1777	1854	1939	2026	2117	2213	2316	2421	2532
Home Care Coordinator	1485	1549	1620	1696	1777	1854	1939	2026		
Homemaker Supervisor	1620	1696	1777	1854	1939	2026	2117	2213	2316	
Human Services Dir. I	1894	1982	2068	2163	2264	2366	2475	2584	2708	2831
Human Services Dir. II	2213	2316	2421	2532	2645	2770	2897	3028	3161	
Human Services Dir. III	2421	2532	2645	2770	2897	3028	3161	3299	3443	
Human Services Supvr. I	1734	1814	1894	1982	2068	2163	2264	2366	2475	2584
Marriage	1696	1777	1854	1939	2026	2117	2213	2316	2421	

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Counselor										
Med.-Care Advisor	1420	1485	1549	1620	1696	1777	1854	1939	2026	
Med.-Serv. Adm.	2316	2421	2532	2645	2770	2897	3028	3161		
Mental Health Worker	1549	1620	1696	1777	1854	1939	2026	2117	2213	2316
Meth.-&-Proc. Analyst	1583	1656	1734	1814	1894	1982	2068	2163	2264	
Meth.-&-Proc. Supr.	1854	1939	2026	2117	2213	2316	2421	2532	2645	
Nursing Care Advisor	1420	1485	1549	1620	1696	1777	1854	1939	2026	
Nutrition Proj. Asst. Dir.	1299	1358	1420	1485	1549	1620	1696	1777	1854	1939
Nutrition Proj. Dir.	1734	1814	1894	1982	2068	2163	2264	2366	2475	2584
Occupa. Supvr. Inst. I.	1241	1299	1358	1420	1485	1549	1620	1696	1777	1854
Occupa. Supvr. Inst. II.	1420	1485	1549	1620	1696	1777	1854	1939	2026	2117
Office Manager	1299	1358	1420	1485	1549	1620	1696	1777	1854	
Personnel Officer	1299	1358	1420	1485	1549	1620	1696	1777	1854	1939
Personnel Director	1814	1894	1982	2068	2163	2264	2366	2475	2584	2708
Physical Therapist	1358	1420	1485	1549	1620	1696	1777	1854		
Planner (Human Services)	1620	1696	1777	1854	1939	2026	2117	2213	2316	
Policy/Program Analyst	1814	1894	1982	2068	2163	2264	2366	2475	2584	2708
Programmer Analyst	1620	1696	1777	1854	1939	2026	2117	2213		
Psychologist I	1549	1620	1696	1777	1854	1939	2026	2117	2213	
Psychologist	1854	1939	2026	2117	2213	2316	2421	2532	2645	

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II										
Psychologist III	2163	2264	2366	2475	2584	2708	2831	2961		
Psychologist IV	2366	2475	2584	2708	2831	2961	3091	3228		
Pub. Health Educator I	1358	1420	1485	1549	1620	1696	1777	1854		
Pub. Health Educator II	1696	1777	1854	1939	2026	2117	2213	2316		
Public Health Nurse	1452	1516	1583	1656	1734	1814	1894			
Pub. Hlth. Nurse (Team Leader)	1516	1583	1656	1734	1814	1894	1982			
Registered Nurse (A.A. Deg., 3 yr. Dip., or B.S. Deg.)	1387	1452	1516	1583	1656	1734				
Sanitarian I	1358	1420	1485	1549	1620					
Sanitarian II	1485	1549	1620	1696	1777	1854	1939	2026		
Sr. Pub. Health Nurse	1583	1656	1734	1814	1894	1982	2068			
Social Worker I	1299	1358	1420	1485	1549	1620	1696	1777	1854	1939
Social Worker II	1420	1485	1549	1620	1696	1777	1854	1939	2026	2117
Social Worker III	1549	1620	1696	1777	1854	1939	2026	2117	2213	2316
Social Worker Trainee	1084									
Soc. Serv. Supvr. I	1734	1814	1894	1982	2068	2163	2264	2366	2475	2584
Soc. Serv. Supvr. II	1894	1982	2068	2163	2264	2366	2475	2584	2708	2831
Soc. Welf. Supvr. III	2213	2316	2421	2532	2645	2770	2897	3028	3161	
Soc. Welf.	1656	1734	1814	1894	1982	2068				

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Supvr. Trainee									
Staff Trng. Supvr. I	1777	1854	1939	2026	2117	2213	2316	2421	2532
Staff Trng. Supvr. II	1939	2026	2117	2213	2316	2421	2532	2645	2770
Student Soc. Worker (Intern)	Rate proposed by appointing authority.								
Student Soc. Worker (SWEP)	Rate proposed by appointing authority.								
Systems Prog. Analyst	1854	1939	2026	2117	2213	2316	2421	2532	
Trainee	Rate proposed by appointing authority and approved by the merit system supervisor and the Commissioner of Public Welfare.								
Vol.-Serv. Coord. I	1299	1358	1420	1485	1549	1620	1696	1777	1854	1939
Vol.-Serv. Coord. II	1620	1696	1777	1854	1939	2026	2117	2213	2316	
Welfare Director I	1814	1894	1982	2068	2163	2264	2366	2475	2584	2708
Welfare Director II	1982	2068	2163	2264	2366	2475	2584	2708	2831	2961
Welfare Director III	2213	2316	2421	2532	2645	2770	2897	3028	3161	
Welfare Director IV	2421	2532	2645	2770	2897	3028	3161	3299	3443	
Welfare Director V	3299	3443	3600	3763	3932	4108	4302	4486	4795	
Work;-Exp. & Trng. Spec.	1620	1696	1777	1854	1939	2026	2117	2213	2316	

B. Support personnel

1. Plan A. The following salary steps in monthly salary amounts shall be applicable to the specified classes of positions. The salary steps shall not include any amounts paid by any county welfare board under Minnesota Statutes, section 471.61.

	1	2	3	4	5	6	7	8	9
Account Clerk	869	908	950	995	1039	1084	1136	1187	

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Accounting Technician	929	973	1017	1063	1109	1161	1212	1269	
Adult Day Care Center Prog. Coord.	887	929	973	1017	1063	1109	1161	1212	1269
Asst. Residential Facility Opr.(s)	712	741	777	813	849	887	929	973	
Case Aide	887	929	973	1017	1063	1109	1161	1212	1269
Chemical Dependency Counselor	1136	1187	1241	1299	1358	1420	1485		
Child Health Aide	777	813	849	887	929	973	1017	1063	
Child Support Officer I	1084	1136	1187	1241	1299	1358	1420	1485	1549
Child Support Officer II	1212	1269	1327	1387	1452	1516	1583	1656	
Collection Services Supvr. I	1387	1452	1516	1583	1656	1734	1814	1894	
Community-Service Aide	596	625	654	683	712	741	777		
Coordinator of Aging	908	950	995	1039	1084	1136	1187	1241	1299
Dev. Achievement Center Inst.	712	741	777	813	849	887			
Family Service Aide I	712	741	777	813	849	887			
Family Service Aide II	777	813	849	887	929	973	1017	1063	
Family Service Coord. I	973	1017	1063	1109	1161	1212	1269		
Family Service/Home Health Aide	712	741	777	813	849	887			
Finan.-Assistance Specialist	1136	1187	1241	1299	1358	1420	1485	1549	
Finan.-Assistance Supvr. I	1327	1387	1452	1516	1583	1656	1734	1814	1894
Finan.-Assistance Supvr. II	1452	1516	1583	1656	1734	1814	1894	1982	2068

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Financial Worker I	887	929	973	1017	1063	1109	1161	1212	1269
Financial Worker II	995	1039	1084	1136	1187	1241	1299	1358	1420
Fiscal Officer	1136	1187	1241	1299	1358	1420	1485	1549	1620
Fiscal Supervisor I	1241	1299	1358	1420	1485	1549	1620	1696	1777
Fiscal Supervisor II	1387	1452	1516	1583	1656	1734	1814	1894	1982
Home Health Aide	712	741	777	813	849	887			
Home Health Aide Coordinator	973	1017	1063	1109	1161	1212	1269		
Housekeeper	Rate proposed by appointing authority and approved by the merit system supervisor and the Commissioner of Public Welfare.								
Housing Coordinator	1109	1161	1212	1269	1327	1387	1452	1516	1583
Licensed Practical Nurse	950	995	1039	1084	1136	1187			
Public Health Aide	596	625	654	683	712	741	777		
Residential Facility Operator(s)	741	777	813	849	887	929	973	1017	
Senior Case Aide	995	1039	1084	1136	1187	1241	1299	1358	1420
Senior Citizen's Aide	596	625	654	683	712	741	777		
Transportation Coordinator	908	950	995	1039	1084	1136	1187	1241	
Welfare Fraud Investigator	1387	1452	1516	1583	1656	1734	1814		
Welfare Fraud Unit Supervisor	1516	1583	1656	1734	1814	1894	1982		

2. Plan B. The following salary steps in monthly salary amounts shall be applicable to the specified classes of positions. The salary steps shall not include any amounts paid by any county board under Minnesota Statutes, section 471.61.

	1	2	3	4	5	6	7	8	9
Account Clerk	908	950	995	1039	1084	1136	1187	1241	
Accounting Technician	973	1017	1063	1109	1161	1212	1269	1327	

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Adult Day Care Center Prog. Coord.	929	973	1017	1063	1109	1161	1212	1269	1327
Asst. Residential Facility Opr.(s)	741	777	813	849	887	929	973	1017	
Case Aide	929	973	1017	1063	1109	1161	1212	1269	1327
Chemical Dependency Counselor	1187	1241	1299	1358	1420	1485	1549		
Child Health Aide	813	849	887	929	973	1017	1063	1109	
Child Support Officer I	1136	1187	1241	1299	1358	1420	1485	1549	1620
Child Support Officer II	1269	1327	1387	1452	1516	1583	1656	1734	
Collection Services Supvr. I	1452	1516	1583	1656	1734	1814	1894	1982	
Community-Service Aide	625	654	683	712	741	777	813		
Coordinator of Aging	950	995	1039	1084	1136	1187	1241	1299	1358
Dev. Achievement Center Inst.	741	777	813	849	887	929			
Family Service Aide I	741	777	813	849	887	929			
Family Service Aide II	813	849	887	929	973	1017	1063	1109	
Family Service Coord. I	1017	1063	1109	1161	1212	1269	1327		
Family Service/Home Health Aide	741	777	813	849	887	929			
Finan.-Assistance Specialist	1187	1241	1299	1358	1420	1485	1549	1620	
Finan.-Assistance Supvr. I	1387	1452	1516	1583	1656	1734	1814	1894	1982
Finan.-Assistance Supvr. II	1516	1583	1656	1734	1814	1894	1982	2068	2163
Financial Worker I	929	973	1017	1063	1109	1161	1212	1269	1327
Financial Worker II	1039	1084	1136	1187	1241	1299	1358	1420	1485

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Fiscal Officer	1136	1187	1241	1299	1358	1420	1485	1549	1620
Fiscal Supervisor I	1241	1299	1358	1420	1485	1549	1620	1696	1777
Fiscal Supervisor II	1387	1452	1516	1583	1656	1734	1814	1894	1982
Home Health Aide	741	777	813	849	887	929			
Home Health Aide Coordinator	1017	1063	1109	1161	1212	1269	1327		
Housekeeper	Rate proposed by appointing authority and approved by the merit system supervisor and the Commissioner of Public Welfare.								
Housing Coordinator	1161	1212	1269	1327	1387	1452	1516	1583	1656
Licensed Practical Nurse	995	1039	1084	1136	1187	1241			
Public Health Aide	625	654	683	712	741	777	813		
Residential Facility Operator(s)	777	813	849	887	929	973	1017	1063	
Senior Case Aide	1039	1084	1136	1187	1241	1299	1358	1420	1485
Senior Citizen's Aide	625	654	683	712	741	777	813		
Transportation Coordinator	950	995	1039	1084	1136	1187	1241	1299	
Welfare Fraud Investigator	1452	1516	1583	1656	1734	1814	1894		
Welfare Fraud Unit Supervisor	1583	1656	1734	1814	1894	1982	2068		

3. Plan C. The following salary steps in monthly salary amounts shall be applicable to the specified classes of positions. The salary steps shall not include any amounts paid by any county board under Minnesota Statutes, section 471.61.

	1	2	3	4	5	6	7	8	9
Account Clerk	950	995	1039	1084	1136	1187	1241	1299	
Accounting Technician	1017	1063	1109	1161	1212	1269	1327	1387	
Adult Day Care Center Prog. Coord.	973	1017	1063	1109	1161	1212	1269	1327	1387

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Asst. Residential Facility Opr.(s)	777	813	849	887	929	973	1017	1063	
Case Aide	973	1017	1063	1109	1161	1212	1269	1327	1387
Chemical Dependency Counselor	1241	1299	1358	1420	1485	1549	1620		
Child Health Aide	849	887	929	973	1017	1063	1109	1161	
Child Support Officer I	1187	1241	1299	1358	1420	1485	1549	1620	1696
Child Support Officer II	1327	1387	1452	1516	1583	1656	1734	1814	
Collection Services Supvr. I	1516	1583	1656	1734	1814	1894	1982	2068	
Community-Service Aide	654	683	712	741	777	813	849		
Coordinator of Aging	995	1039	1084	1136	1187	1241	1299	1358	1420
Dev. Achievement Center Inst.	777	813	849	887	929	973			
Family Service Aide I	777	813	849	887	929	973			
Family Service Aide II	849	887	929	973	1017	1063	1109	1161	
Family Service Coord. I	1063	1109	1161	1212	1269	1327	1387		
Family Service/Home Health Aide	777	813	849	887	929	973			
Finan.-Assistance Specialist	1241	1299	1358	1420	1485	1549	1620	1696	
Finan.-Assistance Supvr. I	1452	1516	1583	1656	1734	1814	1894	1982	2068
Finan.-Assistance Supvr. II	1583	1656	1734	1814	1894	1982	2068	2163	2264
Financial Worker I	973	1017	1063	1109	1161	1212	1269	1327	1387
Financial Worker II	1084	1136	1187	1241	1299	1358	1420	1485	1549
Fiscal Officer	1136	1187	1241	1299	1358	1420	1485	1549	1620

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Fiscal Supervisor I	1241	1299	1358	1420	1485	1549	1620	1696	1777
Fiscal Supervisor II	1387	1452	1516	1583	1656	1734	1814	1894	1982
Home Health Aide	777	813	849	887	929	973			
Home Health Aide Coordinator	1063	1109	1161	1212	1269	1327	1387		
Housekeeper	Rate proposed by appointing authority and approved by the merit system supervisor and the Commissioner of Public Welfare.								
Housing Coordinator	1212	1269	1327	1387	1452	1516	1583	1656	1734
Licensed Practical Nurse	1039	1084	1136	1187	1241	1299			
Public Health Aide	654	683	712	741	777	813	849		
Residential Facility Operator(s)	813	849	887	929	973	1017	1063	1109	
Senior Case Aide	1084	1136	1187	1241	1299	1358	1420	1485	1549
Senior Citizen's Aide	654	683	712	741	777	813	849		
Transportation Coordinator	995	1039	1084	1136	1187	1241	1299	1358	
Welfare Fraud Investigator	1516	1583	1656	1734	1814	1894	1982		
Welfare Fraud Unit Supervisor	1656	1734	1814	1894	1982	2068	2163		

C. Clerical

1. Plan A. The following salary steps in monthly salary amounts shall be applicable to the specified classes of positions. The salary steps shall not include any amounts paid by any county board under Minnesota Statutes, section 471.61.

	1	2	3	4	5	6	7	8
Bkkp. Machine Operator	704	734	766	801	839	877	917	959
Clerical Supervisor	857	895	937	982	1027	1073	1119	1172
Clerk I	616	645	676	704	734	766	801	839
Clerk II	704	734	766	801	839	877	917	959

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Clerk III	784	821	857	895	937	982	1027	1073
Clerk-Typist I	645	676	704	734	766	801	839	877
Clerk-Typist II	704	734	766	801	839	877	917	959
Clerk-Typist III	784	821	857	895	937	982	1027	1073
Clerk Specialist	857	895	937	982	1027	1073	1119	1172
Clerk-Steno I	676	704	734	766	801	839	877	917
Clerk-Steno II	766	801	839	877	917	959	1004	1049
Clerk-Steno III	821	857	895	937	982	1027	1073	1119
Information Systems Specialist	784	821	857	895	937	982	1027	1073
Keypunch Operator	676	704	734	766	801	839	877	917
Swbd. Opr. I	704	734	766	801	839	877	917	959
Swbd. Opr. II	748	784	821	857	895	937	982	1027

Employees in the class of Clerk-Typist I who are assigned on a full-time basis to transcribing machine operation may be paid within the county range for Clerk-Stenographer I.

2. Plan B. The following salary steps in monthly salary amounts shall be applicable to the specified classes of positions. The salary steps shall not include any amounts paid by any county board under Minnesota Statutes, section 471.61.

	1	2	3	4	5	6	7
Bkkp. Machine Operator	801	839	877	917	959	1004	1049
Clerical Supervisor	982	1027	1073	1119	1172	1223	1281
Clerk I	704	734	766	801	839	877	917
Clerk II	801	839	877	917	959	1004	1049
Clerk III	895	937	982	1027	1073	1119	1172
Clerk-Typist I	734	766	801	839	877	917	959
Clerk-Typist II	801	839	877	917	959	1004	1049
Clerk-Typist III	895	937	982	1027	1073	1119	1172

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Clerk Specialist	982	1027	1073	1119	1172	1223	1281
Clerk-Steno I	766	801	839	877	917	959	1004
Clerk-Steno II	877	917	959	1004	1049	1094	1147
Clerk-Steno III	937	982	1027	1073	1119	1172	1223
Information Systems Specialist	895	937	982	1027	1073	1119	1172
Keypunch Operator	766	801	839	877	917	959	1004
Swbd. Opr. I	801	839	877	917	959	1004	1049
Swbd. Opr. II	857	895	937	982	1027	1073	1119

Employees in the class of Clerk-Typist I who are assigned on a full-time basis to transcribing machine operation may be paid within the county range for Clerk-Stenographer I.

3. Plan C. The following salary steps in monthly salary amounts shall be applicable to the specified classes of positions. The salary steps shall not include any amounts paid by any county board under Minnesota Statutes, section 471.61.

	1	2	3	4	5	6	7	8	9
Bkkp. Machine Operator	877	917	959	1004	1049	1094	1147		
Clerical Supervisor	1073	1119	1172	1223	1281	1340	1400		
Clerk I	766	801	839	877	917	959	1004		
Clerk II	877	917	959	1004	1049	1094	1147		
Clerk III	982	1027	1073	1119	1172	1223	1281		
Clerk-Typist I	801	839	877	917	959	1004	1049		
Clerk-Typist II	877	917	959	1004	1049	1094	1147		
Clerk-Typist III	982	1027	1073	1119	1172	1223	1281		
Clerk Specialist	1073	1119	1172	1223	1281	1340	1400		
Clerk-Steno I	839	877	917	959	1004	1049	1094		
Clerk-Steno II	959	1004	1049	1094	1147	1198	1252		
Clerk-Steno III	1027	1073	1119	1172	1223	1281	1340		

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Information Systems Specialist	982	1027	1073	1119	1172	1223	1281
Keypunch Operator	839	877	917	959	1004	1049	1094
Swbd. Opr. I	877	917	959	1004	1049	1094	1147
Swbd. Opr. II	937	982	1027	1073	1119	1172	1223

Employees in the class of Clerk-Typist I who are assigned on a full-time basis to transcribing machine operation may be paid within the county range for Clerk-Stenographer I.

D. Maintenance and trades

1. Plan A. The following salary steps in monthly salary amounts shall be applicable to the specified classes of positions. The salary steps shall not include any amounts paid by any county board under Minnesota Statutes, section 471.61. Janitors who are required to work for a period of at least five hours after 6 p.m. on a regularly scheduled basis may be paid a shift differential in the amount of one salary step above their normal day-work rate.

	1	2	3	4	5	6	7
Auto Driver	735	768	801	834	870	907	947
Bus Driver	801	834	870	907	947	986	1027
Janitor	801	834	870	907	947	986	1027
Laborer	$4.60/hour						
Maintenance Worker	834	870	907	947	986	1027	1074

2. Plan B. The following salary steps in monthly salary amounts shall be applicable to the specified classes of positions. The salary steps shall not include any amounts paid by any county board under Minnesota Statutes, section 471.61. Janitors who are required to work for a period of at least five hours after 6 p.m. on a regularly scheduled basis may be paid a shift differential in the amount of one salary step above their normal day-work rate.

	1	2	3	4	5	6	7
Auto Driver	947	986	1027	1074	1119	1166	1218
Bus Driver	986	1027	1074	1119	1166	1218	1270
Janitor	947	986	1027	1074	1119	1166	1218

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2.841

12 MCAR S 2.841 Provisions for computing monthly, hourly, less-than-full-time, bi-weekly, and four week salary rates.

Salary conversion tables. The supervisor shall publish a salary conversion table as part of the Minnesota Merit System Manual. The table shall list all existing salary rates listed in 12 MCAR S 2.840. For those salary rates, the supervisor shall calculate hourly, daily and payroll period salaries for each of the salary rates listed. This table shall be based on an 8-hour day, 40-hour week and 2088-hour year. Agencies with a normal work schedule which varies from an 8-hour day, 40-hour week or 2088-hour year or agencies with payroll periods other than once every two weeks, every four weeks, or every month, shall supply the supervisor with a salary conversion table.

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